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ERRATA
Unfortunately, the last issue of Torture contained a misprint on page 108 in the book review: Violation of medical neutrality. The second column, starting on line 6, should read: "After outlining the history of international humanitarian law from the 1860s, he described the Geneva Conventions of 1949 and the Additional Protocols adopted in 1977."

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APPALLING PRISON CONDITIONS

Anyone who is engaged in combatting torture witnesses the continuous piling up of two sets of reports: one about the widespread use of torture in many countries (and unfortunately new countries are still being added), the other on the conferences and new centres that are dedicated to the rehabilitation of torture victims.

It is as if the evil and the good forces are in perpetual competition. If someone should feel inclined to connect our century with humanitarianism (because international Human Rights were born in about 1950), it is more than evident that a multitude of conflicts will be solved without respect for humanity, none whatsoever.

But the degree to which the message of Human Rights is disregarded is depressing. Doctors are in the forefront, but their limited power can be witnessed every day in thousands of prisons all over the world, where they are forced to falsify medical documents, and where inmates, whether they are there for criminal or other offences, suffer appalling prison conditions without justification, including lack of visits by a medical doctor, lack of medicine, if indeed they are not exposed to torture.

Human Rights Watch is one of the many private aid organizations, not actually in action, but collecting invaluable information on Human Rights abuses from some 60 countries of the world. Based on the Helsinki Final Act of 1975 — when East and West agreed to improve Human Rights on the condition that the borders of Europe should be left unchanged — Human Rights Watch has grown and is today widely appreciated for its many reports.

A recent report dealt with prison conditions in 20 countries. Maybe few of the readers of this magazine doubt that millions who spend at least part of their lives behind bars are confined in conditions of filth and corruption, and in circumstances where violence is frequent. It is told in plain words in the Global Report on Prisons*.

When Human Rights Watch launched its prison project six years ago, some Human Rights groups had not extended their concern to suspects in cases of common crime. United Nations bodies also focused almost exclusively on political dissenters among the prisoners. Likewise, many activities against torture have the political dissenters in mind.

The report confirmed earlier ones in stating that overcrowding and inadequate conditions cause a great deal of suffering among the world’s prison population. Conditions are often so severe that inmates, especially in pre-trial facilities, have almost no place to sit or room to move. Even turning over while asleep, or stretching, is impossible in some prison cells. In Jamaica, 19 men were confined in an eight-by-seven foot room; three of them died of asphyxia. Prisoners in Russia, the United States, Egypt, Britain, Kenya, Brazil, Peru, and Poland also suffer from overcrowding.

The repression is so strong in some countries, such as China, Syria, and Malawi, that Human Rights groups are not allowed to operate openly. It is worth mentioning that the UN Human Rights Covenant (the one on Civil and Political Rights) of 1966 (in its art. 10) stipulates that “all persons deprived of their liberty shall be treated with humanity and respect for the inherent dignity of the human person”. That goes for any kind of prisoner!

The UN Committee against Torture (CAT), in an account on Turkey, recently expressed its concern at the number and substance of torture allegations that were still received. It considers that torture is used systematically when it is seen to be habitual. It is not used just here and there in Turkey — it is widespread and deliberate. The Committee’s viewpoint is important: “It is of a systematic character, even if it is not resulting from the direct intention of the Government”.

About a year ago, the European Torture Prevention Committee [the Council of Europe’s committee, called CPT] said almost the same thing, but with other words and in more detail, especially with respect to the torture instruments that were found at police headquarters in Ankara and Diyarbakir. Turkey, among other countries, also has disgusting prisons: cells infested with rats, mice, and insects, lack of water, horrible food, even collective beatings. Despite a legal reform in 1992, according to which ordinary suspects in pre-trial detention, in contrast to political detainees, should have immediate access to attorneys, detainees are routinely barred from such access.

The UN Committee took note, with satisfaction, that the Turkish authorities cooperated during the Committee’s visit to Turkey and congratulated them on having acted on many of its recommendations, which were intended to reinforce the implementation of the UN Convention against Torture.

In countries where torture is no longer used, there is almost always a very long road just to have the torture perpetrators barred from work — let alone punished. The VI International Symposium on Torture as a Challenge to the Medical and other Health Professions, held in Buenos Aires in October 1993, dealt thoroughly with that aspect.

Even if torture has now been abandoned in Argentina — where the navy in particular was feared for many years because of its systematic and brutal torture — thousands of people are still frustrated because none of the responsible people has been put on trial. It is good that Argentina was able and willing to arrange an international symposium dealing with torture victims, but it is depressing for the population to be forced to accept no justice with respect to past crimes.

As a counterweight to all these depressing accounts, here is some more encouraging news. Two new centres dealing with torture victims have opened during 1993, in Tirana (Albania) and Cairo. Torture in Egypt is unfortunately still used by the authorities, but there have been no recent accounts of torture from Albania.

Argentina is now enjoying her longest period of democracy — since 1983. It is even being developed through the appointment of an ombudsman, and a new constitution is to be written in 1994, giving the opposition more rights.

Finally, Chile has witnessed the conviction of the former chief of the political police (DINA), General Manuel Contreras, recently sentenced to seven years’ imprisonment for having ordered the murder of the former Chilean Foreign Minister, Orlando Letelier. He was killed in the explosion of his car in Washington in 1976. Justice came — however late — thanks to the efforts of the sister and son of the late Letelier. That this crime could be exempted from the amnesty granted to the torturers and murderers from the time of General Pinochet may encourage a few others.

Small glimpses of hope for a world that is still characterized mostly by violence and disrespect for the individual.

The Buenos Aires Symposium on Torture
A Challenge to the Medical and other Health Professions

By
Else Thorsig*
Henrik Marcussen*
Henrik Dr/Jcker*

The VI International Symposium on Torture as a Challenge to the Medical and other Health Professions, organized by the IRCT [International Rehabilitation Council for Torture Victims, Copenhagen] in collaboration with the EATIP [Equipo Argentino de Trabajo e Investigación Psicosocial, Buenos Aires], took place at the Centro Cultural General San Martin in Buenos Aires, Argentina, 20-22 October 1993.

About 250 medical doctors and others connected with the health profession took part. There were 150 participants from Argentina, 10 from Chile, 11 from Uruguay, and 16 from 12 other Latin American countries. With the exception of Honduras and Guatemala, with which communication went wrong, participants came from all the Latin American countries with which IRCT and/or EATIP had contact. In all, 49 countries were represented. These naturally left their mark on the discussions.

The symposium was divided into three parallel sessions, held in three different halls plus two individual workshops. More than 130 papers were presented by participants from 49 different countries with various political and cultural backgrounds from all parts of the world.

The participants exchanged views and experiences on the rehabilitation of torture survivors and agreed that, through their presence at the symposium, they were taking another step forward in the worldwide fight for Human Rights. Simultaneously, the symposium reflected the continuous search for a broader commitment to the fight against torture.

Aspects of IMPUNITY were high on the symposium's agenda. They were brought forward not only through various presentations of the subject. In addition, concrete case stories, with evidence of torture being carried out by health professionals, were handed over for further action. The symposium stated and reconfirmed that IMPUNITY, unfortunately, was still common practice in many countries.

Endeavours should be continued to strengthen and broaden the ethical commitment made in 1987, when the Argentine Health Ethics Tribunal was set up.

Intercontinental reports played an essential role in the contributions, which gave a good picture of how rehabilitation work stands today: the progress made by those who started early, and the way in which new centres define and handle the work. The contributions described the variations caused by cultural differences, economy, and special local problems. In Latin America, as mentioned, IMPUNITY played an essential role in the new social order - in the new Eastern European democracies the focus was put on helping the victims of the Soviet suppression, especially the Gulag victims and maltreated soldiers. But for these nations it was also essential to get to know how one could help the torture victims among the refugee
contingents which these countries must prepare themselves to receive in the future.

Indirectly, this sixth international congress also showed that the rehabilitation idea is firmly established. The idea was not questioned and there were no expressions of not understanding the problems involved, as there were a few years back, when a lot of time was used at international meetings to explain the importance of rehabilitation work, not least as a stabilizing process for a democratic development of society.

The participants at the symposium were urged to work for more awareness of the consequences of impunity on the torture victims and their families. They should try to break the silence of the press on this important issue. A silence which is first and foremost a local problem. Some countries, however, are more aware of this than others. The international community should see to it that the responsibility for torture is never forgotten.

Diana Kordon expressed this succinctly in her speech at the closing session: “We would like to propose that this seminar will publicly express its opposition to any kind of impunity and express the demand for the governments to make sanctions against torturers, considering that democracy is unattainable as long as torture continues to be an unpunished crime.”

This issue of Torture carries some contributions from the VI International Symposium. They include the opening address by Professor Erik Holst, IRCT’s executive vice president, and the speech, at the closing plenary session, by Professor Diana Kordon, psychiatrist, EATIP, the rehabilitation centre in Buenos Aires, which, together with IRCT, is thanked for a successful and constructive congress.

*IRCT
* Copenhagen

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Nobel Peace Prize Laureate Adolfo Perez Esquivel, Buenos Aires (left), together with Darío Manuel Lagos and Diana Kordon, psychiatrists, both from EATIP.

Erik Holst: Opening address

Healing the wounds – correcting the injustice

The practice of torture as part of political repression is unfortunately an old and widespread phenomenon, whereas the existence of services for victims of torture is a rather recent phenomenon.

Such services are, however, now available in a large number of industrialized as well as Third World countries.

The IRCT supports a network of rehabilitation centres and programmes for victims of torture and promotes both training and research to improve such services and make them available to the rapidly increasing number of victims of torture, who can be identified whenever a repressive political system is giving way to democratically elected governments and respect for human rights.

So we are facing the paradox that the number of victims seeking treatment and rehabilitation increases with each new country that moves from autocratic government to democracy.

This is a process that we have witnessed in Latin America and most recently in Central and Eastern Europe. And a process that is under way in Central and Southern Africa.

So the challenge to the health professions is clearly one of developing and providing relevant somatic and psychosocial services to this new group of patients: survivors of torture.

But torture is also a challenge to the health professions in that individual members of these professions run a risk of becoming involved directly or indirectly in the practice of torture. The health professions therefore have a duty to protect their colleagues against pressure to become involved in torture and to condemn those colleagues who violate their ethical obligations by using their medical knowledge against the interests of their patients or fellow human beings.

The health professions finally have an obligation to denounce the practice of torture whenever they meet cases that must be classified as victims of torture, and as professional organizations speak up against such violations of human rights.

Torture is a cancer on society which should be prevented at all costs and through continued social action for a civilized society.

Where prevention has failed it becomes the duty of a democratic society to do its utmost to help heal the wounds and correct the injustice as far as possible.

People from all over the world have come here to share the collective knowledge accumulated in this field over the ten years of its existence.

It is our hope that the conference will contribute to the spread of awareness of the problem and the possibility of somatic and psychosocial intervention – both in Argentina and around the world.

Erik Holst is Chairman of RCT and Executive Vice President, IRCT.
The awareness of the scourge of torture

Speech at the Closing Plenary – 22 October 1993

By Diana Kordon*

More than 130 abstracts from 43 countries, from all latitudes, from very different cultures and social and political backgrounds, have been presented at the seminar. Representatives from almost every country in Latin America participated as well as colleagues and students from 14 Argentine provinces and from the capital, Buenos Aires.

Today, torture and political repression are used systematically in numerous countries in the world. Not only psychotherapists but also a variety of specialized medical doctors have participated in this VI International Symposium on Torture as a Challenge to the Medical and Other Health Professions.

The great attendance at the seminar of health professionals from Argentina also showed how the care for validity of human rights and the worry about torture continue to be of current interest in our community and in the world in spite of the impunity and the mantle of silence and oblivion which seem to be returning to society.

Invitation to this seminar was open to the professional community as a whole, to the formal institutions in the health system, and to all those who are making developments within the health system and within human rights. In this connection, support and wide public commitment of the professional community is of great interest in the fight against torture and for validity of human rights and justice.

Regrettably, during many years, the professional institutions which, through concrete measures, pronounced against medical doctors who had been involved in the complicities with the repression, were few. Nevertheless, we hope that this seminar will help us to assume this ethical compromise, conveyed in concrete decisions which have an affect on the possibility of these medical doctors to continue to use their profession in practice.

In the same way that the “Tribunal Ético de la Salud contra la Impunidad” [Argentine Health Ethics Tribunal against Impunity], of which we were coorganizers in 1987, was a most important reference instrument to promote the ethical compromise of the professionals within this subject, this seminar can open a new era to strengthen and amplify this ethical compromise.

During the sessions of the seminar, the multidisciplinary character of our work became evident, and so did the efforts to understand the plurality of cultures and the consequences of these differences in the modalities assumed by torture, as well as the way of conceiving the task to assist human beings who have been suffering from torture.

The character of the subject we deal with has had the result that, simultaneously with the process of discussion and reflection, we all had moments when we, with more or less intensity, went through painful experiences, through irruption of memories of traumatic situations, i.e. moments in which emotions affected us.

During the whole seminar, we have seen a great, active attendance both in the numbers of people present and in the numbers participating in the discussions.

It is also interesting to mark the great participation of young people because, in the same way that the trauma can be transmitted to them, it is also possible to transmit the experiences for the possibilities of mending the trauma and to stimulate the motivation in order to continue with the compromise of articulating the professional experience with the demand for justice and the abolition of torture.

Thus we think that this seminar has brought us a step forward as regards the health professionals’ search for an ethical compromise to the problems of human rights, and particularly as regards the awareness of the scourge of torture. The seminar also constituted a sphere of reflection and interchange in the search for ways to make us able to contribute, on the basis of our specific professional roles, to diminish the pain of those who are suffering from violations of human rights all over the world.

From this point of view, we have got to know very different experiences corresponding with conceptual models and different cultures. We have also been able to talk about the necessity of not splitting the phenomenon “torture” from the social, economic, and political reasons which determine the use of torture and the psychosocial derivations affecting the whole population.

The problem of impunity has been dealt with, not only through the abstracts but also through testimonies. Regarding the professional camp in Argentina, we have received the report from our colleagues in the province of Neuquén where a group of medical doctors now find themselves prosecuted for having reported on a hospital manager participating in violation of human rights; again vivid testimonies from colleagues.

