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Front page: Mogens Andersen, Denmark
ACTION AGAINST TORTURE COSTS MONEY

At the beginning of July, Amnesty International published its annual report, which gives an increasingly sombre picture of human rights violations.

At least 112 countries tortured or maltreated civilians during 1993. In 53 countries, at least 100,000 people were kept as political prisoners without being charged or sentenced. Politically motivated murder cost the lives of at least 10,000 people in 62 countries.

But despite this report on the misery of the world community, there has been an increase in efforts and preparations in the fight to secure respect for human rights, and to help to mend harm already done. Several organizations have become more aware of the violations and have increased their activities, and new independent human rights commissions have helped to focus attention on these violations and to increase the pressure on governments involved in torture and other violations, as revealed in Amnesty International's report.

As a consequence of this, and through systematic pressure, the UN this year created the post of High Commissioner for Human Rights for a four-year period. Mr. José Ayala Lasso was appointed to this post (see page 44). He has been Ecuador's permanent representative at the UN since 1989, was formerly Ecuador's Minister for Foreign Affairs, and earlier had several ambassadorial posts.

The creation of this post is an expression of the recognition by the international community of the increasing importance of human rights issues in world politics. The new post is a strong reminder that states can no longer refer to non-interference in internal affairs. It is also a way of giving human rights a proper political tool. Human rights used to be something that politicians all over the world were good at pushing aside and putting at the bottom of the negotiating pile. In the person of the new High Commissioner, the UN Human Rights Commission has a minister who can approach governments at the highest level.

Mr. José Ayala Lasso paid an official visit to Denmark on 27-28 June 1994. He used the opportunity to launch an international appeal for an end to torture everywhere in the world. The launching took place at RCT in Copenhagen. Its message was the importance of eradicating the worldwide scourge of torture. The main task for this is prevention. The appeal stresses the necessity of increasing financial contributions to the UN Voluntary Fund for Victims of Torture (UNVFVT) and to treatment centres that provide assistance and remedies for the physical, psychological, and social rehabilitation of victims of torture.

The High Commissioner suggests that UNVFVT's present budget of USD 2.5 million per year should be gradually increased to USD 10 million by the year 2000.

An editorial in the Boston Globe of 7 July 1994 followed up a debate on a previous series of articles on IRCT and its work, and contrasted the above budget to the aid which is given today to several countries in which torture is widespread (see page 46). In this perspective, the suggested aid for torture victims is a very modest fraction. On behalf of IRCT, we want to draw attention to the IRCT Declaration of Istanbul, an appeal directed to the UN and its Member States and included as an addendum to the UN’s 49th session. It stresses as a matter of urgency the need to increase national governments' contributions to the UNFVT to reach USD 25 million in 1995 and at least USD 100 million before the millennium.

The unabridged text of the Copenhagen Appeal can be read in this issue of Torture on page 45.

H.M.
A new High Commissioner – a presentation

High Commissioner is a title that has a ring to it. British diplomacy used it, and still uses it, for ambassadors to the dominions, nowadays the Commonwealth countries. The United Nations has had such a Commissioner for many years: the one who deals with refugees. Earlier this year the organization got another one: the Commissioner for Human Rights.

About 50 years passed from the initial daring proposal for such a Commissioner (Uruguay suggested it for the first time in 1952) until the world community could agree to establish the job. The large UN Human Rights Conference in Vienna in June 1993 decided on it. The Ecuadoran diplomat José Ayala Lasso took over as “ambassador” for all the victims of human rights violations in February 1994.

You may compare him to the High Commissioner for Refugees (heading the High Commission, abbr. UNHCR), who could be called “ambassador” for the millions of unhappy asylum seekers and refugees – and yet Mr. Ayala Lasso is more than an equivalent for all those suffering under dictatorships and general brutality.

His task is also to be preventive. On the whole, international organizations these days are very much aware that “prevention is better than cure”, which means that much man-made unhappiness, not to speak of floods of refugees, may sometimes be nipped in the bud – if the world is attentive and employs skill and diplomacy with a vengeance! The Council of Europe convention on the prevention of torture is an example of this.

It requires an early awareness, such as Mr. Ayala may teach the world. The quiet 62-year-old diplomat will first have to gain experience in his difficult job. Since he takes an interest in all the 183 countries of the world – as he said recently – he will have to amass an enormous amount of knowledge. It really takes time to try to understand why the greater part of the world continues to persecute, torture, and kill their own citizens, rather than competing and negotiating with them.

And Mr. Ayala is a cautious man. Educated as a lawyer and experienced as a diplomat – he made a very low-key appearance during a stay in Copenhagen in June. He was even reluctant to admit his adherence to “quiet diplomacy”, though he clearly expressed that attitude. Well, sometimes he tends, at least, to use open diplomacy, however quiet it may be at the same time! His first engagement was Rwanda – to mobilize the UN Human Rights Commission to get the UN Security Council assembled in order to prevent further bloodsheds there.

One may ask whether the UN Human Rights Commissioner should commit himself to such a difficult task as interfering in a civil war? And not concentrate on human rights work in countries that are at peace? Yet his journey continued to neighbouring Burundi, which, like Rwanda, was previously ravaged of bloody feuds between the small Tutsi and the majority Hutu tribes. In that country he was on a preventive mission, as he said himself.

Earlier in June, Mr. Ayala had announced that the UN Human Rights Centre in Geneva had established a so-called hotline, through which anyone, whether a private person, an organization, or a government, could easily get in contact with the United Nations via a fax machine. A database will follow so that the special rapporteurs of the UN, among them the one on torture, could follow human rights violations almost on a day-to-day basis.

H.D.

Selected list of publications

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To prosecute or to pardon?: human rights decisions in the Latin American southern cone / Pion-Berlin, David. – In: Human rights quarterly : a comparative and international journal of the social sciences, humanities, and law; v. 16, no. 1, 19940200. – p. 105-130.


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Can moral force make a change in Chile?: if someone dies naturally no ones believe it / Stuart, Angelica. – In: Fairfield County Advocate, 19860129. – p. 11 : ill.

A seal of approval for torture / Marton, Ruchama. – In: Haaretz, 19930715. – 1 p.

The following is the text of the appeal against torture delivered in Copenhagen on 28 June 1994 by the UN High Commissioner for Human Rights

COPENHAGEN APPEAL

"Just a year ago, the World Conference on Human Rights adopted by consensus the Vienna Declaration and Programme of Action. The 171 participating States "... emphasized that one of the most atrocious violations against human dignity is the act of torture, the result of which destroys the dignity and impairs the capability of victims to continue their lives and their activities.""

Already in 1948, the Universal Declaration of Human Rights stipulated, in its article 5, that "no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment." It was 7 years ago, on 28 June 1987, that the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment came into force. Unfortunately, we have to recognize that torture is still practised around the world and that men, women and even children are suffering treatment that is unworthy of our civilized world.

On this occasion, I wish to appeal for a definitive end to, and the total eradication of, this practice, which should have long since disappeared. Today, more than ever before, it is essential to universalize the international legal framework against torture. To that end, I urge all States Members of the international community to ratify the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

I request the States which are already Parties to the Convention to ensure its full implementation. I encourage them to make the declarations recognizing the competence of the Committee against Torture to receive and consider communications submitted by other States Parties or by individuals who claim to be victims of torture.

It is a cause of concern that, to date, only 82 States have ratified the Convention against Torture, and it is essential that we do our utmost to make progress towards its universal ratification. Within the framework of my mandate, I am prepared to enter into a dialogue with all States in order to discuss with them the difficulties and obstacles they face in ratifying the Convention.

I should like to re-emphasize that there can be no exception to the prohibition of the use of torture. No exceptional circumstances – be it a state of war, the threat of war or internal conflicts – can justify such an act, which violates the most basic rights of the victim and which devalues the person who performs it. The impunity enjoyed by the perpetrator all too often merely adds to moral suffering of the victim.

I should like also to pay a tribute to the Special Rapporteur of the Commission on Human Rights on the question of torture, Mr Nigel Rodley, as well as to his predecessors, for their unceasing efforts to make the whole world aware of the horrible realities of this scourge and to make recommendations for its complete elimination. I invite all States to cooperate with him, in a spirit of openness and dialogue, and to respond positively and rapidly to his requests for information and his urgent appeals.

Lastly, I wish to pay a tribute to all those who are working selflessly throughout the world to relieve the suffering of torture victims and bring them help and assistance. I am conscious of and grateful for the tireless efforts of hundreds of Non-Governmental Organizations whose main purpose is assistance to and rehabilitation of victims of torture. Their work deserves the full appreciation of the United Nations and the international community as a whole. I strongly believe that the physical, psychological and social rehabilitation of persons whose bodies and minds have been marked should be considered as a general international obligation and is a concrete expression of the solidarity that unites peoples.

The Rehabilitation and Research Centre for Torture Victims of Copenhagen has played a pioneering role in these endeavours and has inspired the creation of a network of such Centres throughout the world. I hereby applaud and encourage its excellent work over the years and pledge my full cooperation in the achievement of its noble purposes.

I therefore appeal to those Governments which are able to do so to contribute or increase their contributions to the United Nations Voluntary Fund for Victims of Torture or to contribute directly to Centres for the Rehabilitation of Victims of Torture in Copenhagen or elsewhere in the world. As far as the UN Fund is concerned, with some $2.5 million per year, it cannot at present respond to the many requests for assistance that it receives. A doubling of contributions, to $5 million by next year and $10 million by the year 2000, would make it possible to multiply activities aimed at effecting the physical and psychological effects of torture.

It is important that the work of physicians, psychologists and lawyers assisting torture victims be facilitated. I am firmly convinced that, in order to deal effectively with the scourge of torture, the best remedy is prevention. It is therefore essential to strengthen assistance and technical cooperation activities in this area. The training on international human rights standards of the police and armed forces, judges, lawyers and health workers is of crucial importance in that regard.

The International community is now considering a draft optional protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The adoption of this protocol, intended to establish a preventive system of regular visits to places of detention, is bound to strengthen efforts to make this scourge disappear once and for all.

The international community is about to enter its third millennium: a complete cessation of the practice of torture would affirm the moral conscience of humanity and would uphold the most fundamental principles enshrined in the Universal Declaration of Human Rights.

Ending torture is the beginning of true respect for the most basic of all human rights: the intrinsic dignity and value of each individual. I therefore call on all Governments and those in a position of power and authority to do their utmost to put an end for ever to this inhuman practice and truly reaffirm their respect for human beings everywhere on earth.

José Ayala Lasso
High Commissioner for Human Rights
Copenhagen, 28 June 1994,"
Editorial from the *Boston Globe*, Thursday, 7 July, 1994, page 2:

**US is accused of aiding torturers**

Amnesty puts sum to regimes at $5.4b; some funds go to repression

By Stan Crossfield

GLOBE STAFF

The Clinton administration has asked Congress for $5.4 billion in 1995 economic and military assistance to governments that Amnesty International, in a report released today, lists as sanctioning torture.

"I don't think that a superpower should support a government where the power is based on torture," said Dr. Ingé Genelké, founder of a rehabilitation center that analyzed the Amnesty data on torture.

"The United States should be putting pressure on governments to stop torture, and stopping the money is the best weapon," said Genelké, founder of the Rehabilitation and Research Center for Torture Victims in Copenhagen.

The Clinton administration "is not better than the past administration, arguably it's worse," Bill Schulz, executive director of Amnesty International, said in a telephone interview.

Israel and Egypt account for the vast majority of aid, with more than $5 billion budgeted for the fiscal year 1995. More than $3 billion of that is earmarked for military support. Amnesty, in its annual report issued today, accuses both countries of systematic torture and of killings suggestive of extrajudicial execution.

Other countries listed as having government-sanctioned torture include Turkey, which is slated to receive $101.4 million; Bolivia, $66.5 million; Peru, $42.3 million; and Colombia, $40.6 million.

"In Turkey we have reason to believe that US-supplied arms were directly used to bomb Kurdish villagers, and we have called for a suspension of US aid," Schulz said.

In Colombia, Amnesty urged the United States to suspend military assistance because of reports of counternarcotics aid being misused in counterinsurgency efforts and human rights abuses. "Many hundreds of people were extrajudicially executed by the armed forces . . . some political detainees were tortured or ill-treated," Amnesty said.

Amnesty refuses to grade the Clinton administration but was harshly critical of it.