As in many other countries, it has become evident how the owners of the Argentine press keep quiet about this seminar, while hundreds of reporters are scared and threatened. Anyway, we intend to fight to obtain publication of the realization of the seminar and its characteristics in order to break the silence.

We would like to propose

1) that this seminar reaffirms the Declaration of Istanbul which led to a very strong appeal to the United Nations in order to motivate them to take action for the protection of torture victims as well as to induce legal sanctions against the torturers.

2) that all of us participants commit ourselves to fight to obtain the possibility of making pronouncements in the professional institutions to which we belong.

3) that the Organizing Committee elaborates a report on this seminar to be distributed in each of the countries participating in this seminar.

4) that this seminar, by adopting the spirit of the “Argentine Health Ethics Tribunal against Impunity” of 1987, will make the professional community begin to make sanctions against medical doctors and other health professionals who might have been involved in any kind of torture in Argentina or elsewhere in the world.

* Argentine Health Ethics Tribunal against Impunity.
5) that this seminar will publicly express its opposition to any kind of impunity and express the demand for the governments to make sanctions against torturers, considering that democracy is unattainable as long as torture continues to be an unpunished crime.

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The role of the medical profession
Doctors responsible for prisoners’ medical care in South Africa

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

What has been the role of the medical profession in the face of the human rights abuses involving political prisoners under South Africa’s security laws?

While there is some evidence for the active collaboration of medical personnel in security police torture in the banquet, it has generally been through acts of omission that doctors have been implicated in torture in South Africa.

The medical care, and, by implication, the psychological needs of political prisoners have been the responsibilities of South Africa’s district surgeons. District surgeons are appointed by the State and charged with certain statutory duties, such as the performance of postmortem examinations, disability grant assessments and medico-legal documentation. As part of their statutory duties, they provide services to South African prisons.

The majority of district surgeons have little specific training for their positions, and in rural areas are often private practitioners who perform district surgeon duties on a sessional basis.

Full-time prison doctors are thus not available in South Africa, and most district surgeons are poorly equipped to deal with psychological sequelae of physical or mental torture.

District surgeons are often the only access prisoners will have to anyone other than their interrogator under the arduous conditions of section 29. Despite the great potential for preventive and promotive interventions, district surgeons have generally shown little enthusiasm for this role. This reluctance, coupled with the fact that district surgeons are almost always white and usually Afrikaans-speaking, has meant that they are often seen by detainees and political prisoners as part of the “system” and viewed as closely associated with the security police.

Reports obtained from prisoners released recently from longterm detention and imprisonment tell routinely of assaults at the hands of security forces at the time of their initial arrest and interrogation. It is disturbing to note the consistency of their perceptions of district surgeons “working with the security police” who were therefore not to be trusted, and who could not be asked to intervene on the prisoner’s behalf to prevent further assaults or torture. One released prisoner recounted how, when he had informed the district surgeon of his torture, information he had revealed to the doctor was subsequently used against him by his interrogators.

While district surgeons in South Africa are accountable to the structures of the Department of Health, they are also required to submit a report on the detainee’s health to the Director of Security Legislation and to the Police Commissioner. This places them in an invidious position in terms of their ethical responsibilities to their prisoner-patients.

However, it is clear that ethical responsibilities should not be allowed to be subordinated to legal requirements when such actions will lead to human rights abuses. Unfortunately, as the case of Steve Biko illustrated, what happens in practice behind the closed doors of the interrogation centres is that district surgeons all too frequently allow themselves to be controlled by the security forces.

In reviewing examples of deaths in detention, Veriawa has identified nine
areas of omission in the medical care of detainees that imply complicity with torture (Table I). Some examples of these are contained in Appendix IV.

Legalistic approach
Neither the exposure of the unethical behaviour of the district surgeons involved in the care of Steve Biko, nor the many calls for support and guidance from the profession seem to have resulted in a fundamental change in approach by South Africa’s district surgeons. Rather, where they have responded, they have tended to become legalistic in their approach, asking questions of detainees under their care in order to protect themselves from possible legal and ethical consequences without acting on evidence of physical or psychological trauma. Nor has this response had any impact on the safety of South Africa’s detainee and prisoner population, of which three detainees from the profession seem to have implicated the police.

The council’s ham-handed failure in 1985 and 1986, during the height of the crisis, and the bulk of its members, remained aloof from the question of torture at the hands of the security. Massey and Tate were never informed of their rights to see a prisoner who wished to see a practitioner other than the district surgeon. The council’s decision to take action against doctors associated with human rights abuses involving political prisoners in October 1991 is essentially conservative or indifferent to the need to take action on the Biko doctors. As a result of disillusionment with both SAMDC and MASA, many progressive-minded medical personnel began to direct their energies into other health organisations with a vision of a non-racial democratic South Africa where human rights would be guaranteed.

The organised medical profession
The South African Medical and Dental Council (SAMDC) is the statutory body responsible for the maintenance of ethical and academic standards in the medical and allied professions and is comprised mainly of State appointees. The council’s ham-handed failure in 1977 to take action against the doctors involved in the care of Steve Biko, despite widespread public outrage and prima facie evidence of misconduct by the doctors concerned, earned it unprecedented condemnation both from within the medical profession and from the public.

A closer examination of the nature of voting on the council’s decision showed that the vast majority of appointed members of the council opposed any further action on the Biko issue, supporting claims that the SAMDC was assisting the cover up of Steve Biko’s torture at the hands of the security police. The continuing failure of the council to take action against doctors associated with human rights abuses involving political prisoners has made it futile to direct complaints to the SAMDC about the actions of doctors involved in the care of political prisoners.

At the same time, the Medical Association of South Africa (MASA), the voluntary professional body for doctors in South Africa, sought to distance itself from the need to take action on the Biko doctors. As a result of disillusionment with both SAMDC and MASA, many progressive-minded medical personnel began to direct their energies into other health organisations with a vision of a non-racial democratic South Africa where human rights would be guaranteed.

Progressive health professionals
These included NAMDA (the National Medical and Dental Association) and, later, OASSSA (the Organisation for Appropriate Social Services in South Africa) and SAHWCO (the South African Health Workers Congress). Progressive health professionals have worked consistently to expose the abuses being perpetrated under South Africa’s security laws, as well as directly providing medical and counselling services to released detainees, political prisoners and their families.

In contrast, the bulk of the South African medical profession has remained aloof from the question of torture of political detainees. Throughout 1985 and 1986, during the height of the State of Emergency, the columns of the South African Medical Journal, the mouthpiece of MASA, remained astonishingly silent on the widespread terror inflicted on thousands of ordinary South Africans.

In 1985, however, Dr Wendy Orr brought a court interdict to restrain the police from assaulting prisoners in the Port Elizabeth jails; she was transferred from her position soon after by her seniors. MASA, while acknowledging their concern for the allegations of torture of political detainees, declined to assist Dr Orr in what was clearly an action of victimisation by the State, because she was not a member of MASA.

During the period of mass detentions, MASA negotiated an agreement with the government to establish panels of MASA doctors who would be available to prisoners who wished to see a practitioner other than the district surgeon. The purpose of these panels was to prevent a repeat of the circumstances surrounding Steve Biko’s death. In announcing this agreement in 1985, MASA made it clear that it saw this move as demonstrating the value of ‘negotiation in a responsible and dignified and determined manner instead of resorting to confrontation and media publicity’.

MASA’s commitment to Human Rights at that time was clearly one to be negotiated behind closed doors. The sad reality was that political prisoners were never informed of their rights to consult the panels, or, if they were, chose not to use them because of MASA’s lack of credibility, since, by 1987, MASA itself acknowledged the dismal failure of its panel system.

Since the autumn of 1991, there has been a significant change in the rhetoric and, to some extent, the practice of the MASA, with bold shifts in policy toward clear exposition of human rights issues and concerns for the safety of hunger strikers. In many ways this reflects a broad political phenomenon that is taking place in South Africa today as the prospect of a new government looms. For progressives in the health sector, this poses significant dilemmas in terms of how to respond.

Whilst the leadership of MASA appears genuinely committed to pursuing a course that is reasonably different from its previous history, it is abundantly clear that the bulk of the membership is essentially conservative or indifferent to human rights issues and
happy to tread the middle ground in the present delicate transition period in South Africa.

This article is the last one in a series of three articles from South Africa. The first one was printed in Torture 293, pp. 39-41. The second one was printed in Torture 292, pp. 80-82.

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Torture in Israel and the Occupied Territories

By Jonathan E Fine

Evidence of Israeli physician complicity in the torture of Palestinian detainees was described at the two-day international conference held last month in Tel Aviv and sponsored by the Association of Israeli and Palestinian Physicians for Human Rights [AIPPHR] and the Public Committee Against Torture in Israel. According to Dr Ruchama Martin, founder of AIPPHR, a "Form of Medical Fitness", obtained by an Israeli attorney, Tamar Peleg, and first revealed in the newspaper Davar (May 16, 1993), requires that the physician examining detainees before interrogation indicate whether there are any limitations to use of an isolation cell, binding the prisoner, covering his head and eyes, and subjecting him to prolonged standing. The form also requires that the physician note evidence of physical injuries "before entering interrogation". Amnesty International and B'Tselem, an Israeli human rights organisation, deem that the procedures for which detainees have to be certified fit, and other associated practices constitute torture because of their severity and duration.

Studies by international human rights organisations have revealed that detainees under interrogation may have their heads covered with foulsmelling hoods, be deprived of sleep, be threatened with physical injury (including rape and death) or with torture of members of their families, and, in many cases, be severely beaten. In some cases, documented by international forensic specialists, these practices have resulted in death or have probably contributed to suicide of detainees. Routinely, detainees are forced to sign confessions which are used in military courts to incriminate them. Human rights specialists in Israel estimate that since 1988 Israeli intelligence and military personnel have subjected at least 5000 Palestinians a year to these practices.

Several case-histories were described. One was that of Dr Mambouh Al-Aker, a Palestinian urologist, who appealed to the Medical Association of Israel to investigate and discipline physicians guilty of complicity in the torture of detainees and to condemn these practices. He had been detained in 1991 by the General Security Services
Reacting to torture in Israel

Talk given at the conference “The International Struggle against Torture and the Case of Israel”, Tel Aviv, 13 June 1993

By Stanley Cohen*

Two assumptions

Torture and ill-treatment of Palestinian detainees under interrogation by various Israeli authorities has been routine, systematic, and institutionalized for at least the last five years. In each of these years, 6,000 detainees at the very least have experienced some form of treatment which I would call "low intensity torture" and which is forbidden by international human rights law. This is my first assumption.

The second is that this fact is known by the vast bulk of the politically influential sections of the Israeli population. They do not know all the details; they do not know all the laws; they do not know all the jurisprudential arguments. But they do know the general picture. There are, as we shall see, some ambiguities about using the concept "know" in this context – but for this informed, newspaper-reading public, it will simply not be possible in years to come, when historians research our times, to use those terrible words: "We didn’t know", "No one told us", "It couldn’t have happened without us knowing", (or "It could have happened without us knowing").

What happens to this knowledge? I shall concentrate on the reactions of the two sections of the Israeli population which are actively called on to react: first, those in power, official government circles, decision-makers, spokesmen, and supporters (and here there are no real differences between the two major parties, Likud and Labour), and, second, the group that I will call "Meretz liberals" – those who see themselves as the Israeli representatives of enlightened, democratic, "Western", and liberal values.

The rest of the population is non-reactive. They are not called upon to take a position, nobody ever asks them what they think, and we must assume that their silence means passive acquiescence. They are exercising their basic human right: what Daniel Ellsberg calls "the right not to know."

The authorities

The official government response. Here, there is no real difference from what appeared in the text of the original Landau Commission Report in 1987. There is very little difference from what appears all over the world when governments (especially more or less accountable governments) have to
respond to allegations of torture or other gross human rights violations. Whether it is today – the Turkish government against the Kurds, the Indian government against the Kashmiris – or a decade ago – the Argentinian government against their internal opponents – or the French in Algeria forty years ago, the response is much the same. It is almost as if there is a deep structure, a common vocabulary which governments could be borrowing from each other. There are three fixed components to the response.

- The first component is that “Nothing is happening.” That is, a complete and literal denial of the facts. All allegations and evidence are dismissed as lies, fabrications, fantasies, deliberate disinformation. So journalists who have been interviewing government officials in the last few days about the subject of this conference have been routinely told: “It’s all lies. You have been deceived. Only gullible foreign journalists believe these stories from over-imaginative Arabs or from the Israeli left. There is no torture in Israel: how could there be if we have ratified the Convention Against Torture? It’s not happening; nothing is happening.”

- The second component is: “What is happening is really something else.” That is, the facts are admitted (something is indeed happening), but their meaning is denied, re-interpreted, or re-allocated. What is happening is not torture – not at all – but really something else: what the Landau Commission called “moderate physical pressure” or what the French in Algeria termed “special procedures.” There are many other examples of such administrative euphemism or legal jargon.

- The third component is: “What is happening is completely justified.” That is, these procedures are absolutely necessary – to fight the war against terrorism (or communism or crime or fundamentalism or whatever); to preserve national security; in intelligence gathering, extracting confessions, cracking Hamas cells... and so on. The defence of necessity as a moral and legal justification for torture is, of course, as old as the phenomenon itself. No government in history has ever justified torture by saying that they “like” doing it; torture always has to be justified in instrumental, utilitarian terms (“necessity”).

How was it possible that the same government official, the same judicial commission, the same editorial could, at the same time, say things that appeared to be so patently contradictory? But this puzzle only exists if these elements are seen as separate and logically contradictory. In fact, they are politically dependent on each other. There is a fixed official discourse of torture (and other gross human rights violations); these three elements always complement each other.

This, of course, is what torture victims themselves know very well. They have to struggle on two levels: first, against the official response which says that what they claim to have happened to them never in fact happened, and second, against the official claim that they had done such terrible things that they only got what they deserved. This struggle starts from the moment the interrogator says those terrible words: “Scream as much as you like, no one will believe you when you come out.” And afterwards you are indeed not fully believed – and you are also seen as guilty (“They must have done something”). In the classic response to allegations about an atrocity during the Vietnam war: “They are all lying and anyway the bastards got what they deserved.”

In addition to this fixed three-stage sequence, there are a number of other common official deflections which are shared by a wider circle, even the liberal community. These include:

- “It’s worse elsewhere (e.g. Syria, Iraq...)”
- “Why does the world just pay attention to us?”
- “They use a double standard against us.”
- “Look at the violence they inflict on each other.”
- “We always strictly follow the law.”
- “Yes, there used to be abuses in the past, but the situation is now completely changed.”
- “The abuses are extreme and deviant cases – and the offenders are strictly dealt with.”

Appropriate variations on these deflection techniques are virtually universal and not specific to Israel.

The liberals

The second source of response – the “Meretz liberals”. There are, of course, some honourable exceptions and many in this group have been firm, consistent, and vocal on human rights issues. But on the whole, some qualifying prefix is needed to understand the peculiarly compromised nature of Israeli liberalism. Liberals here are not quite what they are elsewhere.

Torture, in most places in the democratic world, is a quintessentially mainstream liberal issue. There is nothing “radical” or “extremist” in the international struggle against torture associated with organizations such as Amnesty International. But in Israel, the identifiable liberal sectors of the community play no active part in the campaign against torture. The Israeli Bar Association, for example, has been totally silent. The only serious opposition comes from more “radical” and marginal groups. The liberal discourse here is much more similar to the official government position than it should be.

There are, of course, some important differences. First, these liberals cannot and do not say that “nothing is happening”. They admit the facts readily enough; they write about them in their newspapers, plays, and poems; they make films and TV documentaries about them. A large culture is in fact devoted to talking about human rights violations. Second, these groups are genuinely, if only privately, uncomfortable with their knowledge. Unlike the fake “regrets” of government apologists, there is a real sense of moral and psychological unease.

But what do people do when they know something but feel that they really do not want to have this knowledge or do not know what to do about it? Or cannot face its full implications? They do what we all do: we decide – sometimes more, sometimes less consciously – that there are certain subjects that it would be better not to know too much about. How often do we all say “I don’t really want to know about that?”

This process is nicely conveyed in a recent reinterpretation of the Oedipus legend by the British psychiatrist John Steiner. The conventional version of the story is that this is a quest for truth. At first, Oedipus does not know the facts – that he has killed his father, that he has had sexual relations with his mother – but then gradually throughout the drama, the awful truth is revealed. This is taken as a parable for psychotherapy itself: the patient, together with his or her analyst, comes to self knowledge through the painful process of uncovering the truth.

But, suggests Steiner, quite another interpretation of the legend is possible. Sophocles leaves us enough clues to show that Oedipus, as well as the other
main characters in the story – the courtiers (or “government officials”, as we would call them today) – must have known the truth all along. They would have been real schmucks not to have known or at least guessed something of what had happened. But everyone had his or her own interest not to know, to evade the truth. The Oedipus legend then is not about the revelation of truth, but the suppression of truth. The story is a cover-up story – like Watergate, like Iran-Contra. Therefore the question: how much did Nixon or Reagan or Bush really “know”? The ambiguous way we avoid knowing too much about what we know is conveyed nicely in the everyday phrase which is the title of Steiner’s paper: “Turning a Blind Eye”.

And when called upon to react, when someone insistently focuses the eye, these liberals can draw on some universal techniques of deflection. “It’s worse elsewhere”, and, in the case of torture, this is true: the Israeli methods are indeed “moderate”. “Everyone is picking on us”, which is also sometimes true. Then there are some special techniques, notably the liberal version of the line taken by official government “doves”: “Regrettably, these things will happen as long as there is no political solution. Therefore we have to support the security services (and policies such as the mass deportation and the closure of the Occupied Territories) as an unfortunate price to pay for some future peace. In fact, the tougher we are now, the easier it will be to make concessions in Washington”.

There is yet another special twist in the rhetoric of Israeli liberals. After giving all their reasons for their lack of active engagement, they will then assure you: “We are so pleased that there are organizations like B’tselem, doing such a wonderful job. This shows how healthy Israeli democracy is”.

Variations of these reactions are, of course, found elsewhere in the world. But again I want to stress the particularly Israeli context. Most important here is the absence of any real fear of speaking out. Israeli democracy, compared certainly with most regimes under which human rights violations take place, offers its citizens, Jewish citizens especially, enormous protection. The contours of civil liberties are more or less intact: freedom of speech and assembly, academic freedom, no gross censorship. The major inhibition that exists to speaking out in other societies – the fear that you will be next in line, that you will be punished yourself, therefore it is prudent to keep silent – simply does not exist here. What has to be confronted here is the self-imposed silence, the internal inhibitions that prevent people from openly speaking about what they know. George Orwell expressed this nicely many years ago: “Circus dogs jump when the trainer cracks his whip, but the really well trained dog is one that turns his somersault when there is no whip”.

To know and what’s more to act
What can be done about those barriers which prevent private knowledge from being translated into public talk and action?

Obviously we have to keep on writing reports and articles, doing research, documenting stories, collecting evidence, and organizing conferences such as this. But it is doubtful whether the mere accumulation of more information will make much difference at this stage. Neither will new laws in themselves be enough without a supportive culture to enforce them.

What we should do is try to create a climate – a language, an opportunity, a set of procedures – to encourage people to speak out about what they know. I mean the wide circles who are being absorbed and co-opted into the network of secrecy: the soldiers who escort detainees to interrogation wings; the doctors who fill out the forms certifying suspects as being “fit” to be hoivered and tied up; the lawyers and the military court judges who routinely accept confessions which they know were obtained by force. These people collude with what is happening not because there is a threat to their lives or personal security if they refuse to cooperate, but first and foremost because non-compliance is simply beyond their imagination.

Our task is to facilitate non-compliance, to make it easier, even rewarding, for people to speak out and to blow the whistle. One way to do this is to make the price of silence heavier than the price of non-compliance and public reporting. The price for silence should be pressure from the international community, especially the medical, legal, and academic communities.

There is little point any more in repeating the moral and legal arguments about why torture is evil. Guilt, some inner sense of moral responsibility, is a rather poor form of social control compared with shame, i.e. the knowledge or anticipation of condemnation from other people who matter. From the trained professional interrogators (the paid “dirty workers”) to the simplest frightened 19-year-old recruit patrolling the alleys of Gaza, the actors in this story do what they do because they know that they will not feel ashamed in front of their relevant audiences. They will not feel ashamed in front of their immediate superiors, in front of the legal authorities if they come to trial, of their friends and families, even of their putative liberal critics. All these observers allow them their rationalizations, allow them to use their techniques of denial, justification, or evasion.

And these observers in turn – the audience of officials, authorities, critics – will continue to use their rationalizations and denials as long as the powers on which they are dependent do not make them feel ashamed.

There are very few generalizations that hold up in criminology. One is that criminals are symbiotically bound to their audiences, those who have observed them and will judge them. This applies no less to crimes of the state (as we call “human rights violations”) than it does to the conventional crimes of every day. This is why “reacting to torture” is part of the explanation of why torture happens in the first place.

Suggested reading
Moderate physical pressure. Transcript of symposium organized by the Public Commission Against Torture in Israel – Jerusalem, 1990.
The interrogation of Palestinians during the Intifada: ill-treatment, moderate physical pressure or torture? Report by B’tselem (Israeli Information Centre for Human Rights in the Occupied Territories), March 1991.

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Poems and Notes by Donald Madisha, South African Detainee

By Dr Michael Simpson*

These are some of the prison writings of Donald Madisha, who died under very suspicious circumstances in prison in Potgieters Rust, South Africa, on 1st of June 1990. He was one of the last political prisoners arrested, in January 1990, before the SA reforms began. He was held, improperly, in solitary confinement for 4 1/2 months before he was found hanging. At the inquest there was clear evidence of medical mistreatment, and peculiarities in his care. On the last night of his life, around midnight, he began screaming that "they are going to kill me" and that "they" were going to kill his parents and wife. Dr van den Berg, called to see him, claims to have given him a complete physical examination, but while the man was standing up in a dimly lit room, and fully dressed and without any of three policemen who were standing in the cell noticing him doing so.

Then he says he gave him a large intravenous injection of Valium (Diazepam). The man was dead 12 hours later – and no trace of Valium was found in his blood. Heavy reliance was placed on this same doctor’s “expert” evidence that when he examined the man, he has been dead for exactly 20 minutes (otherwise other evidence could place policemen in his cell at the time of death); although there is no method known to science to assess such a period so exactly; and the method he admitted to using: guessing the temperature by placing his hand on the man’s forehead, is totally unreliable and invalid. Although the Professor of Forensic Medicine at Pretoria University was acting as an Assessor (a type of co-judge) he never queried such astonishing evidence. Despite much evidence of mistreatment, the court inquest decided that there was no evidence that anything wrong has been done, or that anyone’s actions or negligence had contributed in any way to the death. The senior lawyer who defended the police and the doctor has since been promoted to a Judge of the Supreme Court. These notes and poems were found on Madisha’s body, except for one of the letters, on the inside of a toilet paper-roll, which had been smuggled out to his family. In it, in English, he says that he is being very well treated, but gives Biblical quotations, which say “Blessed are they who are persecuted” and “The ways of the evil man are cruel” suggesting a very different message. Donald Madisha was a lay preacher at his church, and a teacher, and a member of the liberation struggle, and died in his 20’s.

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The Gods Are.

The Word that inspired creation:
That was God; that was God.
The Spirit that suppressed the gods;
That is holy, that is God; that is God.
The Son that rescued the world;
That was quite God; that was God.
The gods were, the gods are.

Father, give me some valour to serve my God;
Aren't they yours too? Are n't they God too?
The Word that inspired creation;
The Spirit that rescued mankind;
The Son that rescued the world.

Let the pagan utter veracity,
Let him not claim the Trinity,
Three in one, three that differ.
Oneness means nothing but unity;
The gods are, the gods were.

See the song that roams joyful in towns great;
See the hopeless eyes that pray to the sky;
See the woman that sells papers of God across streets;
Have n't they seen God the Son gives it free?
The Word of God the Word, the Son that sent it free,
The gods are. Freedom is, heaven is free.

The Word that reached the poor and misused;
The Son that healed the lame and the blind;
I can see now, I'm free to walk now, O God!
Give all my freedoms.
The gods are. The gods will give. The gods were.

The Widower's Song.

A decade
Within which our intimacy to ameliorate
I honestly endeavoured
The rose I so much weeded,
The rose I earnestly watered.

Sometimes took time to select -
Words good as gold; in respect,
How wrong shall I be to scorn -
The Creator's natural plans untempered,
How dauntless must I mourn;
For the rose I thought, I never shall lose,
The rose I so much weeded,
The rose I so bitterly needed.

Heaven, call me to thy haven,
Who else can I dare need and wed,
What else can I dare give love denied,
How far away can I try and rise -
With this timid love and hope craven.

How far Master?
How far must I?
Sometimes I seek my joy at the bar,
For now many more decades shall I have to go,
This going is no better than real going;
My going,
My coming.

Heaven summon me to thy hall,
Tell me not, when thou shalt call,
Do you expect the path to fall;
How faithful must I mourn?
This demise of my role;
The rose I never thought to lose;
The rose I so much weeded;
The rose I so earnestly watered.
DEATH DIES.

Have you said I'm good?
Tell me then, what went wrong.
Born like I were, good and murky,
Bred like you were, human and odd.
Have you said it? Good.

Can't you see you've been killing the dead,
Sending me to pastures grey, pastures green-abound,
Giving me that education of the "NOTS".
Have you said I'm good, when dead?
Born like I were, dead as grave a grave.

Did you hear my belly groan of void hunger?
Did you hear me confess my empoverished sins—
To the opulent minister, of the Church of God,
Sending me to pastures grey, pastures green-abound.

Remember I'm no spectre as I were,
I'm no shapeless, hopeless and bare,
I'm no more victim of that monster's ignorance,
I've risen aloft from that profound grave of oppression.
Where in its nudity like a babe in its cradle—
Oppression remains,
Born like I am, great and murky,
Bred as I am, human and wise,
Have you said it? Dead.
No, alive!

Death dies.

Have they heard the cry that burst like thunder?
Didn't you see that man who crawled like a crab?
That tense cry emerged from that profound well;
That well of poverty, where in nothing goes well.

That man received that strong blow in that black face;
That furious blow emerged from that master of scorn.

The lost seed.

Where across the greatest seas of peace—
Did this furious wind of sorrow blow from?
What have caused those innocent kind minds—
Of the African gods to abide by these odds?

From that land replete with scorn and pride;
From that massive earth amid vast waters;
From that gruesome land called hypocrisy,
These odds grew.

From that Europe our hope crenned—grew.
Don't you see when black turns our future?
Africans! What went wrong?
Don't you seek to eradicate these seed—
So obstinate and its fury wide?
Can't you see our soil is marred.
Africans! What went wrong?

Hypocrites that suck our mother's wealth,
Parasites that abandon our children's health;
The Bullies in Blue
Torture of Guatemalan street children by the National Police

By Bruce Harris*

Hungry, cold, and feeling very alone, 15-year-old Julio César was scuffling along the downtown streets of Guatemala City. It was about 10 o’clock on a quiet Sunday morning last March, on the 14th. Julio was jolted out of his daydreaming when he was stopped by two armed men in plain clothes whom he recognized as policemen. They asked him for his papers. He had none because he was abandoned 3 years ago and tries to survive on the street. The two policemen got angry and said they were going to take him to the police station (even though the Juvenile Code prohibits taking minors to a police station).

On the way to the station, the cops doubled Julio’s thin left arm behind his back and slowly burned him 29 times with several cigarettes. They left Julio, screaming, lying in the street, and said that if they saw him again they would kill him. Then they simply went on with their “police work”.

There are an estimated 5000 street children in Guatemala, trying to survive on the hostile streets where those who are supposed to protect them have turned out to be their worst enemies. Most of the street children are between the ages of 7 and 14 – pre-pubescent children who have no concept of family or being loved. They are the products and victims of a cruel society that does not see them as children. The police would not do to their dogs what they do to the street children.