"The bottom line is that as for a new direction, there isn't one," said James O'Dea, director of the Amnesty office in Washington. "The harsh reality is that military sales are up slightly. This sits through the rhetoric about building democracy and promoting peace. Congress last year asked for a human rights plan, and to date the Clinton administration has not delivered it. How can you stop torture if you can't deliver a human rights strategy?"

Sen. John F. Kerry of the Senate Foreign Relations Committee said a lot of the aid is linked to economic programs. "There's no doubt we should be taking a tougher line with some countries," Kerry said. "Clearly we should be linking aid to government behavior. We should not be selling arms to nations which torture. But a lot of that aid is for nongovernmental programs."

Kerry also said he supports the $1.8 billion in military aid to Israel, the largest military aid expenditure. "They are at war. Twenty-one of 26 countries surrounding them have declared war against them."

Amnesty releases a report each year documenting its human rights work and concerns throughout the world, detailing human rights violations in 152 countries. In addition to well known abuses such as rape and murder in Bosnian, killings in Rwanda and Iraq, imprisonment in China, and abuse of street children in Brazil, Amnesty cited other violations.

In Mexico, "Dozens were detained on account of their peaceful political activities. Frequent torture and ill-treatment by law enforcement agents continued to be reported." In Haiti, "Hundreds of real and suspected supporters of President Jean-Bertrand Aristide were detained unlawfully . . . torture and ill-treatment of detainees was wide spread, and several detainees reported to be the result of torture . . . hundreds of people 'disappeared' or were extrajudicially executed."

The United States is cited for 38 executions of prisoners. Amnesty opposes the death penalty.

The report said extrajudicial executions were carried out by "government forces in 61 countries, including Angola, Burundi, Colombia, Croatia, Egypt, Haiti, Israel and the Occupied Territories, Pakistan and Turkey. More than half of the 2,000 people cited in this report were allegedly extrajudicially executed in Africa."

"Women were the victims of many human rights violations, including rape in 46 countries," the report said.

The report noted that the fall of communism did not bring a decline in torture.

"When Communists fell and the Berlin Wall fell, we thought that torture would decrease. We've found exactly the opposite. In 1989 there were 96 countries where torture occurred and today it's 112. There's also been an increase in government sanctioned torture. The end of the Cold War didn't mean the end of torture by any means. Economic instability leads to political unrest and torture follows."

A research assistant, Brian Kaplan, contributed to this report.

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A review of medical and counselling services for survivors of political repression in South Africa 1987-1992

By
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Abstract
In response to the widespread political repression and violence in South Africa during the past years, progressive health organisations have developed programmes to provide medical and counselling services to survivors of political violence. This programme, coordinated through the Emergency Services Groups (ESGs), is reviewed in the Western Cape region from its inception in 1987 to 1992. Different phases in the programme’s focus are identified in sequence; they reflect the changing political situation during the period under review, with ex-detainees, released political prisoners, and subsequently returned exiles, forming the major client populations served by the ESG initiative. Some features of the ESG model to date have included the use of volunteer professional services, the networking role with client organisations, the widespread use of group work, and the adaptation of existing models of mental health care delivery to the reality of service provision under repressive political conditions. Important lessons are drawn from the ESG experience that will inform the current plans through the South African Health and Social Services Organisation (SAHSSO) to set up a series of Trauma and Rehabilitation Centres for survivors of organised violence in the country. This initiative is particularly critical to addressing the effects of the current waves of violence accompanying South Africa’s transition to political democracy.

Introduction
The maintenance of the system of Apartheid in South Africa over the past decades has necessitated the application of some of the most repressive racist legislation in modern times. Detention without trial, bannings, and arbitrary expression of State powers became routine tactics under successive Nationalist governments to suppress opposition to apartheid. Torture was widespread and systematically used to extract confessions and to intimidate opponents. A host of supplementary laws, such as media restrictions, were utilised to suppress the truth about human rights abuses in the country.

In the second half of the 1980s, the extent of repression in South Africa rose sharply under a series of states of emergency. Unprecedented numbers were detained, including many children and many people with no political involvement. Activists were “on the run” for months, never sleeping in the same place for more than one or two nights in a row, and family members were often harassed. Many of those released from detention were served with restriction orders confining them to their homes and making them vulnerable to assassination and harassment by the activities of mysterious hit squads. Vigilante attacks, random assaults, and community violence became widespread.

Progressive responses to human rights violations and the formation of Emergency Services Groups (ESGs)
For many health professionals, the experiences of that period were shocking and a challenge to ethical and moral principles. Concerned health professionals responded by providing medical and counselling services to people released from detention and by working with activist detainee support groups. Many of the psychotherapeutic models used drew on experiences such as those of the RCT in Denmark. These developments were paralleled by the formation of organisations that were committed to a vision of a non-racial democratic South Africa where health and human rights would be guaranteed. These included organisations of health workers and professionals who were subsequently to merge in 1992 to form the South African Health and Social Services Organisation (SAHSSO).

With the escalation of repression in the mid-1980s, the need for services for survivors of state repression resulted in the establishment of an umbrella network of ESGs, drawing from members of SAHSSO’s forerunners. The ESGs, in consultation with community and mass organisations, provided first aid training for communities suffering casualties under conditions of civil uprising, and counselling and medical services for ex-detainees and political prisoners. As political conditions changed in the country, these counselling and medical services were subsequently focused on programmes for the reintegration of political prisoners, and then for exiles returning to South Africa under the supervision of the UN High Commission for Refugees (UNHCR).

This paper reports on a preliminary review of services provided through the ESG programme in the Western Cape Region from its inception in 1987 to 1992, when the ESGs were incorporated into SAHSSO’s programme.

ESG services: 1987-1992
Over the period 1987 to 1992, a total of 832 people were seen at ESG facilities for individual services (fig. 1), and a further estimated 1500 family and community members through group discussions and workshops. Ex-detainees were the major group seen in the first phase (1987-1990), political prisoners in the second phase (1990-1991), and returned exiled in the most recent period (1991-1992) (fig. 2).

The ESG model has largely relied
for services on volunteer professionals, and has emphasised networking with other resource and referral organisations. Preventive work was an important focus which attempted to educate families and communities to prepare them to cope with the effects of the detention of family members, and to cope themselves in detention.

Overall, only a small proportion of the total number of detentions (estimated at between 1000 and 3000 between 1987 and 1990 in the Western Cape) were seen at the ESG service. This was partly attributable to the politically "macho" culture of resistance in the country as the struggle against apartheid reached a climax. Activists would often emerge from detention and plunge straight back into intense political activity. Accordingly, the role of the ESG service was seen as one of facilitating people's adjustment to an extremely stressful environment. As a result, many people who would have needed some form of short- or long-term therapeutic intervention at the time were not reached by the service. Their potential needs, and the consequences of torture and trauma they may have undergone, remain unaddressed.

After the unbanning of political organisations such as the ANC in February 1990, the government began to release large numbers of political prisoners. During this period, programmes for support and reintegration of released political prisoners formed the bulk of the work of ESGs, particularly in the Western Cape. This included group discussions involving family members and friends, post-release counselling of over 300 political prisoners, the development of a self-help manual, and medical screening as part of a comprehensive reintegration programme run by the Anglican Church as part of its social responsibility programme. Much of the therapeutic work in the groups involved exploration of the ex-prisoners' feelings and fears, and sharing of experiences and strategies that other ex-prisoners had used to cope with their re-orientation. The majority of prisoners seen during this period were released from the notorious prison of Robben Island off the coast of Cape Town, home to most of South Africa's long-term political prisoners for the past 40 years, and today likely to be turned into a museum of apartheid.

In the past four years, the number of prisoners released from detention has declined substantially, and much of the ESG's work has been directed at the needs of returning exiles. A primary reception centre for the repatriation of exiles was established in Cape Town in 1991, through which the ESG delivered a range of services to the exile community, including screening for infectious diseases common in the areas

from which exiles have returned, particularly malaria\textsuperscript{11}, and psychosocial support for complex marital, cultural, and material adjustment difficulties experienced by the exiles and their families.

The model of intervention developed within ESG was to a large extent shaped by the repressive conditions under which the programme developed in the 1980s. At the outset, the ESG clinic was compelled to maintain a low political profile to protect both client and therapist from the possibility of security force harassment. The clinic was sometimes the target of raids by security forces, forcing the service to make use of venues outside the clinic for contacts and counselling, particularly for those living in fear of arrest.

Another factor was the immediate return by many clients to intense political activity, with little time for follow-up after their initial visit. This client expectation of a "psychological check-up" before return to activism necessitated an acceptance of a "once-off" intervention model for ESG services, even though the limitations of such an approach were evident. At a time when political struggles were very militant and charged, ESG was able to maintain a credibility based on its adapting conventional psychotherapeutic models to the reality of dealing with damage caused by repression. Trust was a crucial aspect of the therapeutic intervention and could not be achieved in a political vacuum\textsuperscript{12}.

As a result, the majority of clients seen at the ESG service came for only one visit, and there was little by way of extensive follow-up. However, a certain number of cases needing longer follow-up were handled outside the ESG service by the same volunteer mental health professionals, who incorporated these clients into their routine work setting\textsuperscript{12,13}.

A much smaller category of attenders between 1990 and 1992 comprised survivors of organised violence. Given the repeated waves of random killings, assaults, and attacks frequent in communities throughout the country since political changes began to direct South Africa towards a non-racial democracy, the paucity of this group of survivors among ESG service users is cause for concern. To some extent this is explained by a number of factors:

1. the Western Cape region has been partially spared of the extent of violence that has ravaged the rest of the country
2. relief work with survivors of violence has frequently focused on the immediate physical health consequences and the social needs, rather than on the psychological and emotional damage
3. the definition of organised violence is difficult to make in the context of a country with massive unemployment, rocketing crime rates, and gangsterism and deprivation, and renders difficult any attempts to respond to what one perceives as a "bone fide" survivor
4. the biggest obstacle is that community violence has frequently resulted in physical dislocation of the survivors, who are turned into internal refugees. In the absence of an infrastructure to maintain contact with victims and detect direct psychological needs, access to the ESG service proved inadequate.

These lessons are critical to the challenges that face South Africa at present. Over 13,000 people have been killed in political violence in the country in the past 4 years\textsuperscript{*}), and the appalling levels of violence and its effect demand a coherent response. The experiences of the ESGs have laid the basis for the development of a network of Trauma and Rehabilitation Centres (in collaboration with the Anglican Church in the Western Cape) offering services to victims of violence in the country. Since its launch in July 1992, the Centre in Cape Town has already seen over 600 victims of violence and is continuing to cater for the needs of the many ex-detainees, political prisoners, and returned exiles suffering the long-term sequelae of their traumatic experiences. Ongoing evaluation of the programme is planned to assess the effectiveness of the Trauma Centre initiative in contributing to the process of reconciliation that is needed to build a new and peaceful democracy in South Africa in the future.

Acknowledgements

Acknowledgements to Ms Nikki Moll and Mr Lance Terry for their assistance with data collection. We also wish to pay tribute to the courage and resilience of many South Africans from whose experiences we have learnt so much about the strength of human nature.

\* Personal communication, Jane Connely, Human Rights Commission, Cape Town, March 1944.

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Exile psychology and psychotherapy with refugees in a transcultural perspective

Some theoretical considerations

By
Julio G. Arenas†
Pia Steen‡

To have been exiled means to have been forced to leave one's home country or home area without an immediate possibility of return. The reasons for the exile may be manyfold, but the purpose is unambiguous: it is further punishment and as such a prolongation of the repression in the home country. It is a strategy of repression with the involvement of a national and international collaborating network, which makes exile an effective weapon of a global political power struggle.

These considerations contain a double perspective of the problems of exile:

- exile represents an immediate liberation from very real social violations (persecution, imprisonment, torture)
- exile at the same time produces psychosocial repression, which is the real impression of the punishment.

Thus, exile is the start of a new repressive phase in the life of the exiled person, in which his/her traumatic experiences from the home country are supplemented by privation, sorrow, and reactions of guilt.

The connection between these two forms of repression is the core of the exile psychology and forms part of the theoretical basis on which CEPAR (Center for psycho-social assistance for refugees) is working.

The history of exile psychology

CEPAR has chosen to use the term exile psychology for that part of the psychology which deals with the relationship between psychopathology and culture.