Since March 1990, Casa Alianza (known in English as Covenant House) – a private non-governmental organization – has been documenting the violence against the street children of Guatemala City. Unfortunately, it turns out that the great majority of the violence against the more than 5000 abandoned children in Guatemala City is perpetrated by the National Police and the Army.

Action speaks louder than words
It has always been the position of Casa Alianza that it is insufficient just to denounce what is happening. The real work is to collect evidence and present it in a court of law and put the perpetrators behind bars – whether they are uniformed or not. This, of course, has placed Casa Alianza in a lot of trouble. It is very dangerous to protect children in Guatemala City. Guatemala is not known for its sterling record on human rights, and the State’s security apparatus is a law unto itself.

Since 1990, the Legal Aid Office of Casa Alianza has initiated 93 lawsuits, in which 123 policemen and 48 members of the Military are being sued for abuse of authority, torture, and murder of children. The price has been high: one Casa Alianza staff member is dead; three are living in exile in Canada; the brother of one of the agency’s workers was kidnapped; the Casa Alianza Crisis Centre was sprayed with machine gun fire and death threats are almost a regular event. “But, damn it, we are winning!”

In August 1992, for just the second time in the history of Guatemala, Casa Alianza won a court case in which four uniformed policemen were jailed for 12 years for kicking 13-year-old Nahuman Carmona Lopez to death in March 1990. Another policeman was jailed for 10 years for shooting and killing a 15-year-old street boy. A soldier was convicted of abuse of authority for severely beating a 13-year-old boy. We cannot yet speak of “justice” because the carnage continues. But Casa Alianza has made it known to the authorities that if they ever lay a hand on one of “their” kids, Casa Alianza will track them down.

Ears cut off, eyes burned out
But there has been a lot of torture of children; they are generally suffering badly. Casa Alianza is at a loss as to what else they can do and have turned to RCT for help.
Street children have had their ears cut off, their eyes burned out, their tongues severed. Two policemen jumped up and down on a boy's leg until they broke it, and then left him lying and screaming in pain in the street. The children sniff glue to take away their hunger; the police regularly pour it over their heads and into their eyes or over their testicles to "teach them a lesson". Children have also been forced to swallow the plastic bag containing the glue. One policeman poured the highly volatile glue over a boy's head and set fire to it.

And then there are the surviving child victims. What do you tell the boy who has been burned with cigarettes by the police? The pre-puberty children who have continual nightmares because they witnessed their best friend being kicked to death and they were unable to do anything about it? The 14-year-old girl who keeps repeating what her kidnapped teenage boyfriend said to her the last time she saw him alive—"Run, Maria Eugenia, run. Only you and God can save us now". Neither she nor God were able to save him. Maria Eugenia had to identify the tortured and mutilated body of her friend and three other children ten days later.

Policemen arrested – and quickly released

Guatemala was the sixth country in the world to ratify the UN Convention on the Rights of the Child; it is signatory to a series of UN Conventions banning torture. But the state-sponsored torture of children continues in Guatemala. When Casa Alianza makes a public complaint the authorities say they will investigate just to appease international condemnation. But there are never any results.

In the gruesome kidnapping and torture of four minors, ballistics evidence shows that the bullet that was fired into the head of at least one of the street children (after they had been tortured for a 10-day period) was fired by the gun of one of the two police officers Casa Alianza had accused. The policemen were arrested and within 15 days were set free because the Director of the National Police did not want to inform the judge that the murder weapon had been assigned to the policeman. Basically a cover-up.

Francisco still mourns the death of Nahaman some three years later. His "best buddy" was by Francisco's side when the police came running after them. Francisco escaped and later declared that he could hear Nahaman's screams "two blocks away".

The evidence that Casa Alianza provides is undeniable. The State of Guatemala tortures abandoned children. And what is the world going to do about it?

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Photos:
Courtesy of Casa Alianza/Covenant House.

Nahaman Carmona López in intensive care ward, March 1990.

Selected list of publications

received at the IRCT
International Documentation Centre

Towards a more effective United Nations:

Functioning and jurisprudence: the Committee of the Human Rights of Parliamentarians of the Inter-Parliamentary Union / Despouy, Leandro ; Pivot, Christine ; Inter-Parliamentary Union; IPA. - Geneva : IPA [D], 1993:000. - 288 p.

The politicization of the military / Miranda, Felipe B. - Quezon City : University of the Philippines, Center for Integrative and Development Studies ; University of the Philippines Press, 1992:300. - 17 p.


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La tortura en Latinoamérica : sus efectos inmediatos y mediados en el individuo y en la sociedad / Kedon, Diana. - Reflexión ; v. 6, no. 19, 1993:0900. - p. 30-34.

Empowerment programmes for women affected by organised violence / Family Rehabilitation Centre ; FRC. - Colombo : FRC [D], 1993:000. - x1, 25 p. : ill.


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Sexual torture of male victims

Dutch refugee health centre first to examine this subject in detail

By
Harry van Tienhoven*

With the arrival of large groups of refugees in Europe, care providers, lawyers, volunteers, and organizations such as Amnesty International have been confronted with sexual violence as an aspect of torture.

Until now attention has been devoted mainly to sexual violence against women. That men could also be exposed to sexual violence has been considered only to a very limited extent, both in the literature and in the practice of providing care. Care providers from Chile and El Salvador have already described the presence of sexual torture against men in those countries.

However, because these publications are in Spanish, they are not accessible to a wider readership.

Recent publications from Scandinavia and the Netherlands have devoted attention to sexual violence against refugees who have come into contact with care-providing institutions.

I think it is important to consider this topic from the perspective of the practical experiences of the Refugee Health Care Centre [RHCC] in Utrecht, Netherlands, at which I work. The Centre provides primary medical care to refugees who have just arrived in the Netherlands. Moreover, it also offers assistance for medical and psycho-social problems at a later stage.

In an investigation, the staff (physicians, nurses, social workers) were asked to fill in a questionnaire that was intended to show whether they were familiar with the problem of sexual violence against men, and to give some impression of its extent among refugees who are clients at the RHCC.

The questions included: how many clients did you see in 1990 and 1991 who had been the victim of sexual violence? Which countries did they come from? Were there any factors which hindered the discussion of this topic? Based on the answers, interviews were held with a number of staff members. The results have been included in this presentation.

In what follows, I will discuss the following:

- the definition of sexual violence
- the problem of sexual violence
- some conclusions and recommendations.

The definition of sexual violence

With regard to the incidence of sexual violence against men, various figures are mentioned in the literature, varying from 0-76% of the research populations in question.

Sexual violence is seen as a special form of torture because it violates the victim's sexual integrity. But sexual violence is taboo, and this can inhibit both the care provider and the client from talking about it freely.

In defining sexual violence it is possible to proceed from the extent it has on the victim or from a description of the methods used. Lira and Weinstein chose the former definition, and described sexual torture as the use of sexual acts in whatever form with an aggressive intent and resulting in physical or mental injury. The aim is to humiliate the victim and make him uncertain about his sexual ability, thereby damaging his personality.

The second definition derives from Lunde and Ortman, who describe sexual violence as:

- Physical violence: hitting, kicking or applying electric shocks to the sexual organs.
- Physical sexual violence: this involves direct physical contact between torturer and victim or among detainees, such as pawning, anal rape, forced masturbation.
- Psychological sexual violence: interrogation while naked, sexual humiliation and threats.

In the first definition, justice is done to the nature, the intention, and the direct and indirect consequences of sexual violence.

In the second definition, the various methods are clearly described.

One continually encounters three different aspects in the descriptions, namely the intention of the torturer, the experience of the victim, and the interpretation of the care provider/therapist.

Cultural context may also play a role in the experience of the victim: which feelings of shame and disgrace play a role. Also, the torturer will know which methods of torture cause the most damage in his culture.

All these factors will have to be taken into account.

Reactions to the questionnaire

Responses were received from 17 out of a total of 30 reception centres.

In all, they reported having seen 129 clients who had experienced sexual violence. Four of the centres had more than 10 such clients, 2 centres had between 5 and 10 clients, and 11 had less than 5 clients during the period recorded (1990 and 6 months of 1991).

With regard to origin, 55% of the clients came from the Middle East (including Turkey and Iran), 36% from Africa, 5% from South America, and 4% from Asia.

The questionnaires and the interviews made clear that many of the respondents found the definition too broad. The reason was that physical violence (such as hitting with sticks or gun butts) during torture is very common. When such beating also includes the sexual organs and results in injury, this is not necessarily interpreted as sexual violence by either care providers or victims.

In addition, some respondents had become familiar with sexual violence against women, and because this usually implies rape, they assumed that sexual violence against men would take the same form, namely anal rape.

In some countries certain methods of torture are almost general practice. For example, a number of RHCC staff claimed that the application of electric shocks to the penis, testicles or anus is a common method of torture in Turkey. Research by Sahika Yüksel supports this. She carried out research among
ex-political prisoners (16 men and 6 women) in the psychiatric out-patients department in Istanbul. All the men had been sexually tortured. The application of electric current to the genitals was the most common form of torture. The subjects did not find it easy to talk about sexual torture. Often this did not occur during the first interview. Some initially denied that it had taken place and only discussed it later during psychotherapy.

The categories tend to become blurred: clients report the application of electric shocks to the sexual organs as an ordinary aspect of torture, and RHCC staff go along with this. It would seem that this is not recognized as sexual violence. In summary, I would like to state that knowledge about sexual violence against men is still inadequate, that staff members use different measures for sexual violence, and that they tend to associate it more with women than men.

The problem of sexual violence

Clients appeared to report sexual violence both in relation to somatic complaints or anxieties and as a result of care providers questioning them about their experiences with violence.

Mr. A from Ethiopia consulted a RHCC doctor because of an abscess near the anus and syphilis. At one point he said that he had been beaten unconscious while in prison and had later found blood on his underpants. Both the doctor and the client concluded that he must have been raped while unconscious. He was able to report this when questioned by officials from the Ministry of Justice.

In spite of the relatively short contact which RHCC staff have with clients, it appears that they hear about sexual violence and related problems relatively frequently.

Some clients requested attention primarily for their physical complaints and wanted to be reassured by a physical examination. Others considered their more subjective experiences to be central. The negative consequences of sexual violence were particularly serious in the case of young refugees who had not yet had enough positive sexual experiences. The need for care providers of the same sex, which is described in some publications, does not always seem to be necessary in practice.

Among the refugees the following complaints were registered:

- Pain during micturition, vague urethritis complaints, pain in the scrotum, swollen testicle, scrotal haemorrhage, atrophic testicle. Anal complaints, blood in the stools, abscesses.
- Erection problems, impotence, premature ejaculation. Unintentional childlessness, for which the experience of violence and the fear of infertility were blamed.
- Self-doubt, feelings of impurity, the belief that everyone can see what the victim has undergone, the fear of being a homosexual.
- The recurrence of the experience of sexual torture in nightmares.

Generally speaking it can be said that clients often relate anxiety about the possibility of having children to injury to the sexual organs. Fears of no longer being considered fully a man, or of not being able to function as a man, were often mentioned.

Mr. D., a Kurd from Iraq, had been hit by a phosphorous bomb in the Iran-Iraq war. Later, during interrogation by the secret police, he was kicked between the legs and since then has had pain in his left testicle. He was referred to a urologist, who was unable to find a cause. In an interview with the RHCC doctor, it appeared that he was extremely anxious about his fertility. He was obsessed with the quality of his sperm and had unpleasant memories of his visit to the urologist. Examination revealed pain in the epididymis. His fears were discussed during a series of interviews; sex education was provided, which helped to remove some of his uncertainty. It finally became clear that his biggest problem was not the physical pain but the fear of infertility.

The seriousness of the trauma was not always proportional to the complaints which were reported. There were clients who had been analytically raped and who seemed to manifest hardly any negative consequences. Others claimed that the humiliation of being interrogated while naked was a very drastic event in their lives. The dominant norms and values in a particular culture probably play a role here. It also became clear that, for victims from countries such as Pakistan and Sri Lanka, the taboo on speaking about sexual torture was great.

During detention, Mr. C from Pakistan had been forced to undress. When he stood naked before the prison guards they taunted him about his appearance. In the Netherlands he was inter-viewed by an official from the Ministry of Justice. The official compared his appearance with a photo which was taken shortly after his arrival and made a casual remark about it. As a result, Mr. C became extremely upset. The remark immediately evoked the derisive words of the prison guards.

Also, the taboo related to homosexuality has to be taken into account. In the sharia (Islamic law), for example, homosexual acts are considered indecent and are strongly prohibited. If such behaviour comes to light, corporal punishment, or even the death penalty, may be imposed.

Mr. B from Somalia consulted the RHCC doctor because of various mental and somatic complaints. He felt old and could not cope very well with the frustrations of life as a refugee. He thought that doctors did not take his complaints seriously. After he had received care from the RHCC for 6 months, an Amnesty International doctor made a report. Later, Mr. B wrote to this doctor to say that he had been raped in prison and to ask for a second consultation without an interpreter. He did not think he could talk to his wife or to other Somalis about the rape because they might ostracise him for this homosexual act. It was only when he met the Amnesty doctor that he thought the moment had arrived to talk about the rape.

Some conclusions and recommendations

Sexual violence against male refugees was discussed as a separate topic for the first time at the RHCC. Although this presentation has only given a general impression, I was surprised by the number of male refugees who appear to have been confronted by sexual violence. And the real number is probably even higher. This assumption is based on the fact that there are various obstacles. Contact with care providers in the reception centres is relatively short. Sometimes the presence of an interpreter is threatening.

Various feelings that are once again evoked by discussion of the violent experiences (fear, anger, powerlessness) may restrain both client and care provider. This has been extensively discussed in the literature, for example by Danieli, and has become known as the "conspiracy of silence".

When refugees have been confronted with sexual violence, it is important that the care provider has the expertise to recognize this and to name it.