Exile psychology is not a new invention; it has existed ever since people, forced by circumstances, started to move around. But it has got a new and different institutionalized life, since refugees from the Third World began to come to Europe and the USA in relatively large numbers.

The subsection of exile psychology has been given many names:

- crosscultural
- culture-
- comparative psychology/psychiatry
- ethno-
- anthropological
- transcultural.

The approach to the subject may be differently orientated - it may concentrate on the individual psychology, on the social psychology, or specifically on anthropological aspects. The background is the history of colonization, when the Europeans went into the field to "catch" and civilize "the savages". The so-called "culture-bound syndromes" were identified through a "Western" filter through which culture was made a pathogenic condition in itself. The Western cosmology was seen as the culture-neutral basis from which the rest of the world had deviated. This "ethnocentric" point of view, with various modifications, has remained surprisingly intact till today.

The special approach to migration and mental health started in the USA in the 19th century with the large migrations from Europe, and in Europe after the Second World War and during the de-colonization period in the 1950s and 1960s, partly with massive population movements within Europe itself, partly with streams of people coming from the old colonies.

The research of that period gave no unambiguous answer to the connection between migration and psychopathology, but was primarily based on two hypotheses:

- migration as "stress-provoking in itself"1
- the migration patterns as indicating a sort of self-selection in a positive or a negative direction.

From the 1970s and onwards, two groups of people have left their mark on the European stage:

- migrant workers from Southern Europe, North Africa, and the Middle East
- political refugees from the Third World.

These migrations have created new roots for the transcultural psychology/psychiatry, which is now almost identical with "psychology and psychiatry for ethnic minorities", and is practised mainly by Western "therapists" on non-Western "clients".

It therefore seems that this overall discipline, which was supposed to reveal the relationship between psychopathology and culture in more depth, has become a "tale" about the relationship between Europeans and non-Europeans.

Within the past 15 years, however, a more exile-specific approach has manifested itself, which does not solely focus on the special traumatic conditions caused by previous torture, long imprisonment, and repression, but also compares the above conditions with the conditions of "living in exile", in another cultural context, i.e. the refugees from the Third World in exile in Western Europe or the USA.

In Western Europe, it is particularly the cross-sectional group COLAT (Colectivo Latino Americano de Trabajo Psico- Social = Latin American collective for psychosocial work) in Belgium that has developed an extensive clinical practice concerning refugees in Europe.

Of special interest in COLAT is the fact that the professionals who are in charge of the work are refugees themselves.

It is this approach that CEPAR takes part in and further develops as a treatment and research initiative.
The refugees' psychosocial construction of the reality

Exile can be defined as a situation of loss and deprivation. The refugee experiences exile as a removal from the psychosocial and identity-confirming environment where he/she was a subject of importance. In exile, the life span is subjectively divided in two periods which are not in agreement or continuity with each other, and which even may be in conflict with each other: the one before and the other after arrival in the country of exile. The first is remembered as full of importance, the second as without meaning and controlled by strangers.

This existential lack of continuity - in both time and space - is a consequence of an unwanted transplantation from one psychosocial reality, which was in agreement with the refugee's foundation for identity, to another basically unknown and strange and therefore felt as slightly "unreal". The essential solidarity between the refugee and his present social environment, the country of exile, is broken down by the historical and socio-cultural differences.

The mutual recognition from the interaction with family and friends, from participation in social and political movements, etc. is usually lost on arrival in the country of exile. Here the refugee has to "start afresh". He must adjust his feelings and his perception of himself, his own identity, to the new socio-cultural situation. This process meets with many difficulties of a cause-effect nature, related to the refugee's social disintegration in the country of exile.

The refugee experiences that "the others' history - not my history" is taking place, and that he has no influence over it. He is under continuous pressure to learn new ways of interacting in daily life; he does not know beforehand the values and norms of his new society, and they are not immediately integrated into his system of values. Furthermore, he is cut off from the possibility to offer something, to teach and train, to share his experiences and culture with the Europeans - partly because of the language barrier, partly because his cultural background is not recognized in Europe. This means that the refugee's immediate chances of obtaining recognition by "the others" (i.e. the Europeans) are poor under the described circumstances.

The confrontation between the two cultures is an additional cause of psychological disorganization. The larger the socio-cultural distance between home and exile countries, the higher the refugee's risk of psychological disturbances.

It is also very important that most of the refugees in Europe come from the Third World, whose culture is underestimated and devalued by the Europeans, who consider it "insufficient".

This cultural failure manifests itself psychologically in the refugee, who feels underestimated and marked as incapable of managing his own affairs, and is deprived of the social recognition that is necessary for the feeling of an identity.

The psychosocial manifestations of the refugee

The precondition for understanding and interpreting the psycho-social manifestations which exile psychology tries to treat is a definition of whom you are dealing with.

A classification of various types of refugee points out some essential differences and some common features in their psycho-social circumstances, and can thus give an important lead for a treatment course.

The differences concern the wish to leave the home country, motivation for integration, attitude to country of exile, future perspectives, definition of roles, perspectives for returning home, etc., and the common features within the groups include:

- most refugees have had severe traumatic experiences in relation to the imprisonment, torture, flight, etc., and to being exiled
- most refugees come from non- or less-industrialized countries which differ to a larger or smaller extent from the country of exile with respect to socio-economic structure, culture, religion, ethical codes, etc., and for most this leads to so-called cultural shock

all refugees form a minority in society, and as such they risk personal and social marginalization and isolation, discrimination, racism, repression, etc.

in the long run, this last point tends to wipe out the others so that the problems become more homogeneous between the groups and focus on the conflict between the minority and society.

The pattern of reactions in the country of exile will depend on the circumstances in the home country - whether it was a question of a society in conflict or disintegration, of war, civil war, or various forms of persecution.

The basis of treatment depends on an understanding both of these circumstances and of the special circumstances of the refugees as a minority group in the country of exile.

The psychosocial manifestations that have been documented widely among refugees in Europe must be looked at as individual and collective reactions to crises, i.e. normal reactions to abnormal pressure.

The problems of exile should thus be seen as essentially two-dimensional:

- exile as a collective phenomenon which leads to a collective crisis with collective strategies for solutions
- exile as an individual and personal phenomenon which leads to individual crises and models for solving the crises.

In this way, the refugee is not considered as a patient - neither in his perception of himself, nor in the perception of others. He is recognized and respected for what he is and for what he has been through, and he is not deprived of his responsibility as an adult person, nor of his activity and ability to take actions.

Culture, refugee, and psychotherapy

Psychosocial work with refugees requires the development of a particular theoretical understanding and methods, the basis of which is a holistic approach to the problems of exile.

CEPAR defines psychosocial work with refugees as a transcultural field of work. This work takes place in the dynamic situation of the refugee and is a product of:

- the persecution in the home country
- the flight
- the adaptation to the country of exile.

The framework for this transcultural field of work, and the psychosocial work with refugees, is set by the controversy between various cosmologies:
when refugees from a non-Western culture are transplanted to a Western culture, cultural traditions and manifestations face each other.

Western culture focuses on the individual as a "freely floating, isolated, biosocial unity" without its cultural context and its influence on the development of personality. In the West, "independence" and "individual independence" are to a large extent considered as synonyms for "psychological maturity and health". Psychological disturbances are considered a result of "return to immaturity and dependence". Western approaches within psychotherapy therefore aim at "self-knowledge" and "insight", which can lead to re-establishment of the "individual independence".

Non-Western cultures in general focus on the direct opposite: the group, the collectivity, the solidarity, being a member of a family, a clan - the network is all important. The individual is nothing without this context. According to the non-Western concept, independence is not an identity-confirming value, whereas "social" and "family-related capacity" are key words.

These two different culture strategies in relation to the individual and the group are connected with the strategies of the psychological and psychotherapeutic field of work and thus with the understanding of the refugees' mental crises and their cultural background.

The fragmented Western concept of the individual and the world penetrates the psychotherapy given to refugees; it not only omits the collective as a way of restoring health, but puts itself outside it by continuing to look at crises as "private affairs".

Thus, Western psychotherapy practices individualistic self-searching and a critical analysis of the personality of the individual as the basis and cause of the psychological disorder. The final holy goal is a "maturation process", in which the individual gains "higher" degrees of "autonomy" - in principle in a social vacuum.

As mentioned, the non-Western perception of the world is largely the opposite: it is in particular the group and the collectivity which determine and define, and it is in this collective environment that crises and conflicts of all kinds are revealed and solved. The context is the text.

From the transcultural point of view of the treatment of refugees, the suitability of the psychotherapy should be considered. It is important to consider the following aspects:

1. Concepts of "mental health" and "psychological disorders" The interpretation and treatment of these conditions are culture-related. The therapist therefore has to develop methods that must solve not only the problem of the "language barrier" but also that of cultural differences. Such an understanding requires that the therapist is conscious of his own culture and its influences, both in his clinical evaluations and in the therapeutic relationship.

2. Manifestations of the symptoms While Western culture to a large extent deals with body and psyche as two separate entities, the non-Western concept of body and psyche is holistic, i.e., mutual dependence on each other. The somatic reactions can therefore not only be interpreted concretely, but must at the same time be understood as metaphors for a more extensive state of crisis. The symbol-value of these metaphors requires partly a socio-cultural understanding, partly a linguistic code, which makes the interpreter a central and important person.

3. The refugee's concept of psychotherapy and psychological treatment Many refugees who are offered psychotherapy have never considered or been in need of such treatment. This is the first barrier to be overcome. For instance, many refugees do not know the terms "psychologist", "psychological treatment", etc. Furthermore, they have not gained sufficient knowledge of the social conditions of the country of exile, and this is to some extent a precondition for a good treatment result. This situation is related to the refugees' marginalization with respect to work and social activities, which is yet another hindrance to successful treatment.

At the same time, the intimacy with respect to the therapist is encumbered with adverse feelings. The therapist must master the horror while "taking over" the refugee's sorrow and pain. This is complicated, because the therapist has both a concrete or an abstract understanding of the refugee's past (persecution, imprisonment, torture), and is concretely involved in a social situation of the present, with which the refugee has a controversial or no relationship.

4. Only Western diagnostic categories, without interpretation In trying to understand, we often interpret the refugee's situation from a Western cultural angle, which the refugee feels as threatening to his identity. These interpretations are the essence of our culture's attitude to the psyche, the individual, and reality, but they are strange for the refugee.

Treatment centres must therefore be aware of the difficulties in evaluating and interpreting symptoms and behavioural patterns.

We feel it is too risky only to use the un-interpreted Western diagnostic categories. One must be aware of the difficulties in categorizing a mental condition in a person from another cultural background, and of the treatment centre's risk of hastening and maintaining the mental conditions.

5. The role of the psychotherapist and the function of the institution Society's answer to the psychosocial problems and crises of the refugees is at the moment increased institutionalization - a solution strange to the refugee. The staff of the institution - including psychotherapists - become to some extent accessory to making them patients, unable to handle their own affairs.

In our Western culture, these institutional initiatives are "natural" and to some extent they "serve a purpose", but refugees from non-Western cultures do not look at them in this way.

The psychotherapeutic contribution In our opinion, only a comprehensive holistic approach to refugees' psychological and psychosocial life makes it possible to understand the relationship between political repression/organized violence, refugees, exile, and mental disorders.

The psychotherapist must always approach these subjects at two levels, from which the refugee's basic problems should be revealed and defined:

1. The history of the individual/group - persecution in the home country (imprisonment, violations, torture) - the flight (the breaking away in time-space-action) - adaptations in the country of exile (confrontation with a strange socio-cultural reality, possibilities of action, personal resources, the character and course of the crisis).
2. Degree of integration/disintegration in the existing social situation

Culture shock, discrimination, racism, insufficient information about the society, minority status in the country of exile, isolation, language barriers, housing conditions, family/community life, social network, political, social, and cultural activities, etc.

These basic conflicts always depend on a time dimension, i.e. at which stage of exile the refugee is. The exile and the accompanying psychosocial manifestations and crises - is not a steady state but a process undergoing changes. This fact should always be remembered during the treatment.

The psychotherapy of refugees and the therapeutic environment should not be an isolated island, but, on the contrary, an active preparation for life outside and an inclusion of this "life" in the therapeutic process.

In this sense the psychotherapy is a transitional phase in which the refugee has a chance, within a protective framework, to restore and develop his psychological space.