The research was carried out among care providers in the reception centres. 134
The definition and description of sexual violence which was presented to them caused quite a lot of discussion. For some care providers, the definition was too broad. They had seen clients who, given their description of the methods used, had been sexually tortured, but who had not experienced this as such. As a result one may be inclined to take the victim's experience as the most important criterion. However, experience from psychotherapy has shown that victims can repress the intrusion into their sexual integrity which occurs during sexual torture. It is only when these experiences are worked through during therapy that the reason becomes clear and the victim may come to recognize that an event which was initially repressed did indeed have a great influence on self-experience and integrity. That is why I consider it justified to conclude that we should stick to the description and definition as presented earlier. Sexual problems may be an indication that sexual violence has occurred, but that this need not necessarily be the case.

Sexual violence is not an isolated incident; it forms part of violent experiences more generally. Being arrested, experiences in prison, the flight into exile, the separation from relatives and native country, and the fear and uncertainty in the new social environment are all stress factors which can lead to sexual problems.

Here the context is of great importance. That is why it is important to find out what the torturers actually said, what kinds of threats they made, and which fears they evoked. It is probably only through an extended therapeutic relationship that the true extent and nature of sexual violence will become apparent. This does not mean that those who are involved in providing care to refugees should not keep their eyes open for sexual violence which both men and women may have undergone. The medical examination that the RHCC offers to all refugees provides the opportunity to evaluate physical injury and, if necessary, to treat it. In cases in which fear and anxiety are dominant it is necessary to offer the refugee the opportunity to talk about his experiences, perhaps for the first time.

References


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Brainstem evoked potentials

Examination of released prisoners from Serbian concentration camps during the war in Croatia 1991-92

By
Andelko Vretz*

The frequency of pathological values of interpeak latencies (P1-P3) and (P3-P5) BAEP differed greatly between a group of released prisoners from Serbian concentration camps and the general population. The most frequent pathological values are expressed as differences in IPL (BAEP) right-left, and unilateral changes. The relative frequency of pathological IPL (BAEP) changes showed a positive correlation with the number of alleged blows to the head and neck, and a negative correlation with the lapse of time from the last blow to the head and neck. Dissociation of the frequency of pathological changes in IPL (BAEP) at the peripheral (P1-P3) and medullary level (P3-P5) are shown by a fall in relative body weight, which appears to have a serious influence at the medullary level. From the very beginning of their aggression in 1991-92 against newly independent countries in the Balkan areas, Serbian forces have organized concentration camps, which they have attempted to present as military prisons. However, with the evidence of exchanged or escaped prisoners-in-war, the real nature of these monstrous institutions was quickly made known. 80% of the prisoners were civilians, including women, children, and "old people" unfit for work or army service. Almost everyone was subjected to physical and psychological maltreatment.

Every tenth prisoner hospitalized

The subjects of the study were
prisoners released from Serbian concentration camps, who had been captured in the second half of 1991 during the war in Croatia.

During May 1992, approximately 200 released prisoners arrived in Zagreb. Every tenth was hospitalized because of impaired health.

During a general medical examination the need for a neurological examination was indicated in many of those ex-prisoners who, during physical maltreatment in the camps, had received a blow on the head and neck or in whom neurological impairment was found or suspected.

Approximately 75 of these prisoners were examined in our neurological department.

Every third prisoner, i.e., 25, with a history of blows was chosen at random for further study. Median age was 33.7 years, ranging from 20-53. More than three-quarters of them were aged from 25-35 years. The average length of stay in the camp was 189 days, ranging from 138-260 days.

The locations of the camps were Sremska, Mitrovica, Stajicevo, Begejci, Nis, and Belgrade.

All the subjects were male, and none had ever had significant head injuries or had ever lost consciousness. The examinations were carried out on average 5 days after release from the camps, and none of the subjects had received any medication apart from occasional sedatives and analgesics.

Brainstem auditory-evoked potentials were performed in all subjects by stimulating each ear by the "click" stimulus, rarefaction type, 2048 times, frequency 15/second. Responses were detected over the C2 electrode. Bandpass recording with digital filtering was 150 to 1500 Hz. The intensity of stimulation was the same in all subjects, 110 peSPL intensity click and 50 peSPL intensity contralateral masked noise. Interpeak latencies (IPL) were analysed, P1-P3 and P3-P5 as satisfactory representatives of conduction through the peripheral and medullary part of the auditory pathway and for each of these interpeak latencies the difference right-left was 0.29 ms. Results were considered pathological when they were outside the above values.

The results are presented in tables in 3 classifications, so that each classification included approximately one third of the subjects, i.e., 8 or 9. Apart from absolute values of frequencies of pathological IPL, both relative values are shown in percentages. Only those relationships of pathological IPL changes are shown when the relative frequency in all 3 classifications retained a progressive or regressive course.

**Pathological changes**

At least one pathological value of the examined interpeak latencies was found in 21 of the 25 subjects (84%). Most IPL (BAEP) pathological changes were found in differences in conduction right-left, both at the peripheral and medullary level, and unilateral at the medullary level (Table I).

The result demonstrates the non-symmetry with a predominance of sensitivity of the medullary component.

According to the evidence of released prisoners-of-war certain forms of physical maltreatment in the Serbian concentration camps have been selected and correlated with the frequency of pathological changes in the above IPL (BAEP). Attention was primarily paid to blows on the head and neck.

It can be seen from Table II that with the increase in the number of alleged blows, pathological changes in the interpeak latencies increased, as did the difference right left at the medullary and peripheral level, and unilaterally at the medullary level. The results are similar, as are the total changes shown in Table I, showing that blows to the head and neck are the most important aetiological factor of IPL (BAEP) changes in prisoners from the concentration camps.

Table III shows the relationship between the time elapsing from the last alleged blow on the head and neck and the frequency of pathological IPL (BAEP) changes. It can be seen that the only percentage of changes in the differences right-left at the medullary level decreased consistently with the increasing time lag. This relationship strongly confirmed the sensitivity and correlation between the conduction through the brainstem and cranio-cerebral injury.

**Loss of consciousness reduced the blows**

If the frequency of loss of consciousness caused by the blows to the head and neck is placed in a relative relation-
Table III. Time elapsed from the last blow to the head and neck and IPL change in BAEP of released prisoners-of-war.

<table>
<thead>
<tr>
<th>Time elapsed in days</th>
<th>Peripheral level (P1-P3)</th>
<th>Medullary level (P2-P3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One side</td>
<td>Both sides</td>
</tr>
<tr>
<td>&gt;80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N = 8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25%</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>N = 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>81-130</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N = 8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25%</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>131&lt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N = 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0%</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>22.2%</td>
<td>0%</td>
<td>22.2%</td>
</tr>
</tbody>
</table>

Table IV. Loss of consciousness and IPL changes in BAEP of released prisoners-of-war.

<table>
<thead>
<tr>
<th>Peripheral level (P1-P3)</th>
<th>Medullary level (P2-P3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>One side</td>
<td>Both sides</td>
</tr>
<tr>
<td>With loss of consciousness</td>
<td></td>
</tr>
<tr>
<td>N = 10</td>
<td></td>
</tr>
<tr>
<td>20%</td>
<td>2</td>
</tr>
<tr>
<td>Without loss of consciousness</td>
<td></td>
</tr>
<tr>
<td>N = 15</td>
<td></td>
</tr>
<tr>
<td>13%</td>
<td>2</td>
</tr>
</tbody>
</table>
| Total number of subjects who had lost consciousness = 10 (40%).

Table V. Relative loss of weight and IPL changes in BAEP of released prisoners-of-war.

<table>
<thead>
<tr>
<th>Relative loss of weight in %</th>
<th>Peripheral level (P1-P3)</th>
<th>Medullary level (P2-P3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One side</td>
<td>Both sides</td>
</tr>
<tr>
<td>&gt; 11%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N = 8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.4%</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>12-16%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N = 8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.2%</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N = 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.2%</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

ship to the frequency of pathological IFL (BAEP) changes (Table IV), then the only interesting changes seen are the differences right-left, both at the peripheral and medullary levels. It is particularly interesting to observe that at the medullary level this relationship is negative, and at the peripheral level positive. The reason for this can probably be found in the circumstances under which the blows occurred in the camps. We speculate that loss of consciousness of prisoners during physical maltreatment had an effect on the person administering the blows so that he stopped the maltreatment. It follows therefore that loss of consciousness reduced the next series of blows, which would in any case have been more dangerous for the health of the prisoner than the loss of consciousness alone.

The IPL (BAEP) changes showed sensitivity as the difference right-left at the medullary level and, according to the relative loss of body weight, as one of the many factors of maltreatment of prisoners in Serbian concentration camps (Table V).

Acknowledgements

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References


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Vicarious Traumatization in therapists treating victims of torture and persecution

By Johan Lansen*

It has become clear during recent years that therapists exposed to traumatic “material” run the risk of becoming traumatized themselves: vicarious traumatization.

It is not yet known what risks are involved in this respect for therapists treating victims of torture and persecution. In order to get an impression of the extent of this phenomenon, a questionnaire was sent to many centres in the world involved with this work. An inventory was made of the casualties involved and the measures that are taken to prevent this phenomenon. About ten per cent of the therapists seem to be affected. Supervision by an experienced senior staff member, peer group supervision, and monitoring case-load are considered to be important preventive measures.

Introduction

Therapeutic work on man-made disaster victims is work which leaves no one untouched. It is the kind of work that, in many ways, frequently involves therapists personally. There are indications that therapists treating patients with post-traumatic stress disorders, caused by man-made disasters, are in danger of negative impacts on themselves.

Different headings under which these reactions have been described include “countertransference feelings” and “vicarious traumatization”. Danieli (1984) interviewed 61 therapists who worked with Holocaust survivors. The most frequent reaction she observed was “bystanders’ guilt”, but feelings of shame, guilt, powerlessness, and anger may alternate in complicated patterns of defence, and many more reactions may result.

Danieli’s ideas already reflected the fact that the classical concept of countertransference is totally insufficient in this sort of treatment.

In more recent psychoanalytic literature, other aspects of the patient-therapist relationship also receive attention. De Jonghe et al. (1991) mention a number of different aspects. They make a distinction between the realistic relationship, the working relationship, the transference relationship, and the primary relationship.

This last one, the primary relationship, originates in the pre-oedipal part of the patients’ inner world. On this level the possibility of distinguishing between self and objects does not yet exist or is incomplete. The patient is functioning at the level of the symbiotic or separation-individuation phase. This can also be the case in deeply traumatized patients. My point of view is that psychotrauma – especially caused by torture and persecution – deeply disturbs the traumatized patients’ elementary schemes of cognition of self and other. On an elementary level these schemes are not only cognitive, but also affective; they are essentially polarized into opposites, e.g. strong-weak, aggressor-victim, superior-inferior, good-bad, etc. These schemes, these patterns structure the experience of the traumatized patient. This also happens in the therapeutic relationship. The patient engages the therapist into relationship patterns, which repeat the themes of traumatization. Even without presentation of the actual trauma material, the therapist might be sucked into a pattern which is a repetition of an aggressor-victim theme: a pattern of persecution, of powerlessness, and of guilt. This is also expressed in patterns of overidentification with the victim or in keeping too much distance. Therapeutic relationship patterns of a destructive sort may in this way damage the therapist’s personality. The effects may be that the therapist shows characteristics of a posttraumatic stress disorder himself.

McCann and Pearlman (1990) describe the psychological effects of working with victims from a different point of view. A part of the therapist’s feelings has not so much to do with the patient’s personality as with the patient’s history, the story which he tells, the atrocities, the suffering, the human cruelty. These authors use the term “vicarious traumatization”; maybe “transmitted traumatization” would be a better name.

Several other authors have pointed at these phenomena. Van der Veer (1991) describes how working with victims of torture and persecution deeply affects the therapist’s life outside the therapeutic sessions. Munroe (1990) proved, in a retrospective study, that trauma-related effects exist in therapists working with combat veterans with PTSD, and that these effects are distinct from burnout. Bustos (1990) describes how dealing with the “unbearable” has effects on therapists and institutions for the treatment of survivors of torture; splitting phenomena and paranoia develop in the therapeutic team.

Literature about these treatments abounds, if one has an eye for it, and albeit not very systemically, in remarks about parallel processes in therapists and supervision, and in descriptions of short- and long-term effects. Fortunately, positive and stimulating effects are also mentioned. Furthermore, there is general agreement that a form of “debriefing”, especially for assistants in acute crisis-situations, is necessary (Talbot, 1990).

General outline of the investigation

For the sake of simplicity, I will refer to these phenomena as “vicarious traumatization”. This article is meant to be a provisional enquiry about the nature and extent of this phenomenon in the treatment of tortured and persecuted refugees.

In the 1980s, and especially since the establishment of the Rehabilitation Centre for Torture Victims (RCT) in Copenhagen, attention has grown for treatment of tortured refugees from countries in Latin America, southern Africa, the Horn of Africa, the Middle East, and many other areas. With growing experience and the development of other centres all over the world for the treatment of torture victims, it seems opportune to investigate whether these centres and therapists are familiar with the phenomenon of vicarious traumatization, what sorts of effect might be present, what is being done to prevent it, and what are considered to be the best measures of prevention.

A questionnaire was constructed and sent to 99 addresses all over the world, appearing on a list of the IRCT, the international branch of RCT, Copenhagen. This list not only contained the
addresses of treatment centres, certainly a minority on the list, but also centres for refugees in general, university institutions of a more sociological character, political interest movements, etc. In order not to miss centres, the questionnaires were sent to all addresses on the list. The directors of the centres were asked to fill in the questionnaires, and if they were not medical or psychological professionals, they were asked to do this with the help of professionals.

Results
We received 25 filled-in questionnaires, 23 from treatment institutions and 2 from individual therapists. A few centres treated refugees for all sorts of mental health problem, including effects of physical and psychological torture. There were huge caseloads at those centres, but we included only the traumatized patients (by torture) in our figures. The following data may reflect the size and work of the centres involved.

Total number of workers in all centres at 1 January 1992 310
Total number of non-professional volunteers in these centres 181
Total number of traumatized patients + 4,600

A substantial number of the 181 volunteers came from 3 centres only. Most centres worked without non-professional volunteers.
The total number of new traumatized patients in these centres per year was approximately 4,000-6,000.