The otherwise prohibited aggressive discharges are allowed a free scope, and the psychotherapist is willing to listen. These demands cannot only be interpreted as "transfers".

The psychotherapist represents in turn the home country, family, friends, and is the one who can provide information about work, social conditions, social isolation, etc., as well as solutions to related problems. The therapist must also have an understanding for the refugee's bad experiences at various previous confrontations.

On this background it is necessary to have the treatment process under continuous reconsideration. The psychotherapist must have a realistic idea of the limitations of the individual work related to the problems of a wider social dimension.

The psychotherapeutic efforts should aim at a transfer of insight and thus to support the refugee's ability to choose, to increase his possibilities for action and his attachment to the social network.

This is an active process between primarily two persons: psychotherapist - refugee. Despite fixed roles in the therapeutic process they maintain an equal relationship in which it is a precondition that the therapist has a transcultural competence, an understanding of the chemistry of exile, and a sympathetic attitude to the individual conflicts. Secondarily the whole of the refugee's network should be involved as a necessary part of a "vigorous" solution to the crisis.

A restoration strategy as outlined here excludes any form of making the refugee feel infantile, dependent, and unable to manage his own affairs.

The psychotherapeutic approach to refugees must therefore change from the traditional individual-orientated clinical practice to a broader social approach - both in the understanding and interpretation of the refugee's psychological problems, as mentioned above.

In this connection there is an important prophylactic effect in supporting the refugees' contact with and involvement in relevant political, cultural, and social networks - which has been called "psychotherapy's social extension".

Concluding remarks

CEPAR is very much aware that transcultural work requires transcultural staff at all levels. Staff training must be continuous so that their understanding and concepts of their work keep in line with new social experiences. The work must be constantly searching, led by curiosity, openness, and dynamism.

Psychotherapists should thus orientate and engage themselves in the refugees' various relations: in their personal life/activities (for instance at home visits), and in their social life/activities (various efforts by the organizations, political, cultural, and social, in relation to home country and country of exile). They should make an effort to improve the refugees' living conditions in the country of exile.

In its transcultural work CEPAR wants to stress reciprocity and equality as the main tools, and participation and influence as the logical consequences.

With these considerations about the importance of the transcultural dimension, we wanted to emphasize that psychosocial work with refugees should not develop into a disguised ethnocentric adaptation program. On the contrary, it must be based on the dialogue as a strategy. It should be a meeting in an intercultural field, which is not finally defined beforehand, but which always makes room for changes, development, and new thoughts.

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Addressing human response to war and atrocity : major themes for health workers / Summerfield, Derek ; Medical Foundation for the Care of Victims of Torture, 1993/3000. - 6 p.

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World Medical Association Statement on Body Searches of Prisoners

Adopted by the 45th World Medical Assembly Budapest, Hungary, October 1993

The prison systems in many countries mandate body searches of prisoners. Such searches, which include rectal and pelvic examination, may be performed when an individual enters the prison population and thereafter whenever the individual is permitted to have personal contact with someone outside the prison population, or when there is a reason to believe that a breach of security or of prison regulations has occurred. For example, when a prisoner is taken to Court for a hearing, or to the hospital for treatment, or to work outside the prison, the prisoner, upon returning to the institution, may be subjected to a body cavity search which will include all body orifices. The purpose of the search is primarily security and/or to prevent contraband, such as weapons or drugs, from entering the prison.

These searches are performed for security reasons and not for medical reasons. Nevertheless, they should not be done by anyone other than a competent person with some medical training. This non-medical act may be performed by a physician to protect the prisoner from the harm that might result from a search by a non-medically trained examiner. The physician should explain this to the prisoner and should furthermore explain to the prisoner that the usual conditions of medical confidentiality do not apply during this imposed procedure and that the results of the search will be revealed to the authorities. If a physician is duly mandated by an authority and agrees to perform a body cavity search on a prisoner, the authority should be duly informed of the necessity for this procedure to be done in a humane manner.

The search should be conducted by a physician other than the physician who will provide medical care to the prisoner.

The physician’s obligation to provide medical care to the prisoner should not be compromised by an obligation to participate in the prison’s security system.

The World Medical Association urges all governments and public officials with responsibility for public safety to recognize that such invasive search procedures are a serious assault on a person’s privacy and dignity, and also carry some risk of physical and psychological injury. Therefore, the World Medical Association exhorts that, to the extent feasible without compromising public security,

- alternate methods be used for routine screening of prisoners, and body cavity searches be resorted to only as a last resort;
- if a body cavity search must be conducted, the responsible public official ensure that the search is conducted by personnel with sufficient medical knowledge and skills to perform the search safely;
- the same responsible authority ensure that due regard for the individual’s privacy and dignity be guaranteed.

Finally, the World Medical Association urges all governments and responsible public officials to provide for such searches by a physician whenever warranted by the individual’s physical condition. A specific request by a prisoner for a physician shall be respected, so far as possible.

The World Medical Association adopts this statement for the purpose of providing guidance for National Medical Associations as they develop ethical guidelines for their physician members.

Comments by Hernán Reyes, MD, on the 1993 WMA Statement on Body Searches of Prisoners

Having been asked by the journal TORTURE to write a short commentary on the above-mentioned WMA Statement, it would perhaps be wise to start by mentioning briefly how this statement came into being. The World Medical Association put the subject on its agenda in 1990. A first draft statement was presented by the Ethics Committee and discussed at Committee and Council sessions. As an observer at the WMA Ethics Committee, the ICRC was also asked to comment on the subject, based on its experience in the field. Several intermediate versions were drawn up by the Danish and Swedish Medical Associations. The final statement was approved by the World Medical Assembly at Budapest in late 1993.

The reason for a Statement on the subject of intimate body searches – or "Body Cavity Searches", to use the term in the Statement – from an organization such as the World Medical Association, was that repeated cases of prisoner harassment via such practices have been reported in recent years. Furthermore, the question of whether such a procedure should be performed by a medical doctor was clearly controversial. In some countries, only doctors are considered competent to perform an intimate body search. In other countries,
medical orderlies or other para-medics are considered qualified. The whole question of whether a body search is a medical act in itself came under discussion.

Finally, after taking into account the obvious necessities of any prison or custody system, it was found necessary to define a prisoner's rights as to what should normally be an exceptional procedure in the first place.

This whole issue, evolving around physicians performing body cavity searches under certain circumstances, made it necessary for the trans-national authority of the World Medical Association to establish ethical guidelines that could be accepted by the whole medical community.

The final version of the Statement is of necessity a compromise after discussions, sometimes heated, on several occasions, sometimes heated, on several issues, sometimes heated, on several issues, sometimes heated, on several issues, sometimes heated, on several issues, sometimes heated, on several issues. As such, however, it warrants further consideration. The following comments are made by the ICRC observer at the WMA Ethics Committee who participated in the actual shaping of this document from the beginning, with the physicians from various National Medical Associations. The comments are, however, personal and are not to be seen as acknowledged by or in any way binding to the World Medical Association.

The text referred to is WMA Statement 17. FF on Body Searches of Prisoners, in its original English version. This Statement is found in the WMA Handbook of Declarations in its 1993 updated edition.

The first paragraph of the Statement says that "... prison systems in many countries mandate body cavity searches for prisoners". Furthermore, the same paragraph at the end states that "... the purpose of the search is primarily security and/or to prevent contraband...".

This could seem to "take for granted" the fact that prison systems require body cavity searches as part of routine security procedures, and also that such searches are always performed for justifiable reasons, namely security and contraband.

It should be underlined, however, that the same paragraph also says that "Such searches... may be performed... when there is a reason to believe a breach of security or of prison regulations has occurred". The point here is that a Body Cavity Search is not a commonplace act, but an invasive one (this is stated, but only in paragraph five), and as such should be used only as a last resort. (This is set out in the Statement, admittedly, three paragraphs from the end.) The main point here is that a recognizable person with authority has to be accountable for mandating such a procedure, so as to avoid abuse of the system. This is what is meant by "... duly mandated by an authority..." in the last sentence of the second paragraph.

The last sentence of the first paragraph states that searches are performed "... to prevent contraband, such as weapons or drugs, from entering the prison". So far as weapons are concerned, this is taken to mean a straightforward case, where there is a legitimate reason for a Body Cavity Search. In the case of drugs being smuggled, however, and although there are many prisons where this may be the rule, a Body Cavity Search is not the solution, and the Statement should not be interpreted as suggesting that it is. In cases of "body-packing" or "drug mules", medical surveillance may indeed be warranted, although in many or most cases, letting physiology take its course should be sufficient. The mere physical act of performing what is defined in the Statement as being a Body Cavity Search - which does not include any instrumental technique - does not solve the problem, nor is it safe, if performed without adequate medical surveillance.

The further question of medical confidentiality not being the rule in the case of a physician performing a Body Cavity Search is another point that needs explaining. The relationship here between prisoner and physician is not a real doctor-patient or therapeutic relationship. Indeed, in paragraph three of the Statement it is explicitly said that "... the search should be conducted by [someone]... other than the physician who will provide medical care to the prisoner". A physician duly mandated to perform a Body Cavity Search acts as a medical examiner, and obviously has to report what s/he finds to the authority which requested the examination.

However, and this is perhaps not clear enough in the Statement, this lack of confidentiality concerns only what is required of the search itself. For example, if a doctor performing a search for explosives in a High Security Prison is told by the prisoner concerned that she is pregnant, but that she does not (for whatever personal reason) want the authorities to know this fact, the doctor should not betray this, since it is not related to the object (explosives) he was mandated to look for.

One specific issue which has been said to be lacking in the World Medical Association Statement is that of consent.

There should be no confusion here. Whether or not a prison system makes body searches mandatory, and whether or not a prisoner complies with this rule is a subject (complex enough) for penitentiary science. As has been said, a Body Cavity Search is not a medical act, and therefore, apart from the specific cases stated, a physician need not be involved.

However, if and when s/he does become involved, either by being duly mandated, or, as is said in paragraph six, if the prisoner puts in a request for a physician, then there is a situation where the physician has to rely on his/her own ethics for guidance. Obviously, no physician respecting an "individual's privacy and dignity" (paragraph five) and convinced that a Body Cavity Search has to be done "in a humane manner" (paragraph two) would consent to do a forcible search.

Indeed, and this should have been perhaps emphasized a bit more, a physician should make sure that the prisoner has indeed consented to the procedure. Although the very issue of "consent" in a custody situation is, of course, relative, a doctor should, in the course of explaining to the prisoner what the search comprises, be in a position to ascertain whether coercion is being used by the detaining authority. In such a case, or if the safeguards (dignity, privacy, etc.) are not respected, the physician should not carry out the search and intervene accordingly.

It is hoped that, with these few clarifications, the true intent of this document will be seen. The Statement should comprise sufficient safeguards in its wording to prevent a detaining authority from using medical doctors merely as retrieval auxiliaries for Security or Police purposes. It also allows for prisoners with legitimate medical conditions to have access to medical help, i.e. a doctor, whenever this is possible.

Hernan Reyes, MD ICRC Medical Division Geneva Switzerland
Both the State and private Turkish citizens violate human rights

A lot of pertinent information in the 1990-92 report from the Human Rights Foundation of Turkey

By Henrik Döcker, Journalist

Turkey belongs to the group of strange countries of this world where torture is widespread – and medical doctors are free to treat the victims at open rehabilitation centres. Turkey is also a country where both government and private organizations use torture.

Despite many problems, the Human Rights Foundation of Turkey is doing a great job. In 1992, 343 applied for treatment in the three centres – Ankara, Istanbul, and Izmir. As many as 300 medical doctors and psychiatrists cared for them.

Fifty different torture methods

Since 1980 over a million people have been subjected to torture in Turkey. It is well known that the Kurdish Workers’ Party (PKK) uses brutal measures in its fight for Kurdish self determination, and that the government has often declared a state of emergency in several provinces for that reason – facts which, however, must not influence the obligation of doctors to combat torture whenever use it.

The HRTF report enumerates about 50 different torture methods. 60% of the detainees were exposed to 4 types of torture, 36% to more than 4 types. Two-thirds indicated that the torture took place at a police station. The applicants for treatment complained mostly of psychological problems (63%); both physical and psychological complaints were made by 26%, compared with 10.9% of a total of psychological complaints. Torture was used in prisons to a lesser extent.

The commonest physical complaints were orthopaedic, due to long periods of torture. Gastrointestinal diseases due to psychosomatic disorders were the second commonest. Memory impairment, anxiety, and sleeping disorders were also frequent.

Few completed rehabilitation

Only 11.8% completed their rehabilitation. The Turkish centres consider this situation alarming. Several reasons prevented the victims from completing what was prepared for them: accommodation problems caused by the various kinds of obligation to the spouse, the job, and the army.

42% of the applicants who were in prison for more than a year had psychological and physical complaints, compared with 29% when the period was less than a year. Worries of being abandoned by their parents were often heard.

Since this HRTF report was published, the UN Committee Against Torture went public with the message that Turkey, despite numerous promises to abolish torture, still practices it systematically. The Turkish government has informed the UN that it is currently carrying out investigations regarding 457 people suspected of having used torture and mistreatment against prisoners in the period from 1 January to 30 August 1992. 450 people were duly charged.

Fear, intimidation, threats

The UN Committee emphasized that it should not be possible for an administrative body to abolish a judgment against a torturer passed by a court of justice. The Committee further stressed that the prohibition against torture is absolute.

Neither the UN Committee nor the Council of Europe Torture Prevention Committee, nor the HRTF for that matter, wants to gloss over the tremendous problems which face the Turkish government vis-à-vis the PKK. The HRTF regrets, however, that it has still not been possible to establish a centre for torture victims in the east Turkish town of Diyarbakir, centre of the Kurdish population.

Why? Because of the omnipresent atmosphere of fear, intimidation and threats to individuals, and the repression of any kind of associations, democratic civil organizations, vocational training institutions, labour unions, and political parties. The situation is tense; some people in Turkey even fear a virtual civil war.

As it must be acknowledged that torture is endemic, there is unfortunately little hope as yet for an eradication of this evil. Still, the fight for the victims continues, based on the goodwill and heavy work of numerous HRTF volunteers. The international society keeps an eye open on Turkey, trusting that the many reports of torture may some day have an effect.

Selected list of publications received in the IRCT International Documentation Centre

Cameroon : the situation of torture survivors and their relatives in Cameroon: history and culture, politics and economy of Cameroon / Sama-Kwende, Gilles, [19940000]. – p. 2-5.
Incidence and prevalence of torture condition for torture rehabilitation work in Cameroon / Buma-Fodje, Jonas, [19940000]. – p. 6-9.
Common health problems of victims of systematic violence: Sri Lankan experience

By
S. Sivayogan, MBBS, MD*

Purpose: to study physical and psychological sequelae of systematic violence in Sri Lanka.

Country perspectives and background information

The population of Sri Lanka is c. 17 million. It may be categorized by language and religion. The majority community is Sinhalese, who are mainly Buddhists and Christians. Tamils, mainly Hindus and Christians, are a minority. Muslims are either Tamil- or Sinhala-speaking.

The Tamils benefitted from superior English education provided by Christian Missionary Schools in Northern Sri Lanka; they had better employment opportunities and economic prospects under British rule of the island up to 1948.

Sri Lanka became a sovereign state in 1948, with a constitution that was modeled on the British parliamentary democratic system. This enabled the majority community to have a major share of legislative and executive powers, and to marginalize the Tamils.

The Tamil community, alleging discrimination in employment, education, and crown land allocation, agitated for redress. This, fuelled by periodic racial conflicts, culminated in an insurgency movement that campaigned for a separate state.

The government struggled to maintain Sri Lanka as a Unitary State and adopted countermeasures, using its armed forces. This internecine strife has continued unabated over a decade.

Indian intervention in this internal conflict, as a mediator with a military presence in the form of a peacekeeping force, engendered a backlash from militant Sinhala youth belonging to a party proscribed by the government.

All the parties to the conflict have inflicted systematic violence on detainees.

Objectives
Categorization of alleged types of torture; tabulation of common complaints by victims; medical examination of victims of violence for diagnostic purposes and to determine a correlation between types of torture and physical or psychological disorders; assessment of effectiveness of rehabilitation efforts; suggestions for ways of improving rehabilitation measures.

Methodology
The sample consisted of ex-detainees in refugee camps and rehabilitation centres. It was not possible to use a structured questionnaire. Case records completed during medical examination were used instead. The primary purpose of the medical examination was treatment, and only information that was relevant to arriving at a correct diagnosis was obtained.

Results
Information from the case records on types of torture and complaints is given in Tables 1 and 2.

Discussion
Complaints of torture are difficult to substantiate. Even if witnesses were present, locating them and obtaining corroborative evidence is a difficult task. Perpetrators of alleged torture are unlikely to confirm it, even anony-
mously. The possibility of exaggeration, to win sympathy and obtain material benefits, must be allowed for in evaluating information given by respondents.

Wherever possible, alleged forms of torture were related to complaints of physical and psychological ailments. Quite often, with a few exceptions of permanent structural damage, physical

Table 2. Complaints.

<table>
<thead>
<tr>
<th>Complaints</th>
<th>n = 69</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>46 67</td>
</tr>
<tr>
<td>Arthralgia</td>
<td>38 55</td>
</tr>
<tr>
<td>Shoulder</td>
<td>32 46</td>
</tr>
<tr>
<td>Lower back</td>
<td>33 48</td>
</tr>
<tr>
<td>Other joints</td>
<td>46 67</td>
</tr>
<tr>
<td>Painful soles</td>
<td>8 12</td>
</tr>
<tr>
<td>Myalgia</td>
<td>26 38</td>
</tr>
<tr>
<td>Peptic ulcer symptoms</td>
<td>22 32</td>
</tr>
<tr>
<td>Irritability</td>
<td>32 46</td>
</tr>
<tr>
<td>Depressed feeling</td>
<td>46 67</td>
</tr>
<tr>
<td>Fear (particularly of going back to home station)</td>
<td>63 91</td>
</tr>
<tr>
<td>Anxiety</td>
<td>31 45</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>24 35</td>
</tr>
<tr>
<td>Nightmares</td>
<td>12 17</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>22 32</td>
</tr>
<tr>
<td>Loss of weight</td>
<td>8 12</td>
</tr>
<tr>
<td>Visual problems</td>
<td>18 26</td>
</tr>
<tr>
<td>Impaired hearing</td>
<td>4 6</td>
</tr>
<tr>
<td>Skin infections</td>
<td></td>
</tr>
<tr>
<td>Scabies</td>
<td>12 17</td>
</tr>
<tr>
<td>Fungal infection</td>
<td>18 26</td>
</tr>
<tr>
<td>Non-specific</td>
<td>6 9</td>
</tr>
<tr>
<td>Loss of memory</td>
<td>6 9</td>
</tr>
<tr>
<td>Phobia (blood, security forces, etc.)</td>
<td>4 6</td>
</tr>
<tr>
<td>Dental</td>
<td></td>
</tr>
<tr>
<td>Periodontal diseases</td>
<td>18 26</td>
</tr>
<tr>
<td>Loss of teeth due to torture</td>
<td>3 4</td>
</tr>
<tr>
<td>Chest pain</td>
<td>18 26</td>
</tr>
<tr>
<td>Dizziness</td>
<td>12 17</td>
</tr>
<tr>
<td>Lack of concentration</td>
<td>24 35</td>
</tr>
<tr>
<td>Malunited fractures</td>
<td>2 3</td>
</tr>
<tr>
<td>Feeling of tiredness</td>
<td>16 23</td>
</tr>
<tr>
<td>Hyperventilation</td>
<td>2 3</td>
</tr>
<tr>
<td>Tremors</td>
<td>5 7</td>
</tr>
</tbody>
</table>

Table 2. Complaints.

The following complaints would have disappeared by the time the victims had access to outside medical help, particularly when the torture was inflicted early in detention and the detainees were released long after it.

Although verification is difficult, the demeanor of patients in narrating their traumatic experiences, and consistency in their statements, tend to prove that such complaints have some measure of truth.

Psychological sequelae of torture are difficult to measure and evaluate. Patients' case records may be classified into cognitive symptoms (confusion/disorientation, memory disturbance, impaired reading, poor concentration), psychological symptoms (anxiety, depression, irritability/aggressiveness, emotional lability, self isolation/social withdrawal), and neurovegetative symptoms (lack of energy, insomnia, nightmares, sexual dysfunction). In the absence of reliable case records of such patients before torture episodes, it is difficult to relate such complaints to traumatic experiences.

Responses to traumatic experiences may be magnified or diminished by cultural influences and innate resilience of individuals, making it difficult to specify that a given type of torture episode results in a given type of emotional impairment.

Ex-detainees are quite often unable to return to their place of permanent residence. Loss of house, relatives, and sources of income, and social stigmatization may contribute to their reluctance to return. The experience of being condemned to refugee status is a potent secondary traumatic stress. It is difficult to assess how much present emotional impairment relates to the primary stimulus (torture episode) and how much to the secondary stimulus (displacement).

Conclusion

This study reaffirms the difficulties in establishing a link between torture and physical and mental symptoms, due to the following reasons:

1. Reliable historical data on the health status of victims before the traumatic episodes are not available to serve as a control and to help to decipher the aetiology of the general symptoms and their connection with torture.

2. There is often an inordinate delay between episodes of torture and subsequent medical examination.

Even if such difficulties are overcome, the lack of specificity between type of trauma and psychological impairment is an impediment to the reaching of generalized conclusions. First, psychological problems are not necessarily phenomena that are rooted in the individual and adjudged to be present or absent; they are socially mediated, and responses and coping strategies are culture- and class-bound. Second, there is no reliable way of measuring damage to the most intimate functions of the mind - the capacity to love, to laugh, to achieve.

Although a rigorous outcome survey to assess the effectiveness of medical treatment and psychological counseling has not yet been undertaken, there have been few relapses, mainly attributed to the inability of victims to return to their former residences and resume gainful employment.

This suggests a need for an integrated programme that comprehensively addresses not only medical but also socioeconomic problems. Furthermore, optimum results may only be obtained when the situation in the country returns to normal.

Selected list of publications

received in the IRCT International Documentation Centre


Mänskliga rättigheter och läkare identer : påverka kollegor som handlar oetsk! / Eittinger, Leo. – In: Läkar­tidningen v. 91, no. 22, 19940000. – p. 2251-2254 : ill.


Sudanese torture victims set to take gov­ernment to court / Bowcott, Owen. – In: Sudan human rights voice : v. 3, no. 4, 19940400. – p. 4.
Is torture a Post-Traumatic Stress Disorder?

By AP Reeler*

Although most disorders within the field of psychopathology rely upon some notion of stress, the notion of the stressor involved in any particular disorder is often vague and ill-defined. Nonetheless, nosologies retain the notion of stress, and DSM-III even provides a specific axis for classification of disorders in which stress is argued to occupy a dimensional existence, from "minimal" to "catastrophic", and the presence of a defined stressor is argued to be a good prognostic sign. Hence, Brief Reactive Psychosis, which requires a stressor, is argued to have a better prognosis than schizophrenia, which has no stressor and has an insidious onset. However, this assumption that a stressor is a good thing may be questioned, and the notion that insidious development of a disorder is a bad thing may reflect clinicians' ignorance rather than any real state of affairs. In some disorders, however, stress is clearly not a good prognostic sign, but the reason for the disorder itself, as is the case with Post-Traumatic Stress Disorder (PTSD).

PTSD has been argued to be a useful classification in dealing with stressors of an extreme nature, specifically those of a "catastrophic" nature according to Axis IV of DSM-III and DSM-III(R). The stressor no longer forms part of the background theory of a disorder, as is the case for many disorders, but forms the rationale for the disorder. However, it is argued by some workers, largely those working with torture survivors, that the notion of stress-induced disorder is insufficient to deal with the extent and nature of the trauma caused to a person by torture and repressive violence. This paper examines this debate.

Post-Traumatic Stress Disorder

PTSD came into existence in order to provide a description for disorders and symptoms in which the stressor seemed to be of a "catastrophic" nature, and was clearly demanded by a socio-political reality; the large numbers of soldiers who suffered disorders after the Vietnam War were difficult to ignore. There were, however, many previous attempts to give expression to the effects of trauma that were not easily covered by the existing nosologies. These earlier descriptions had been classified mainly by reference to the precipitating event, and "concentration camp syndrome", "post-Vietnam syndrome", and "rape trauma syndrome" are all well-known examples of this approach to classification. However, impetus for a specific classification for disorders caused by trauma came with the recognition that diverse forms of trauma seemed to produce similar clinical pictures in the sufferers.