Study of the material reveals that the more typical centre which specializes in the treatment of tortured refugees has a range of 5-14 workers, no non-professional volunteers, and about 55-120 patients.

Especially in northern Europe, there are centres of the same size but with many more (part-time) therapists. The centres were mostly located in North and South America, Europe, and Asia.

Question 1
"Are you aware of the possibility of vicarious traumatization of therapists (including workers of different disciplines) in your centre?" was answered positively 23 times, negatively once, not answered once. Apparently there was almost general awareness with the respondents about this event.

Twelve respondents became aware of vicarious traumatization from incidents (at the centre) and from the literature. Several mentioned their own experience. Training had made respondents aware four times. The majority of the respondents (14) became familiar with this phenomenon during the years 1986-1991, mostly since the establishment of their centre.

Question 2
This question went into more detail concerning the workers' problems during the last three years (1989-1991). What sort of events or casualties did they have?
Only 14 therapists (in 8 centres) had to leave because the work was emotionally too difficult for them. This amounts to 2.5% of the total number of therapists. Emotional burnout and fatigue occurred, however, in 52 persons in 17 centres. This does not take into account the remarks by a few respondents that at times everybody in their centre felt overburdened and tired.

At least 13 of these 52 workers also suffered because of personal trauma and tragedy, working in 2 centres where the actual oppression had disappeared shortly before, or was still going on to some extent. Some of them had no news from missing relatives and suffered also because of that.

Apart from symptoms of burnout and fatigue, more specific questions were asked about PTSD-symptoms and symptoms belonging to the broader concept of PTS-spectrum.

How many therapists experienced PTSD-symptoms? Answers:
mild 15
moderate 11
severe 7

The total number of 33 reflects an occurrence of about 11% in the total number of 310 therapists.

How many therapists developed addictions? One only (alcohol); addiction apparently is no problem.

How many therapists developed depression?
mild 10
moderate 5
severe 4
not specified 4

(none of them committed suicide).

In 310 therapists, this might reflect a somewhat higher percentage (7.5%) than would on average be expected in a 3-year period. However, no exact data for comparison are available given the cross-cultural population of the therapists.

A number of therapists fell ill without apparent somatic cause – probably another effect of psychological stress. This happened with 22 workers in 8 centres (7%).

Other sorts of casualties mentioned (in 8 centres):
- personal traumas (not specified) with remaining effects
- marriage problems
- "non-necessary" team conflicts
- premature labour in female therapists working with traumatized children (2 cases)
- psychosis (1 case).

Question 3
"What sort of worker is most endangered?" Psychologists were mentioned 12 times, psychiatrists 8 times, medical doctors 8 times, non-professional volunteers 7 times, physioterapists 5 times, social workers 5 times, nursing staff 2 times, and others from different professional backgrounds 7 times.

Perhaps the answers reflect the composition of each centre's staff, since the centres differed greatly in staff composition (we have no exact data though). The best answer might really be "all equally who get involved deeply".

Question 4
This question considered the measures that had been taken to prevent vicarious traumatization. Some suggestions were given to choose from, as well as the possibility of giving an open answer.

These are the results:

<table>
<thead>
<tr>
<th>nr. of centres</th>
<th>supervision by experienced senior staff members</th>
<th>monitoring worker's caseload</th>
<th>peer group supervision</th>
<th>outside consultant monitors' team functioning and team psychohygience</th>
<th>work on a part-time basis as a rule</th>
<th>other measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td></td>
<td>12</td>
<td>10</td>
<td></td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>

The category "other measures" includes a diversity of answers such as:

- creation of a permissive team atmosphere
- teamwork is essential
- recruiting procedures: vulnerable personalities should be screened out
- organization structure which reduces stress
- organized anti-burnout strategies
- staff tension reduction therapy
- social activities amongst staff members
- other work at the centre, e.g. taking part in secretarial work and household chores
- instruction for understanding of the political and cultural situation of refugees, without too much political involvement.

Those results indicate that supervision is important, and is mostly being given by an experienced senior member of the centre’s staff.

Monitoring caseload and peer group supervision are also considered important. Furthermore, all sorts of measures are being applied which deal with team atmosphere, prevention of too heavy a caseload, reduction of tension in individuals and teams, etc.

**Question 5**

“What measures are considered most effective?” Leaving out the setup and statistical discussions, and looking at the results with caution, it is perhaps not surprising that supervision by an experienced senior staff member, monitoring worker’s caseload, and peer group supervision were again the measures which were considered most effective in the prevention of vicarious traumatization.

Some priority was given by 9 respondents to “work on a part-time basis as a rule”, which again seems to indicate how important it is considered that workers are not completely immersed in this work.

If we may consider the answers to question 4 as the practical reality and the answers to question 5 as the desired reality, there was much agreement between the two realities. However, contrary to the existing situation, more therapists should be working on a part-time basis as a rule than is the case in reality.

**Summary of the results**

About 25% of the questionnaires were returned completely filled in. As some of the addresses did not belong to the proper target group, the response to the questionnaire might be considered higher.

Apart from 2 centres which were still under heavy actual stress from political situations in their country, the responses were given by centres which were working under peaceful conditions.

Although only 2.5% of the therapists had to leave their centre because their work was emotionally too difficult, emotional burnout and fatigue existed in about 17% of the workers. If one subtracts the number of therapists in centres where some degree of political suppression still existed, or had only recently disappeared, the remaining figure is still 13%.

It is not clear whether these are the same persons who also suffered from PTSD-symptoms. For the sake of clarity, these figures are considered separately. PTSD-symptoms in the strict sense of the concept existed in 11% of the therapists.

About 7.5% of the therapists developed depression. Becoming ill without apparent somatic cause occurred in about 7%.

Other sorts of casualties or events which were mentioned add up to a picture which is suggested by this material, as follows:

Work with patients who have been traumatized by torture and persecution involves a risk for those who treat them, rather independent of the professional discipline of the worker. Even if one considers “burnout” as a normally occurring phenomenon in those who work with difficult patient categories, the percentage is relatively high (13-17%).

Apart from burnout symptoms, further material suggests that, even if one does not add up the figures which were obtained for PTSD-symptoms, depression, and being ill without somatic cause, the number of therapists involved in some sort of “vicarious traumatization” might be at least 10%.

**Conclusions and recommendations**

Although this study has a provisional character and does not pretend to be thorough, the conclusion seems to be justified that “vicarious traumatization” exists in therapists who are treating torture victims. A more thoroughgoing investigation is required into the nature and extent of this phenomenon, as well as into the means of transmission: is it a surface transmission from the story of the trauma, or is it a deeper transmission since trauma involves injuries affecting the primary therapeutic relationship.

A practical conclusion is that working alone is to be avoided. Therapy should be done preferably in a team. Team supervision, team psychohygiene, and caseload should be considered.

Administrators and government authorities should consider the necessity of such arrangements.

Finally, the treatment centres might consider other measures such as staff composition, training, recruitment, and anti-burnout strategies and courses.

**References**


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By Maria Piniou-Kalli*

Greece is the country where democracy was born, but it is also a country where freedom and human dignity are the most important and precious things in people's minds. Greece has a painful past and knows very well what governmental torture means and how it can be a destructive weapon against democracy. Since one of the objectives of the World Conference is democracy, please allow me to focus your attention on its worst enemy, torture. It should concern all of us.

Torture, this humiliating and inhuman treatment of people, is almost the same age as man himself. Amnesty International states that in the 1980s torture "lives and reigns" in more than one third of the world's countries; even in Europe, according to AI's report, there are denouncements of such human rights abuses in police stations in 16 countries.

Torture exists, in spite of all the international treaties and declarations against it, in spite of the coordinated endeavours of the organizations for the protection of human rights. So, torture lives and reigns and constitutes the stigma and shame of the human being, some of whose representatives in the dawn of the twentieth century did not hesitate to put into the service of torture the achievements of the human mind: science and technology. They are more "scientific" and "refined", so as to leave fewer signs and to achieve their aim more effectively. The aim of torture is to destroy the personality of the victim, to deflate his morale and to terrorize his mind, to engrave indelibly his soul, so that, should he survive, his life afterwards, as much the personal as the social, will not be the same again.

Furthermore, the survivors are filled with anxiety and irritability, they suffer from nightmares, bad concentration, bad memories, headaches, and somatic pain, and feel isolated and alone. Other members of the society who see them do not want to put themselves in the same situation. This is why we say that torture, performed with the knowledge of governments, is the most effective and destructive weapon against democracy.

Through the medical groups of Amnesty International, the IRCT in Copenhagen, the personal contribution of Dr. Inge Genefke, and more than 50 rehabilitation centres in the world, focus has been placed over the last 20 years on the aims of torture, its physical and psychological methods, the physical and psychological sequelae in the individual survivors, and of course treatment of the victims. Today we have medical proof of the psychological and physical sequelae of torture. In other words, we are now able to diagnose these sequelae. This is the first step in the prevention of torture.

Under human rights law and humanitarian law, freedom from torture is a right which must be protected under all circumstances, including times of internal or international disturbances and armed conflicts.

We call on all states to end this scourge immediately through full implementation of the relevant conventions and, where necessary, strengthening of existing mechanisms. We strongly support consideration of the appointment of a special commissioner for human rights.

We request more support for the rehabilitation centres for torture victims and many more resources for the UN Voluntary Fund for Victims of Torture.

We declare that grave and systematic violations of fundamental human rights, such as torture, disappearances, and summary executions, are crimes against humanity that cannot be pardoned or considered for amnesty. Massive violations of human rights must in all cases be submitted to an individual, objective, and impartial investigation. An international criminal court should be established to judge such crimes.

In the final draft document for the conference PC/98, the issue of torture is rightly placed under the main heading: equality, dignity, and tolerance, but the whole subject is still within square brackets. If the World Conference really wants to talk about dignity, they have to remove the brackets and not the words.

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History
The CCVT is a non-profit, registered charitable organization, founded by several Toronto doctors, lawyers, and social service professionals associated with Amnesty International. They had begun to see victims of torture in their practices as early as 1977. Many of the victims were in the process of claiming refugee status in Canada. The doctors saw the need for specialized counseling for the social and legal problems faced by this particular group of clients. Lawyers, social workers, and community groups saw clients who were survivors of torture, often badly in need of treatment by doctors and other health professionals. The CCVT was incorporated in 1983 as the Canadian Centre for the Investigation and Prevention of Torture. The name was changed in 1988 better to reflect the Centre’s mandate. The Centre was the second such facility to be established in the world. The first was in Copenhagen in 1982.

Mandate
The mandate of the CCVT is to respond to the continuing needs unique to survivors of torture and their families in Canada and abroad, and to increase public awareness, in Canada and abroad, of torture and its effects upon survivors and their families.

Structure and funding
The CCVT has a 16 member volunteer board which sets policy and guidelines for the operation of the Centre. The board is elected from the membership of the Centre at the Annual General Meeting. Currently, board members include volunteers with the Centre, members of the Centre’s medical and legal networks, and community activists.

Decisions of the board are implemented by the executive committee of the board, the executive director, and the staff of CCVT. There are 13 paid staff members whose job descriptions correspond to the areas of service provided by the Centre.

The CCVT is a non-profit, registered charitable organization (#07439555913) which receives funding from Federal, Provincial, and Municipal governments, the United Nations Voluntary Fund for Torture Victims, foundations, religious organizations, and individuals.

The survivors of torture
Since its inception, the Centre has assisted approximately 4500 survivors from 68 different countries. The survivors are: people who have been subjected to severe torture or prolonged severe multiple experiences of victimization; children and adolescents subjected to torture or witnessing violence; sexually traumatized women; people who have gone through traumatic exit, transit, and exile experiences.

Survivors are people who are forced to leave their countries because of threats to their own lives, or for the safety and security of their families. These traumatic experiences, compounded by the disorienting effects of establishing new lives in a new country, produce severe physical and psychological damage.

Services provided
A. Coordinated professional services
The CCVT provides the link between the survivor of torture and a professional service and support network of doctors, lawyers, social service workers, and volunteers.

The medical network includes experienced physicians, psychiatrists, and other specialists. Referrals of survivors of torture are accepted and the CCVT intake staff will assess a survivor’s physical and psychological condition and refer the survivor for appropriate medical attention and treatment with one or more of the CCVT’s associated physicians.

The Centre has developed a medical protocol for doctors to examine torture survivors and document their experience. This may be necessary, for instance, if requested by the survivor’s lawyer to support a refugee claim before the Immigration and Refugee Board. The Centre is now providing some professional services at their own premises. A crisis counsellor was hired in 1989, and a public health nurse with a speciality in mental health is available regularly at the Centre. Counselling services and specialized settlement services, sensitive to the needs of survivors, are also provided.

There is a reciprocal referral service for legal and social assistance when required. For instance, a CCVT survivor, if requested, will be put in contact with a lawyer who is knowledgeable and experienced about the issues and problems faced by a survivor of torture. In turn, a lawyer who has a refugee client can refer to the Centre for assistance. Welfare and social assistance workers are able to contact the CCVT about clients who they feel could benefit from its services.

The CCVT acts as an advocate on the survivor’s behalf when requested to do so by the survivor, especially with regard to immigration and other government agencies.
B. English as a second language  
The ESL programme at the CCVT was established in 1984 and continues to be a major Centre activity. The programme and its curriculum are especially designed for survivors.

It is difficult to learn a new language as an adult, to adjust to a new and different culture, and deal with the everyday problems of a newcomer to Canada, such as financial, employment, and immigration difficulties.

The survivor of torture faces additional unique problems. Some of the after-effects of torture, such as lack of concentration, distrust of strangers, and fear of groups and authority figures, are barriers to learning a new language. ESL classes at the Centre are small and informal. They are in comfortable, familiar surroundings and have a calm non-threatening atmosphere. Literacy classes and individual tutoring are provided as part of this programme. Child care is available.

The ESL classes at the CCVT can help to reduce a survivor’s isolation, providing him or her with emotional encouragement and support.

C. Support and group programmes  
In 1989, the CCVT began to provide professional services on the premises. The position of crisis counsellor was created and a group support programme was begun.

Group programmes now include a drop-in programme, which assists survivors to access services available to them in Toronto and overcomes the isolation they may feel. It allows clients to meet other survivors of torture in a comfortable and informal atmosphere. Child care facilities are on the premises.

The Mutual Support Group for Somali Women was started in 1990 and addresses the unique and specific problems faced by this group. A bilingual staff member, a volunteer physician who is a member of the medical group of the centre, as well as a volunteer public health nurse with a mental health speciality, are some of the resources available to the Group.

The success of this project has led the Centre to expand the programme to include a projected 10 groups. The model for this programme is available on request.

These programmes reflect one of the premises of the CCVT: that some survivors can best support and encourage one another, since they may share similar backgrounds, experiences, and problems.

D. Public education  
The public education programme of the CCVT responds to the numerous requests the Centre receives for information, assistance, and consultations on torture and the effects of torture.

The centre answers individual inquiries from community groups, researchers, and professionals. They have conducted numerous seminars and workshops, particularly for those working with survivors of torture. Public education is aimed at enhancing awareness and sensitivity to the particular unique needs of survivors of torture.

Associated members of the CCVT carry out public education as well. Many conduct research, publish in academic journals and the popular media, and speak publicly on torture-related issues.

The CCVT is concerned with expanding the network of social service agencies which can provide survivors of torture with much needed assistance. They are a member of many of the local and national groups working with refugees and newcomers, such as the Toronto Refugee Affairs Council, the Ontario Council of Agencies Serving Immigrants, and the Canadian Council for Refugees. The CCVT is also an active participant in efforts to promote and encourage governmental policies to meet the needs of survivors of torture and their families in Canada.

E. International projects  
As part of the mandate to respond to the needs of survivors abroad, as well as in Canada, the CCVT supports the efforts of three clinics in Central America that offer treatment to children traumatized by the continuing violence in the region. The Centre is also a Canadian partner with the Imbali Rehabilitation Centre, South Africa. The projects are supported by the United Nations Voluntary Fund for Torture Victims.

The CCVT is associated with a coalition of centres which support victims of violent repression and torture, in exile or in their own countries.
The national response to the needs of survivors of torture and trauma

A Report to the Parliamentary Committee on Immigration and Ethnic Affairs

Canberra, 5 November 1992

Compiled by Martin Chittleborough, STTARS [Survivors of Torture and Trauma, Assistance and Rehabilitation Service].

The response in countries of settlement

The first service to help refugees was established in Denmark in 1974. From about 1980 the USA, Canada, and several European countries established services. In 1985, the Mater Hospital in Queensland began services because of the need to respond to a 3-year-old boy whose family had been tortured; the hospital worked with the family for a year. This need to respond to people was typical for all the Australian states and was the driving force for the establishment of services. TRUSTT [The Rehabilitation Unit for Survivors of Torture and Trauma] was formally established in Queensland in February 1988.

In 1987, Dr. Janice Reid and Timothy Strong submitted a report to the New South Wales [NSW] Department of Health; it was so shocking that the department responded with substantial funding for STARTTS. The Victorian Foundation was established in the same year. In 1990, Transact received a $20,000 grant from the Department of Housing and Community Services. Work began to establish a service in South Australia [SA] in 1988, but neither the State nor Commonwealth governments responded until mid-1991. Establishment grants were given to Western Australia [WA] and Tasmania, but their future is uncertain because no on-going funding is assured.

Who are being helped and how many are there?

The question always asked by the funding services is “How many people would use such services?” This information is by nature difficult to obtain, but it is clear from the people’s response that the numbers have been consistently underestimated. They have gone from 10% to 30% of all refugees, but now they are generally believed to be much higher. Perhaps the most in-depth study is Eileen Pittaway’s two-year study of 204 refugee women. She concluded that 76 (37%) had experienced a high degree of torture and trauma, while 149 (73%) had experienced a high or medium degree of trauma and torture. This should not be surprising when the criterion for being a refugee is “a well-founded fear of persecution”.

Australian services are seeing people from about 25 countries, the numbers from each depending on settlement patterns and on which bilingual workers the service has on its staff.

What is the model?

Initially the services tended to be clinically centred, focusing on a medical model. In Australia, in the absence of a national policy, the services developed very differently in each state, depending on the state’s history and the available resources. There is now a strong consensus on the elements that are needed to provide a holistic model. NSW has summed it up for all the states by describing their model as “A holistic model focusing on assessment, counseling and advocacy for individuals and family. Also group work and community development.” Within this holistic approach, Queensland describes itself as a “needs-based model”, seeking to meet the needs of the torture survivor and family, both in the TRUSTT unit as well as in the community. Victoria emphasizes the counselor/advocate model, while the smaller states, starved of funds, struggle to provide a similar service, using networks and volunteers. That the smaller states are effective demonstrates the willingness of people to support the refugees generously in time and skills.

Nationally, there is a growing desire to work more closely, sharing resources, using common databases for recording information, sharing training facilities, and, perhaps above all, to present a national picture and to demonstrate strongly that torture in any form is totally unacceptable.

What is a viable organization?

At the national forum meeting in September, there was universal agreement

Map of Australia.
that the minimum number of staff equivalent positions for a viable organization was six, acknowledging that, with a large volunteer group, four staff equivalent positions might possibly be sufficient. However, a volunteer network requires a great deal of resources, including money and the time of a co-ordinator. This minimum number is necessary because of the range of skills required, continuity of staff, holidays, conferences and training days, and the need to provide a regular service. This is in line with common organizational practice. The larger states would add additional positions to cope with the additional numbers.

All the states expressed uncertainty about funding, but very real concern was expressed at the action of giving establishment funding to states, such as Tasmania and WA, without planning for core funding. It is detrimental to the well-being of a group of clients to raise their expectations by exploring a need already so clearly demonstrated in other states, and then not to fund it.

Issues
1. Repatriation. The High Commissioner of the UNHCR, Sadako Ogata, has declared 1993 the year of Repatriation. This option has been taken up with Chilean refugees in Victoria and SA.

2. Asylum-seekers who are waiting for a decision as to whether they can remain or have to leave. The Services see Australia as having an obligation under the UN Convention on Torture (1987) to grant asylum to people who have been tortured. At the moment, such people are not eligible for any benefits apart from small grants given on unclear criteria. They cannot use Medicare, rarely gain permission to work, are not eligible for education or dental care. With no money for travel or entertainment, boredom is a very real concern.

3. Separated families. A number of people who come have been separated from their families through various circumstances, such as fleeing across the border from prison. While they are able to bring their families out through the family reunion programme, they do not have the thousands of dollars necessary for fares, and, further, the agencies which have revolving travel funds expect the borrower to be employed. The anxiety from this separation makes it impossible to cope with the psychological issues and delays the process of settlement.

4. The counselling of families. Family relationships are often under great strain, and the members are changed by their experiences. For example, although work may start with a child being brought for help, the work will expand to involve the whole family as trust is established.

5. Women. As the majority of torturers are male, this predetermined power relationship, or specifically the constant threat of sexual violence against women, which is a product of abuse of this relationship, is an added part of the torture experience for women. Because of their sex, or their family role, or the torturer’s perception that they are not fulfilling traditional roles, women are often singled out for particular types of torture by government agents. Rape is a particularly degrading form of assault, but other forms of sexual abuse, such as the threat of rape, verbal humiliation, and forced degrading acts are also practised on women detainees, in addition to the torture forms that are practised on men.

6. Men. A large percentage of the people who come to the services are men, and it is becoming increasingly clear that men do not cope well with the refugee experience. They are no longer the wage-earner, often have difficulty in learning English, and are often too proud to ask for help. Added to this, only little information and few services are aimed specifically at men’s needs. The aim of the torturer is to destroy a man’s integrity, and so it focuses on destroying his sexuality. This includes the use of electric shocks to the genitalia, and rape by men, women, and animals. We are becoming increasingly aware of the link between the torture experience, the inability to relate to women, domestic violence, child abuse, and sexuality. It is important for this aspect to be addressed.

7. Children. The tragic reality is that children are often deliberately targeted in order to intimidate and terrorize parents and the wider community. Young people caught up in situations of war and civil conflict face serious abuses and deprivation at the most critical stage in their growth and development. The assumption is usually made that children reflect the experience of their parents. However, often traumatized and grieving parents will withdraw emotionally, and the refugee child may feel confusion or guilt in the face of this isolation. They are also individuals with their own unique response. How can they best be assisted?

The uniqueness of the services
1. The Services are built on trust. Trust affects an individual’s capacity to trust their bodies (physical effect), their minds (psychological effect), their understanding of the world (spiritual effect), their families (family effects), and their community (community effects). Services need to develop services that heal at all these levels.

2. The people we work with are marginalized. The aim of torture is to dehumanize people. Torturers methodically strip them of all their identity, integrity, and anything which they value and which makes them human. When this aim has been achieved to a lesser or greater degree, the victims are frightened of other people because of their shame, they are frightened of their community group because of spies, of social groups because of their feelings of worthlessness, of personal relationships because this involves self-revelation that has resulted in abuse in the past. Consequently, many are extremely isolated.

3. Complementary methods of healing. To help to restore people to the human race, other methods of healing have been extremely effective. Learning to touch people again can be helped through massage; anxiety and stress can be lessened through various relaxa-
tion and meditation methods. The spiritual dimensions of a person's world - learning how to trust, to love, to hope, to believe in a future, and talking about the meaning of the events and life in general - are very important; help is offered when appropriate.

4. A safety net. In some states, the people have no ethno-specific welfare and so the Services provide a safety net for them.

5. A point of access. Because of the feeling of alienation, the Services provide a point of access to mainstream services. A high percentage of clients opt out of the effort of relating to a number of services and appointments that are often a long way apart. It is not easy to use out-patient services, nor to understand what busy medical staff are saying. Staff, or more often volunteers, accompany people for support and to remove the fear of going to different departments. "Imposing" buildings do in fact often impose on people, but people gradually learn to use the services that are available.

6. Multi-disciplinary. The Services are not easy to categorize, because they are concerned with the healing of the whole person - mentally, physically, spiritually; and socially. Should they relate to DILGEA [Department of Immigration, Local Government and Ethnic Affairs] because so much time is spent on settlement issues, or to the various Departments of Health because of the medical issues, or to Ethnic Affairs because of the transcultural nature of the work? This multi-disciplinary nature can seem a difficulty when governments wish to simplify their funding.

All the Services have developed large networks so that they can tap into a wide variety of skills, STTARS, for example, has a core group of 12 and a professional network of 65.

7. Community education. All Services give considerable time and energy towards this. Not only is there the need to provide information so that potential clients might know where to come, but all services have a large component of training other services, and in educating the wider community. When whole communities have been traumatized, the healing takes place, not only within specialized services, but also in the wider community. People from refugee communities need to know that suffering is not the norm for living. For example, Transact, the smallest established group, gave 18 talk/lectures in 1991 to specified target groups.

8. Training mainstream and ethno-specific workers. STARTTS and the new NSW Education and Training Foundation have just produced a training manual, video, and overheads to assist in this work. The video won an award in 1991 and consists of three parts - on Torture, Post Traumatic Stress Disorder, and Refugees. These will be available in all states. Both Victoria and NSW have filled very important training roles of other services and of government services.

Conclusion

This paper has attempted to describe how services concerned with the survivors of torture and trauma have come into existence. How they all started from a community concern and response to human need. It outlines the models, staff, and budgets. It has attempted to describe the current issues and some of the features which make them unique, and to point the way to the future.

In pragmatic terms, the Services aim to give people the power to change from victims to survivors, to move to a new level of living where they can become participating and contributing members of society.

More importantly, the Services have demonstrated their ability to restore people to humanity and to enjoy life as it should be lived.

The services, particularly in the smaller states, are desperately under-funded, although there is clearly enough evidence about need. The people who use them will never be in a position to pay for them themselves, yet they are a legitimate part of our humanitarian response to cruelty and horror.

The Services are often asked, "Why have we only just become aware of the needs of people in this area?" Part of the
answer is that the enormity of the horror wants us to shut our minds and deny its existence. Certainly, this aspect comes up when the question of funding is raised. And this is a pity, because it is only by bearing witness against the world’s inhumanity that one of the great shame{s} of our time will be stopped.

National services for survivors of torture and trauma in Australia

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At RCT/IRCT we often receive manuscripts concerning the inauguration of new centres dedicated to the treatment of survivors of torture. With this issue of *Torture Journal* we make a presentation of such centres.

We would like to make presentations of these centres for the rehabilitation of torture victims a regular feature in the journal. In order to ensure the best possible exchange of information, a certain measure of uniformity in the manuscripts is called for (please see the guidelines below).

We are well aware that the presentations in this issue do not follow the mentioned guidelines but we hope to uniform the descriptions in the future.

New address from 1 April 1994:

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CENTRE PRESENTATIONS

The manuscripts should, preferably, answer the following questions:

A) The centre itself. Where is it situated? - country, city. The physical framework. Is it in a house in a residential area, a flat somewhere - or perhaps attached to a hospital? What kind of interior design has been carried out to make the place suitable for the treatment of torture survivors? (In describing these physical features, small things might be symbolic.) How long has it been in existence? or - How long has the preparatory period been? Who took the initiative for starting the treatment?

B) The economy. How is the work funded? Does the institution receive contributions from international agencies?

C) The staff at the centre. How many work there? What are their fields of work? - how many doctors, physiotherapists, nurses, etc. How did they become involved in the work. What motivates them?

D) Who are the patients? Are they nationals? - survivors of an earlier dictatorship, refugees, asylum-seekers? What kind of treatment do they need? How big is the need? How many are estimated to be in need of treatment. (Some experiences from the first period of work might be appropriate here).

E) What model is being used in the therapy? What have been the experiences till now? Is there anything you particularly want to share with other professionals? For instance, are you involved in research projects which might be of interest to colleagues?

These questions are only to be seen as a guideline and a check-list. It does not necessarily entail that the structure of the manuscript has to follow these points mechanically. This we leave to the discretion of the author. But one thing has to be included as the last para: Name, full address, country, phone number (if any), fax number (if any), and telex (if any).
Liliane Bernard

One of the key persons in the creation of medical groups that work with torture is no longer. Liliane Bernard died on 18 April 1993 at the age of 53.