This recognition, that diverse stressors could produce remarkably similar effects, was codified in DSM-III in 1980 with the invention of PTSD. This was quickly followed by clinical studies and research, and resulted, in 1987, in the amended definition and description given in the revised version of DSM-III. Some brief consideration should be given to these two descriptions and to the amendments that have taken place. There are also plans further to amend this last definition.

As can be seen from tables 1 and 2, there are several marked changes in both the definition and the descriptive criteria. First, the stressor concept itself is amended, from "recognizable" stressors that cause "significant distress in almost everyone" to stressors that are "outside the range of usual human experience" that are "markedly distressing to almost everyone". This marks PTSD off as a disorder in which the stressor would have to be at least "catastrophic" on Axis IV of DSM-III. It is not clear whether this continues or alters the notion that stress is dimensional, and does not deal with the problem that the stressor is exceptionally difficult to define in objective terms.

Second, re-experiencing the trauma (Criterion B) needs now to be "persistent", with the inclusion of intense distress on exposure to events that may symbolize the original trauma. Third, numbing of responsiveness, Criterion C in DSM-III, is replaced by persistent avoidance, Criterion C in DSM-III(R), with a much expanded range of symptoms. Fourth, there is the replacement

Table 1. Post-Traumatic Stress Disorder: DSM-III.

<table>
<thead>
<tr>
<th>A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.</th>
</tr>
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<tbody>
<tr>
<td>B. Re-experiencing the event as evidenced by at least one of the following:</td>
</tr>
<tr>
<td>1. recurrent and intrusive recollections of the event</td>
</tr>
<tr>
<td>2. recurrent dreams of the event</td>
</tr>
<tr>
<td>3. sudden acting or feeling as if the traumatic event were re-occurring, because of an association with an environmental or ideational stimulus.</td>
</tr>
<tr>
<td>C. Numbing of responsiveness to or reduced involvement with the external world, beginning some time after the trauma, as shown by at least one of the following:</td>
</tr>
<tr>
<td>1. markedly diminished interest in one or more significant activities</td>
</tr>
<tr>
<td>2. feeling of detachment or estrangement from others</td>
</tr>
<tr>
<td>3. constricted affect.</td>
</tr>
<tr>
<td>D. At least two of the following symptoms that were not present before the trauma:</td>
</tr>
<tr>
<td>1. hyperalertness or exaggerated startled response</td>
</tr>
<tr>
<td>2. sleep disturbance</td>
</tr>
<tr>
<td>3. guilt about surviving when others have not, or about behaviour required for survival</td>
</tr>
<tr>
<td>4. memory impairment or trouble concentrating</td>
</tr>
<tr>
<td>5. avoidance of activities that arouse recollection of the traumatic event</td>
</tr>
<tr>
<td>6. intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.</td>
</tr>
</tbody>
</table>

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Table 2. Post-Traumatic Stress Disorder: DSM-III(R).

A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost everyone.

B. The traumatic event is persistently re-experienced in at least one of the following ways:
   1. recurrent and intrusive distressing recollections of the event
   2. recurrent distressing dreams of the event
   3. sudden acting as if the traumatic event were re-occurring
   4. intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the event.

C. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma), as indicated by at least 3 of the following:
   1. efforts to avoid thoughts or feelings associated with the trauma
   2. efforts to avoid activities or situations that arouse recollections of the trauma
   3. inability to recall an important aspect of the trauma (psychogenic amnesia)
   4. markedly diminished interest in significant activities
   5. feelings of detachment or estrangement from others
   6. restricted range of affect
   7. sense of foreshortened future.

D. Persistent symptoms of increased arousal, as evidenced by at least 2 of the following:
   1. difficulty in falling or staying asleep
   2. difficulty concentrating
   3. hypervigilance
   4. exaggerated startle response
   5. physiological reactivity upon exposure to events that resemble an aspect of the traumatic event.

E. Duration of the disturbance (symptoms in B, C, and D) of at least one month. Specify delayed onset if onset of symptoms was at least six months after the trauma.

of the range of allowable symptoms in DSM-III, Criterion D, with the notion of persistent increased arousal in DSM-III(R), Criterion D. DSM-III(R) adds a fifth criterion, Criterion E, which includes a time course of at least one month's duration, as well as allowing for a delayed course. These changes together indicate a much clearer definition and a disorder that is clearly more severe than had been previously assumed.

Validation of the disorder by epidemiological and clinical research has accompanied these changes in classification. This work has been reviewed recently by McNally. In his opinion, the studies indicate that PTSD forms a coherent syndrome. There is good reliability in diagnosis, since reliability coefficients range from 0.58 for unstructured interviews to 0.86 for research studies using trained interviewers. There can still be questions about validity.

Prevalence is rather variable, and has been assessed in two ways—in the general population and in “at risk” groups. The Epidemiological Catchment Area (ECA) Survey estimated the lifetime prevalence of PTSD at about 1.3% in the general population, and at 3.5% in persons exposed to civilian or military violence, while a rate of 20% was found for veterans wounded in Vietnam. The clear suggestion was that the rate depended on actual exposure to violence, and this was bolstered by studies of at risk groups.

The National Vietnam Veterans Readjustment Study reported lifetime prevalence rates of 30.9% for males and 17.5% for females, while, for those exposed to high war zone stress, the current prevalence rates were 38.5% and 17.5%, respectively. This again bolstered the notion that the stressor could be objectively determined, as well as that there was a continuum along which stressors could be ordered, and according to which the severity and prevalence of PTSD could be predicted.

The degree of exposure to violence seems to affect the course of PTSD, and an American study on children attacked by a sniper at school showed this clearly. One month after the attack, 77% of the children who had been in the playground when it was attacked showed PTSD, while 67% of the children who had been inside the school also showed PTSD. 14 months later, 74% of the former group still showed PTSD, but only 19% of the latter.

There therefore seems to be a dose-response effect due to the magnitude of the stressor, and, according to this argument, torture will represent the most severe of all stressors, and the prevalence of PTSD should be highest in this population. This would seem to support the dimensional concept of stress, but, as pointed out above, this argument is somewhat modified by a recent empirical study, which demonstrated that, although PTSD was a probable result of physical injury, it was more a consequence of the perception of injury than the actual severity of the injury itself.

Although there is little doubt that PTSD usually follows trauma, there has been some debate over the notion that there is a delayed subtype. This argument has been partially resolved by a recent study from Israel, in which veterans who sought psychiatric help between 6 months and 5 years after the 1982 Lebanon War were examined. This study suggested that 40% of cases represented delayed help-seeking, 33% exacerbation of subclinical PTSD, 13% reactivation of old PTSD, and 10% delayed onset PTSD.

The debate is complicated even further by recent studies of Holocaust victims, which demonstrate clinical disturbance in third-generation survivors, but it is not clear whether the disturbance measured in the grandchildren of concentration camp victims can be described as PTSD. The issues around the course of the disorder and its long-term effects are yet to be clearly resolved.

All of this epidemiological work has been substantially supported by the more empirical work. Laboratory studies have shown that PTSD sufferers have marked and significant responses to noxious stimuli, with sufferers showing both psychological distress and physiological reactivity to battle sounds, war imagery and the like, and marked avoidance of these stimuli: 80% of PTSD sufferers in one study terminated exposure to audiotaped combat stimuli, as opposed to 0% of healthy combat veterans.
Studies of sleep show that traumatic dreams occur in both REM and non-REM sleep, as well as difficulties in both falling asleep and maintaining sleep. In general, the sleep studies show a wide range of differences between PTSD sufferers and other populations, both civilian and military. Other studies, investigating intrusive cognitive activity, have shown marked effects of intrusive cognitions, with PTSD sufferers showing positive interference for Vietnam-related words (BODYBAG), but not for other intrusive words (GERMS).

Thus, some of the key features of PTSD, sleep disturbance, intrusive cognitions, psychological reactivity, and physiological distress, seem to be supported empirically, and there is support for the notion of a specific disorder produced by trauma, and capable of being delineated from other disorders. It seems clear that exposure to violence has severe, persistent, and delayed sequelae, with a dose-response effect, but there still remain some difficulties, and some critics. The major critics come from amongst those working with torture survivors, who are critical of the PTSD definition, and suggest that there may still be such a thing as a "torture syndrome" apart from PTSD.

**Torture**

Torture clearly represents an extreme form of exposure to violence, in that the effects are premeditated and designed, the process usually involves attacks of both a physical and a psychological nature, and, most importantly, torture has an explicitly political purpose in a clear socio-political context. One estimate sees "government-sanctioned torture" as being present in 78 countries in the world, while another estimate reckons that between 5% and 35% of the world's refugees have suffered at least one torture experience. So it is well to have an understanding of the scale of the problem, and to see that it has a particular socio-political value. In general, those who work with torture survivors argue that PTSD is an insufficient definition of the consequences of torture. This argument requires some brief consideration.

At the outset, it is worth noting several important features of modern torture, for it is clear that torture, as a socio-cultural phenomenon, may well have had different effects through history. Contrasting ancient and modern torture, Rasmussen notes that torture was an accepted practice in previous times, that it was practised publicly, and that it was usually carried out after legal proceedings, whereas today torture is clearly not acceptable, is invariably carried out in secret, and is mostly arbitrary in its infliction. This last point is not trivial, for it is well-established that torture is specifically used as a political weapon in order to achieve political ends: the use of terror and torture as an arbitrarily applied means of political coercion is an increasingly common feature of modern life. Thus, the meaning of torture has altered over time, and it seems pertinent to remember that torture may differ from other trauma because of its meaning alone.

It may seem to be hair-splitting to raise the socio-political meaning in a consideration of psychopathology, but it is obvious that it is just this aspect of torture that set it aside from disasters, catastrophes, wars, accidents, and abuse. It is the specific purpose of torture that sets it aside from most other trauma. Torture and repressive violence are specifically targeted at individuals and groups with the specific intention of causing harm, forcing compliance, and destroying political will, frequently in the absence of war, but always in a situation of civil conflict.

Thus, there is considerable debate over whether torture should be conceptualized in a narrow medical framework, or should be seen in some broader framework, including the political. The deliberate and systematic attack on people, and the attempt to destroy personality and political will, are felt to be such intrinsic features of torture that a narrow definition, such as PTSD, may miss this. For this reason, many workers in the field prefer the concept of "Psychosocial Trauma" to PTSD, for it seems specifically to allow for links to be made between the causes of trauma and trauma itself.

As Başoğlu has pointed out, this means that problems are involved in the classification of torture, and three main arguments may be identified. First, torture is a political phenomenon, and thus is not easily captured within a psychiatric diagnosis; this refers specifically to some criterion of meaning. Second, PTSD does not apply to torture since it does not reflect the understanding that torture is only one of a series of ongoing trauma affecting a survivor. Third, psychiatric labels are stigmatizing and should be avoided. The rationale behind each of these views can be given quite briefly.

The first point relates to the validity of psychiatric diagnosis, and, in particular, the validity of PTSD. As was pointed out above, it is not in question that the diagnosis of PTSD can be made reliably. Studies of the prevalence of PTSD in torture survivors clearly demonstrate high rates of PTSD in torture survivors. For example, in a study of Turkish prisoners, 85% of the sample had been tortured. Of the tortured group, 39% showed PTSD, while none of the non-tortured group had the disorder, and, of those who showed physical sequelae of torture, 71% had PTSD. A study from Gaza showed that more than 70% of political prisoners had received more than one form of torture, 30% showing PTSD. So, it is not in dispute that PTSD can be found in torture survivors, nor that torture is a cause of PTSD, but it can be argued that the meaning of torture is not well reflected in the current classification of PTSD.

The narrow classification of torture as PTSD also does not reflect the reality for torture survivors, and, in particular, the finding that torture is merely one of a series of stressful life events for the survivors. Survivors do not merely suffer psychic and physical injury; they also lose families, jobs, educational opportunities, and suffer alienation, displacement from their communities, and frequently end up as refugees. In fact, torture survivors suffer a wide range of adverse consequences, and this frequently means that the process can carry on over a very extended time period. For this reason, many workers feel that "ongoing traumatic stress disorder" would be a much more accurate expression of torture.

The problem of "labelling" is equally not trivial. Many workers feel that the reduction of torture sequelae to a psychiatric condition places a very unhealthy emphasis upon the victim, ignores the entire process behind torture, and can even ignore the likely probability of psychopathology in the perpetrators of torture. This criticism is only partially vitiated by the advantages of including torture in international classifications, and the recognition that torture is recognized as a cause of psychopathology.

From a theoretical and epistemological perspective, the criticisms about the narrow definition of PTSD are rather more serious. The deliberate infliction
of harm seems to place torture in the position of a distinct form of stressor, and the specific purpose behind torture makes it very different from random violence or catastrophe, whether natural or man-made. Furthermore, the violence is decidedly purposive, with the aim of the systematic destruction of individual and community identity, and it is very hard to know how to include in a definition what is surely a notion of "evil", however unpalatable this notion might seem to a scientist. But in the final analysis, the claims for torture as distinct must rest on empirical as well as logical and moral grounds, and thus it needs to be demonstrated that a torture syndrome exists separate from PTSD. Little such evidence exists, nor has the issue received much empirical attention, but the clinical work does suggest that a torture syndrome is more than a logical or moral construct, although there are dissenters from this view.

The Torture Syndrome

At the outset, we should note that there are different methods for approaching this problem. One approach, which has already been extensively described, is to examine the range of pathologies already shown, and then to construct a syndrome. This is the preferred approach of psychiatry, and is the explicit method behind the construction of the DSM-III definitions. The second approach is to generate hypotheses based on an understanding of current theory, and then to test these on the problem at hand. This is generally the favoured approach of psychology, and is effectively a hypothetico-deductive empirical method. Both have their advantages and disadvantages, but it should be pointed out that the former is frequently argued to have greater validity because of the strong observational base behind the description. Actually, this is a spurious claim, since it is evident that the observations are very rarely unpolluted by theoretical bias, and, certainly, within psychiatry there can be no claim that a symptom exists independent of the measuring device.

If the second of the two approaches above is adopted, then it becomes possible to see the ways in which torture differs from PTSD. Turner has provided both interesting argument and clinical support for the view that torture has consequences not covered by the PTSD definition. This theory argues that there are four themes common to torture survivors: incomplete emotional processing, depressive reactions, somatoform reactions, and the Existential Dilemma. The first covers many aspects included in the definition of PTSD, such as psychic numbing, re-experiencing of trauma, and avoidance, which can also be described as the attempts by survivors to split emotional and cognitive components of their feeling. It also reflects ways in which many survivors coped with the torture process, which is frequently described as having to learn to dissociate in order to survive.

The second theme is important, and relates to an important aspect of the definition of PTSD, that of its conceptualization as an anxiety disorder. As Turner points out, repressive violence usually leads to a wide range of losses, which are more frequent precipitants of depressive reactions than of anxiety. Indeed, depressive symptoms are very frequently reported by torture survivors, and are not explicitly mentioned in the DSM-III definitions.

Somatoform reactions are equally important. Most torture requires the sufferer to learn very complex associations between physiological and psychological events, and these may be adaptive during torture, but turn out to be maladaptive subsequently. Thus, it is apparent that the survivors may have a very wide range of idiosyncratic conditioned and formerly adaptive responses, and this needs to be included in the understanding of the response to torture. The point here is that the range of reactions may be exceedingly diverse, and it may be doubtful that even the reduction behind this taxonomic category, somatoform reactions, will be an adequate description.

The final criterion is perhaps the most important, because it rescues the four-dimensional model from a narrow and reductionist definition. The Existential Dilemma expands the theory away from mere consideration of conditioned responses, and reflects the ways in which the survivor's sense of Self and position in the world are affected. Alienation, shame, guilt, inability to trust, personal change, relationship difficulties, and sexual difficulties are all reported by torture survivors. Clearly, there must be difficulties in the operational definition of this dimension, but it does reflect some of the considerations that demarcate torture and repressive violence from other forms of trauma.

The model may be preferable to both PTSD and the single entity theory of a Torture Syndrome, but it too has disadvantages. To relegate the meaning of torture to an existential dilemma is not clearly an improvement, nor an answer to the criticism raised by Başoğlu, for example. Causing an existential dilemma in a person may be the intent behind torture, but it seems unlikely that torturers and educators are only distinguished by their methods; the intention to harm and the perception of this intent suggest that torture and repressive violence must be described not only by behavioural and medical criteria, but also by moral, ethical, and political criteria.

Thus, it does seem that there are good grounds for thinking about torture as having unique consequences, and consequences that might not be easily covered by the PTSD definition. It is also clear that some kind of conceptual analysis is also necessary as a preliminary to the construction of any syndrome entity, and this will determine the kinds of observations that are made. This will not preclude the approach of existing epidemiology, that of examining persons in populations that have suffered repressive violence, but it may point out the limitations of the approach. As Faust and Miner have commented in their analysis of the epidemiological basis of modern psychiatric nosologies, purely descriptive observations do not exist in psychiatry, and all observations are theory-driven. It is crucial, therefore, to make explicit the theory behind the observation language, and this is as true for torture as it is for any other disorder. Thus, there needs to be an interaction between the two methodologies outlined earlier: neither will be satisfactory alone.

The more difficult epidemiological question, that raised implicitly by the concept of Psychosocial Trauma, has scarcely been addressed. As Başoğlu has commented, torture (and repressive violence) are political acts, and conceptually this marks off these forms of torture as distinct from disasters, accidents, and the like.

Vis maior may be the same as the hand of man, but this still needs to be established, both empirically and logically. It is difficult clinically and epidemiologically to differentiate PTSD and a Torture Syndrome at present, but the problem is not merely a measurement problem, for there remain complex conceptual problems that are not
simply solved by more complex models\(^b\).

**Conclusions**

Clearly no definitive comments can yet be made about this debate at the moment, but the problems and issues raised deserve serious consideration. The acceptance of PTSD as a psychiatric (and medical) disorder has led to a focus on the problems caused by man’s violence to man, and to an increasing awareness that violence may be a cause of considerably more harm than is commonly accepted. It led, for example, to the understanding that the witnessing of violence may cause disorder no less than the experiencing of violence. It has also led to the suggestion that the effects of violence may rear damaged children, so too may the violent continue the cycle of their own violence in their children.

The definition of PTSD makes visible the consequences of organized violence, but it may equally make invisible many of the processes in the causation of the disorder as well as many of the consequences. Whether torture should be regarded as an "ongoing traumatic stress disorder", and hence distinct, or should be seen as the most severe form of PTSD remains to be seen. The reduction behind psychiatric definitions can have many positive effects; it can facilitate identification of formerly undetected disorders, can lead to necessary descriptive work, and can allow scientific communication. However, reduction is only useful when it encompasses all the relevant variables, which is the cause of the present debate.

The deliberate infliction of harm has powerful biological, social, and psychological consequences, and seems to place the stressor concept in torture in rather a different position to the other kinds of stressors known to cause PTSD. It seems to have the quality of evil about it, which may be a reason why it produces such pronounced countertransference effects\(^c\). Evil and politics may not be the common currency of the healing professions, but do we not need to consider whether the attempt to produce a definition by reduction takes the meaning out of torture and repressive violence?

**References**


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Egypt has been bound by her ratification of the UN Convention against Torture for more than seven years – and yet torture continues. In November 1993, Egyptian doctors took an important step in their endeavours not only to help torture survivors, but also in reality to combat torture itself. Together with other Human Rights protagonists, they arranged the first international conference on Medicine and Human Rights.

Still many violations in Egypt
The USA State Department and Amnesty International have condemned Egyptian authorities for not having investigated the numerous complaints of torture lodged by lawyers, victims, and Human Rights organizations. Arbitrary arrests and torture of hundreds of people have taken place during police searches for Muslim fundamentalists. Unfair trials of civilians in military courts demonstrated last year “a travesty of justice”.

Fortunately, the Egyptian Organization for Human Rights has existed since 1988. At the above-named conference, it demonstrated its commitment to the campaign against torture, as well as the responsibility of the medical profession in that respect. About 100 participants, mostly doctors, attended. The IRCT, which was the main sponsor of the conference, took part, with Inge Genefke and Mahboob Mehdi, medical doctors of Denmark and Pakistan, respectively, as speakers. Important contacts were made with the two Egyptian psychiatrists Sozan Fayad and Abdullah Mansour, chief physicians at the El-Nadeem Center for Treatment of Victims of Violence, Cairo.

Centre for “all kinds of violence”
As stated in the introduction leaflet at the centre, victims of violence (the word torture is omitted, as in some other countries of the world) do not have a resort for their psychological rehabilitation from their traumas. Psychological injury is greatly neglected. They openly admit that the medical institution of Egypt lacks the infrastructure and orientation needed for rehabilitation.

The attitude towards political opposition and gender-related violence has been ambivalent and reluctant, and sometimes hostile. The centre was established to care for victims of all forms of violence, “of both sexes and all age groups, irrespective of who is instigating the violence and irrespective of the ideological or the political background of the victim”.

But most important at the conference was the defining of the proper role of the personnel in the rehabilitation of the victims of torture, and the lesson that was learned from hearing about the experiences of doctors from other countries who are involved in rehabilitation.

H.D.

The recommendations of the conference:

1. The necessity for founding non-governmental centres for the treatment and rehabilitation of the torture victims in Egypt and the countries of the region which lack such kinds of centres.

2. In countries where it is virtually impossible to found such centres (e.g. Sudan), it is the duty of the E.O.H.R. to undertake the burden of the treatment of victims coming from such places.

3. Working on the introduction of a legislation that protects health personnel when they refrain from participating in any manner in the application of cruel punishments (in Egypt, for example, the medical supervision of whipping in prisons) and protects them during their work in order to be able to document any harm inflicted upon the victim, or to enable them to assist any such victims or casualties.

4. The passing of legislation that gives the Egyptian medical syndicate and all its branches the right of direct supervision on its practising members employed in prisons, and facilitates the reception of monthly reports from doctors to their syndicate, and gives an open permit from the prosecutor general for representatives of the syndicate or those delegated by it of different medical specialities to visit prisons in order to solve the problems of doctors during the practice of the profession in their daily work.

5. The necessity for transferring the sub-ordination of the prisons from the ministry of the interior to the ministry of justice. This would require the application of the judicial police system to secure the guard tasks on the prisoners, the transfer of the detainees or those serving sentences to and from the competent authorities.

6. The necessity of the overall development of prisons in Egypt – along with the abolition of the exceptional prisons – technically and financially (buildings, water systems, general hygiene, social and psychological specialists and the penalty regulations). In order to realise the philosophy of penalties (reformation) as a substitute to slow death as a result of the overcrowding and the health and behaviour deterioration currently taking place. Also the excuse of the lack of facilities must be overcome even if that requires requesting the interna-
The necessity of technical financial and personnel enhancement and granting the privilege of immunity to the doctors of forensic medicine in accordance with the recommendations of the top specialists in the field of the necessity to follow a fixed set of rules of presenting the defendant three times to forensic doctors. First upon arrest, after the interrogation, and prior to his release, as a mechanical safeguard that prevents the infliction of torture or that permits its documentation as soon as it occurs and also to reveal any false allegations of torture.

The necessity of legislation that mandates triple representation in the case of the occurrence of a death during detention, prior to the issuing of the death certificate the three representative parties are to be the following:
- the prison doctor
- the forensic doctor
- a specialist delegated by the medical syndicate.

The recommendation to allow human rights NGOs to enter the prisons and the various detention sites to inspect conditions, as has previously been permitted last year to an international watch organization.

To appeal to the Egyptian government for the strict application of the stipulations of the international convention against torture, ratified by our government in 1986.

The request from the participant international organizations to cooperate with us in the production of documentaries of an advanced technical level on the victims of torture (priority to be given to the case of Basil Hamouda) and on the victims of medical malpractice.

On the basis of the researches conducted by the organization Physicians for Human Rights (Boston), the conference adopted the recommendation of the necessity of banning tear gas bombs, since they are chemical weapons that have grave health hazards in the long run.

Concerning general health:

1. The necessity of the participation of the experts in universities and the ministry of health in the formulation of set standards in monitoring the improvement or deterioration of the right to health for the citizens on the grounds that it is a genuine right in the international covenant and ratified by the Egyptian government, since such standards lack tangible qualities so that it would not become a hollow theoretical right.