It is not only a colleague who has left us. Liliane was a person of great integrity, professionalism, earnestness, with a strong sense of humour, who threw herself into work with torture victims with unbounded energy.

From her home in the Rue de Miromesnil, supported by her husband Dr. Alain Bernard and their two sons, she created a centre for this work, based on an atmosphere of warmth, humanity, and tolerance; a centre which we all loved to visit. A haven, but a very living one.

We spent many evenings there, few or many of us, even 40-50 people. Liliane and Alain’s home was always open to those who from the very start supported medical work against torture. Their country home also welcomed us.

The first years, the early and mid-1970s, were full of hard work to make others understand the ideas behind what was created, of the fight against ignorance, but also of friendship.

Herman van Geuns, Erik Karup Pedersen, Ole Vedel Rasmussen, Sherman Carroll, Eva Forest, Liliane and Alain – we were not that many in the beginning, but the work grew in friendship. Within a few years, several thousand doctors were organized in Amnesty International’s Medical Advisory Board, an advisory body for the Executive Committee.

Liliane and Alain Bernard were not only very efficient in the international medical work against torture. They created “La Commission Médicale” within the French section of Amnesty International. Liliane Bernard was the coordinator of this commission up to her death.

She helped to organize the first international medical meeting against torture: “Violations of Human Rights: Torture and the Medical Profession”, which was held in Athens 10-11 March 1978. Doctors from 15 countries participated.

It was at this meeting that various working groups were created, among them one for work on rehabilitation of torture victims. This is the main background for the existence today of rehabilitation centres in more than 50 countries.

France was one of the first countries to create a rehabilitation centre, AVRE [Association pour les Victimes dé la Torture en Exilé], under the leadership of Dr. Hélène Jaffé. Here, as everywhere, Liliane Bernard was always ready to help, by word and, especially, deed.

Apart from the daily routine, Liliane was behind several meetings, large and small. The largest international meeting she organized was probably that of January 1989: “Médecine à risques: servir ou subir la répression”, which was held in the UNESCO building in Paris. Most continents were represented. As always when Liliane was involved, cooperation with the press was excellent. A lot of publicity resulted from the meeting, as well as a book: Médecins tortionnaires, médecins résistants, which has been translated into English (Doctors and Torture, London, 1971) and Arabic.

Liliane Bernard was modesty itself, always putting others into the limelight. She had a particular talent for publicity, and understood its importance for the promotion of the cause. The purpose of the work and the results always counted first with her, never herself.

Someone who works with such unselfishness and intelligence, an unusual combination, will always accomplish something worthwhile. What Liliane did during her life reflected her personality: a complete human being of great integrity.

It was sad that she should pass her last years alone, without a complete family life. She bore the sorrows with dignity, courage, and strength. We, her friends, had all wished a happier end to her life than the hard one she got, but she knew what she meant to us, and, despite her modesty, she knew that she had used her life well.

Inge Geneke
Medical Director
RCT

Liliane Bernard

Photo: Eva Forest
**NEWS IN BRIEF**

**RCT centre in Albania**

*By Dr. Afrim Dangllia*

The RCT centre in Tirana began its activities on 16 August 1993. The setting up of this medical unit was made possible thanks to financial support from IRCT, Copenhagen, and the particular efforts of Dr. Peter Vesti (psychiatrist).

The centre is situated near the University Hospital of Tirana. This closeness will make it easy to refer patients, should they require hospital treatment. The staff of our centre comprises four medical doctors (2 psychiatrists, one neurologist, and one general practitioner). There is already increasing interest from the population, ex-political prisoners, and victims of persecution and torture. These individuals are suffering from psychological and physical conditions.

As yet the centre has little medical equipment, but we hope to improve our technical conditions in the future. The doctors at the centre have a certain amount of experience with the work that is required. They have, for instance, taken part in seminars at RCT, Copenhagen, and have exchanged views with colleagues in foreign countries.

It remains for us to work with passion and goodwill.

*Psychiatrist*  
ARCT  
Tirana  
Albania

**BOOK REVIEWS**


This book covers a very important and controversial subject, representing a typical cross-sectional problem. It discusses medical, political, social, and legal consequences of torture, and brings a new, very comprehensive approach to this shameful area of mankind at the end of the 20th century.

Torture and human rights violations are now even more “up-to-date” and painful themes than they were two or three years ago when M. Basoglu and his coauthors were writing chapters of this unique book.

Physical and mental impairment in torture survivors attracts more attention now because of the merciless ethnic and civil wars in the republics of former Yugoslavia and former USSR.

It attracts our attention because of cruel conflicts in many African countries and because of the enormous and increasing number of refugees in Europe, which was peaceful for decades after World War II. Similar floods of refugees bring enormous problems to the African and American continents, and Asia is not free of these problems either.

Diagnostics, clinical care, and scientific research are now dominant themes among teams of medical professionals and psychologists who are dealing with torture and its sequelae all over the world.

Divided into seven parts, this monograph covers all fundamental aspects of torture prevention, prevention of medical code infringements, and protection of human and civic rights. It deals with various diagnostic approaches and with a complete therapeutic and rehabilitation approach.

R. Mollica’s opening chapter defines and identifies the philosophical dimension of the task, giving a comprehensive summary of the philosophical and methodological consequences of torture.

The following five chapters deal very clearly with physical, psychosocial, and psychological aspects of torture in various social and political conditions.

R. Baker’s chapter, exploring the “triple trauma paradigm”, is undoubtedly useful now, especially for Europeans facing the influx of the Balkan war refugees. N. Soloff’s view of the Holocaust heritage is also warming and inspiring, especially for readers from continents other than Europe.

It is necessary to pay attention to an important aspect that is analysed in this book – physical and psychological sequelae of torture are as varied as the social and cultural life conditions in which the torture survivors live. There are certainly some “basic” core symptoms of stress-related disorders, though torture-related impairment can be extremely varied. The multi-causal approach throws more light on the varieties of torture impact.

Psychological consequences of severe trauma are comprehensively described in J. Saporta’s chapter, which contains several neurophysiological and neurobiochemical facts that are important for the better understanding of the above mentioned “core” universal symptoms. Mechanisms of physiological reactions provoked by stress, trauma, and aggression are identical, but the manifestations may be modified by various factors. Biological models of the inescapable shock that leads to a syndrome of “learned helplessness” are important for a better explanation of many aspects of torture survivors’ behaviour abnormalities.

The importance of a multidisciplinary approach is well explained in L. Willigen’s and Bohjholm’s chapters. McNally’s summary of the psychopathology of post-traumatic stress disorder fits perfectly into the framework of Saporta’s, Kolk’s, and Molica’s chapters that deal with assessment and diagnosis of treatment impairment.

Parts IV and V are extremely important and useful; they describe in 150 pages the very wide scope of rehabilitation and psychotherapeutic approaches focused on the use and outcome of various therapeutic methods. The balance that has been achieved between
behavioural and psychodynamic approaches offers a very broad menu of therapeutic possibilities, not dominated by any one approach.

The necessity to protect the medical ethical code and Hippocratic oath is pointed out in T. Dowdall’s description of a very complicated situation in South Africa. He deals with highly contrasting approaches of medical professionals and offers excellent and disturbing examples.

Bæsgå’s *Torture and its Consequences* can be highly recommended to all those who look after the survivors of torture and patients suffering from serious mental/physical stress disorders.

Medical professionals, and in particular psychiatrists and neurologists, physiotherapists and clinical psychologists/psychotherapists, will use this book as a valuable source of information about the diagnosis and treatment of torture.

It is a very useful manual, not only for medical professionals, but also for social workers, lawyers, and politicians. Some of them should read through the key chapters of this stimulating and disturbing book, thinking about an effective prevention of torture and the necessity to punish the torturers and their leaders.

Martin Bojar
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This is a very good book.

It deals with the importance of trauma for psychological and psychiatric ill-health, as well as treatment procedures in life-restricting conditions such as Post Traumatic Stress Disorder.

The book is dedicated to Professor Emeritus Leo Eitinger, Oslo, on his 80th birthday, 8 December 1992. Through Leo Eitinger’s research on survivors from European concentration camps, and through his clinical work in Oslo during the 1950s, 1960s, and 1970s, the Oslo Group has pioneered psychological and psychiatric research in trauma. Few groups in the world have achieved the same quality. Comparable scientific and clinical units are only to be found at Harvard (Boston) and in Los Angeles.

The work of the Norwegians was made clear for us in Sweden by the way they handled the survivors and their relatives at the bus catastrophe in 1988, in which 12 schoolchildren and four adults from Kista died. We are far behind in Sweden with respect to clinical research on the sequelae of trauma and their treatment. Few researchers and therapists are interested in the raped woman, the mal-treated child, and the tortured refugee.

In their preface, Lars Weiseth and Lars Mehlum write that, among all the factors that influence man and his psychological balance, we have rediscovered the psychological trauma as a decisive factor. The book is not only addressed to health and hospital staff, but also to all groups with an interest in the deeper understanding of “man’s encounter with trauma”.

The book’s 260 pages comprise 19 chapters in four sections, followed by information on the contributing authors. It is worth noting that the oldest author, Leo Eitinger, was born in 1912 and was imprisoned in Auschwitz and Buchenwald from 1943-1945. The contributors, sixteen of them Norwegian, include Elie Wiesel, philosopher and author (born 1928), Nobel Peace Prize winner in 1986. Elie Wiesel met Dr Eitinger in Auschwitz, where he was his patient.

The main editor, Lars Weiseth, is Professor of Catastrophe Psychiatry at Oslo University; he also works at the Department of Catastrophe Psychiatry at Gaustad Hospital, Oslo.

The only Swedish contributor, Ulf Otto, is lecturer in child and youth psychiatry at Kristianstad. He has large experience with crises following trauma in children and young people.

The other non-Norwegian contributor is Dr Inge Genelke, specialist in neuromedicine and medical head of the Rehabilitation Centre for Torture Victims in Copenhagen since 1981.

*Section 1* deals with psychological trauma, looked on as an extreme environmental factor, caused by natural disasters or disasters due to technical failure or human action, the latter either in error or by design. It is emphasized that violence by design is the most difficult – torture, acts of violence, maltreatment, the bank robbery.

*Section 2* deals with the classical background to all understanding of trauma, i.e. the intensive trauma in which the stress factor has been so strong that all involved will usually develop symptoms of stress related to the event. The subjects are war (Lars Weiseth and Arne Sund), torture as a weapon against democracy (Inge Genelke), and “Is trauma inheritable?” (Ellinor F Major). The last-named is at present taking part in a study on the influence of fathers’ war experiences on their children (second generation trauma).

*Section 3* relates the knowledge about stress to the great traumas of our generation – concentration camps, Second World War, Vietnam, etc. A comparison is also made between violence in the family, incest, maltreatment of children, battered wives, suicide, and misuse of drugs and narcotics.

Loss and sorrow are given a special chapter, as is alcoholism as a product of trauma.

*Section 4* consists of Leo Eitinger’s and Elie Wiesel’s highly personal chapters. They give a historical anchorage to the whole clinical picture that is presented in the rest of the book.

Comprehensive references are listed at the end of each chapter – a total of 365. The various chapters are well-connected and the language flows, even for those who are not so familiar with Norwegian.

The book is worth reading and can be recommended to all general practitioners, psychiatrists, surgeons, forensic specialists, etc. who meet the acute and chronically traumatized patient in the ward or elsewhere. The book is particularly suitable for courses in medical training, perhaps already in the first year, as for the training of nurses, social workers, police officers, the fire brigade, military personnel, and journalists.

A Swedish publishing house ought to translate this essential book, just as it should be translated into English.

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Editors note:
The book is about to come in Danish from Hans Reitzels Forlag, Copenhagen, in 1994.
Instruction to authors

General remarks
TORTURE is grateful for small news items as well as articles on everything connected to torture and the fight against it.
However, it is advisable to contact the editors before writing the article! The editors will then consider the material for possible publication.
The editors retain the customary right to style and if necessary shorten material accepted for publication.
Your manuscript should as possibly be prepared in correspondence with the uniform requirements for manuscripts submitted to biochemical journals. This requirements - the *Vancouver* system - are in details described in Br Med J 1991; 302:338-41 or N Engl J Med 1991; 334: 424-8.

Book reviews
If you want to make a review of a pertinent book with relation to torture, please remember to inform about the publisher, number of pages and the price, preferably in US$ or UK£.
The review should in the shortest possible way give a personal evaluation of the book - a mere description of the contents and some quotations are not sufficient.

Summary of requirements
Please type the manuscript on white bond paper, A4 (212x297 mm), with margins of at least 40 mm. (1½ in).
Type only on one side of the paper. Use double-spacing throughout, including headline, text, acknowledgments, references, tables, and legends for illustrations.
Please notice that we seldom publish more than two pages on the same subject, corresponding to approx. 250-300 lines with 52 characters per line. A good illustration (photo, drawing or table) is always very welcome.
If the manuscript is written on personal computer with DOS compatibility, please send the disc (5.25 or 3.5 in) with the manuscript formatted in ASCII or DOS.
The manuscript should be accompanied by a covering letter with the name, the address, and telephone and/or fax number of the corresponding author. The letter should give any additional information that may be helpful to the editor.
Details of address of author, a single qualification such as MD or PhD, and full professorship are published as a footnote to papers, and this information should be provided on the title page of the manuscript. A full address should be provided for the corresponding author.

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

Articles in journals
*Standard journal article* (List all authors, but if the number exceeds six give six followed by et al).

*Organization as author*

*No author given*
Coffee drinking and cancer of the pancreas [editorial]. BMJ 1981; 283: 628<>

Books and other monographs
*Personal author(s)*

*Editor(s), compiler as author*

*Organization as author and publisher*

*Chapters in a book*

Other published material
*Newspaper article*

*Audiovisual*

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

The International Rehabilitation Council for Torture Victims is a private non-profit foundation, created in 1986 by the RCT. The objectives of the foundation are, on an international basis, to support research into all aspects of torture, to support education and training of health professionals and of other relevant personnel in the medical, social, legal and ethical aspects of torture, and to serve as an international clearing house for information about torture activities.