2. The necessity for the presence of a national written and declared pharmaceutical policy that guarantees the extended surveillance of the effectiveness of medication in the Egyptian market and the scientific evaluation of the feasibility of the local products in comparison to the imported counterpart, thus achieving the availability of an effective medication at a reasonable price that prevents the experimentation in the field of drugs and the divergence from the advanced pharmaceutical knowledge and the scientific research schools.

3. The necessity to form unions for the beneficiaries of medical services for non-governmental supervision of the performance of medical care in the public and private institutions.

Concerning the psychological health of women and children:

1. The amendment of the law of citizenship, so that it becomes the right of the Egyptian mother to give her nationality to her children, because the article concerning that matter is contradictory to the equality between citizens stipulated in the Egyptian constitution, and naturally contradicts international conventions against discrimination ratified by our government (it is a logical request to equate a mother who has brought up her child to a mother who abandoned her child in front of an orphanage). According to the Egyptian contribution, an illegitimate or abandoned child has the right to Egyptian nationality. It is important to stress this point due to the widespread occurrence of this phenomenon in the past two decades in our open society.

2. The necessity that the medical syndicate adopts a firm attitude in order to ban the members of the profession from the practice of circumcising young girls.

3. Giving more concern to the study of the phenomenon of the homeless children in Egypt in order to get solutions before its aggravation and the collision with its grave future consequences.
BOOK REVIEWS

Linares – a book from CINTRAS


In September 1992 I was invited to participate in The Human Rights Seminar, Mental Health, Primary Care: A Regional Challenge, organized by CINTRAS and promoted by IRCT.

It was on that very important occasion that CINTRAS inaugurated their new premises and launched their new book.

The contents of this book reflect two aspects that, in my judgment, are essential to the task carried out by the organizations working in the field of human rights violations. The first reflects the immense richness that is added to the interpretation of the phenomenon to be studied by looking at it in a multiaxial and interdisciplinary way. The second relates to a specific and novel way of focusing on the training of a significant number of professionals in mental health and human rights issues, thereby showing the strong motivation which these issues produce in young people working in the health care and teaching sectors of that country.

To write about this kind of training experience is, no doubt, a valuable contribution for us who work under similar sociopolitical and psychosocial conditions in Latin America. First, I wish to emphasize the procedures which CINTRAS used to create suitable conditions for their activities in a region in the south of Chile. It is obvious that it was no easy task to assemble 150 professionals for three intense days of debate about the psychological consequences of state terrorism. The seminar was the final result of a situation which had been elaborated in the region during 6 months in 1990 - just after the end of the military dictatorship.

At this II Seminar: Human Rights, Mental Health, Primary Care: A Regional Challenge the organizers suggested the following:

1) To amplify knowledge on some specific aspects of the psychological and psychosocial damage caused by the political repression, and study some rehabilitation models.
2) To discuss various regional experiences connected with primary care and the work of the community.
3) To learn about some international experiences with the treatment of mental health and human rights problems.
4) To give training in some specific techniques, therapeutic and oriented towards mental health.
5) To discuss the socio-historical, legal, ethical, and psychosocial aspects of human rights issues of the democratic transition period and its connection with the development, on a national scale, of a social consciousness about the rights of man.

The design of the book follows the structure of the seminar, thus allowing a clear view of the application of techniques in the same order as they were presented. It was novel that the number of seminar subjects exceeded the classical psychological and psychosocial aspects of political repression. In this way there was space for other serious problems of mental health that are linked with situations of extreme poverty, the socially marginalized, general mental disturbances, etc. This combination of different facets of a similar psychosocial reality enriched the interpretation of the phenomena which the book introduces. This interconnection provided the context of the secondary psychosocial damage caused by human rights violations in relation to other problems of mental health.

Finally, the seminar set up international links. In fact, from the exchange of experiences with specialized teams from Argentina (EATIP) and Denmark (RCT) it was possible to get an all-embracing view of the various aspects of this social trauma.

The publication in detail of the conferences, round table discussions, and workshops makes it unnecessary to comment on specific subjects which have already been mentioned there. I will, however, not fail to mention that all the subjects which dealt with violations of the right to live are valuable contributions for us who work with the therapeutic assistance to the victims.

Torture, prison experiences, enforced disappearances, political executions, and exile were studied thoroughly from a medical, psychological, and psychosocial point of view, and the ethical, legal, political, and historical aspects were constantly, though cautiously, present as components of an indivisible socio-historical event.

Perhaps the most outstanding thing about this seminar is that it demonstrated the unquestionable importance of primary health care for the programming and starting of preventive activities in relation to human rights. The participants from the state health care services released the immense potential of the health care worker and the structures of state health care services. They act as instruments and multiplying carriers of preventive strategies at the three levels – medical, psychological and psychosocial – of problems that originate from violations of human rights.

The book is beautifully produced, and because of the fact that it was put together by torture victims in the workshops at CINTRAS, it effectively fulfills the task of preserving an extensive testimony of a multidisciplinary work oriented towards the protection and defence of life and essential human rights.

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This report is a compilation of most of the papers, testimonies, and addresses presented during a three day international symposium in Washington on torture in Guatemala, organized by the Guatemalan Human Rights Commission/USA, and held in November 1992. Although Confronting the Heart of Darkness is loosely divided along thematic lines, four main themes are interwoven throughout the different presentations. These are: the characteristics of torture and its use in contemporary Guatemala, especially during the past 15 years; the effects of torture on the individual, the family, the community, and the nation; treatment of victims of torture; and ways to end and prevent this inhuman practice.

In addition, the report also includes a section of "appendices", covering various related themes, such as human rights facts in Guatemala, the international legislation on torture binding on Guatemala, a statement made by the then US Ambassador to Guatemala, Thomas Stroock, at a November 13 US Congressional Human Rights Caucus Briefing, and a brief introduction to the history and activities of the Guatemalan Human Rights Commission/USA.

Regarding the characteristics of torture, and its use in contemporary Guatemala, this was first presented by the keynote speaker, the investigative journalist, writer, and lecturer, Allen Nairn. In addition to describing many of the concrete types of torture used in Guatemala, Nairn also pointed out that the victims came from every sector of society, from all age groups, including infants and the elderly, from all occupations and professions. However, his most important contribution was the historical overview he gave, in which he traced the systematic use of torture by the Guatemalan state from 1954, when a democratically elected government was overthrown by the armed forces, to 1992, when a civilian, the third in this long period, occupied the presidency. Nairn also clearly brought out the role of the United States Government in that 1954 overthrow, as well as in creating, supporting, and perfecting the repressive state which followed. Moreover, he stressed the fact that, without US support, the Guatemalan State, and its systematic use of torture, could not have remained intact for over 38 years.

The concrete forms of physical and psychological torture used by the state during this long period, as substantiated by the victims/survivors of torture, human rights advocates, therapists, and others working with Guatemalan torture victims, included death threats, persecution, physical and verbal harassment, beatings, bodily mutilation, burning, the application of electric charges, suffocation, almost to the point of death, hanging, rape and multiple rape, the kidnapping of persons in broad daylight, and their subsequent disappearance, and the placement of dead bodies, sometimes decapitated, and often with signs of torture, in highly visible public areas, such as on city streets or along highways.

Concerning the Guatemalans directly responsible for the affliction of torture, several presentations described a complex network. This network includes a sophisticated intelligence apparatus, the military, the various police forces, heavily armed men dressed in civilian clothing, who often use cars without licence plates (or with foreign plates), and polarized windows to kidnap or injure victims, and other civilians. Throughout the years, this network, with the support of many privileged groups in the society, has been attempting to silence any opposition to the unjust status quo. Most of the presentations mentioned the condition of impunity as one of the underlying causes for the continued use of torture.

On the national level, the torture, killing, and other forms of repression between 1980 and 1992 caused some 200,000 children to lose one or both parents, thousands of minors to live alone on the streets, tens of thousands of women to be widowed, several hundred thousand Guatemalans from all sectors to seek refuge abroad, and an increase in the shanty towns, with the subsequent negative economic, social, and psychological consequences on their dwellers.

Addressing the issue of treatment, Confronting the Heart of Darkness includes a wide variety of methods and techniques put forward by specialists from the Minnesota Center for Victims of Torture, the Marjorie Kovler Center for the Treatment of Survivors of Torture, the International Rehabilitation Council for Torture Victims in Copenhagen, the Argentine Team of Work and Psychosocial Investigation, and Centro Ignacio Martin Baro, of Berkeley, California, where Guatemalans have received help.

Regarding termination and prevention, although once again many ideas are interwoven throughout the papers, two propositions predominate: to stop torture, as well as prevent its continued use, the impunity of the torturers must be ended; and all foreign assistance to the institutions responsible for torture must be effectively withheld. It was also stressed that both solutions require the active participation of the citizens of countries whose governments support the Guatemalan repressive system, as well as that of human rights groups, and international organizations such as the United Nations and the Organization of American States. The role of the Guatemalans themselves, however, was not minimized. Indeed, several speakers pointed out that their brave denunciations and testimonies continued to be a crucial element in the attempts being made to stop and prevent torture.

Let me conclude by saying that, brief as this report is, there is no doubt that it is an important tool for understanding the problem of torture in Guatemala, and, I believe, for motivating the reader to try to find some way of becoming involved in the search for solutions to end it.

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BOOK REVIEWS

Health hazards of organized violence in children


The studies presented addressed a wide range of topics, such as inter­generational aspects, sexual abuse, identity, the importance of culture, etc. Some studies also concerned children at various age levels. Issues beyond psychotherapy were discussed as well. These include the role of professionals, training of para-professionals, advoca­cy work, and building support sys­tems outside the home.

We appreciate this range of topics because we believe that they should all be taken into consideration if an appro­priate and holistic approach towards helping is desired. This understanding is based on the assumption that this kind of reading should also help para-professionals to gain a better under­standing of this field of work. In some studies, which listed the symptomatology as well as the existing services for children and families through the present­ation of case studies, we would have appreciated a more elaborate exposition to help para-professionals to under­stand the relationship between case presentation and identification of prob­lems or symptoms (e.g. Montgomery’s study) or the treatment process (e.g. Yüksel’s study). Van der Veer pre­sented a good case history but could have better integrated the details to come up with a deeper analysis. The vast range of literature cited in the references was very helpful and enrich­ing, but they were not exhaustively discussed in the study (e.g. Hjern, Yüksel).

As far as the content of the proceed­ings is concerned, we believe that it is relevant in the European context, espe­cially at this time when there is war in former Yugoslavia. The papers reflect the need to provide psychosocial care for a much greater number of traumatized children than northern profes­sionals are used to in their daily prac­tice, and also to reflect about the individualistic frameworks professionals employ, sometimes ignoring the demands of other cultures, and thus to begin to challenge western theories and methods of practice in terms of their appropriateness and effectivity across borders. Children’s Rehabilitation Centre (CRC) feels that these issues should be addressed collectively, necessitating the concerted efforts of various sectors and especially improving the cooperation of professionals and para-professionals who are in­volved in work with survivors of orga­nised violence. Along with this, there is the need to underscore the im­portance of advocacy work, training, and research and documentation on issues and methods of helping which are culturally-sensitive.

Lastly, more attention should be given to the formal presentation of the proceedings. Language/grammatical edit­ing is required and a more logical clustering of related topics would provide better orientation for the reader. The section on conclusions and recommen­dations should be contextualized by presenting the discussion points, gaps, and resolutions that were reached during the plenary sessions. In this way, the readers would be properly guided in the development of the studies as well as in the discussions that took place.

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Police interrogation


In recent years, more and more light has been shed on the way in which interroga­tions take place behind closed doors. Many aspects are involved, the main one being that injustice and violations of human rights can occur quite easily when the act of interviewing takes place without supervision, evaluation, or quality control. The open-door interro­gation that is practised in the court rooms, with harsh cross-examination of suspects and witnesses, gives an indica­tion of the minimum pressure that can be put on anyone on the stand.

The goal is to reveal the truth
A series of apparent violations of jus­tice have occurred in the UK in recent years, including the cases of the Guild­ford and Birmingham bombings. Inno­cent suspects have been released by the Court of Appeal many years after their imprisonment. These events have led to increased interest in the many aspects of how information is collected in its broadest sense; this particular mono­graph is concerned with the back­ground of false confessions when the suspects have incriminated themselves while in police custody.

The author originally served as a
criminal detective in Iceland, but turned gradually towards forensic psychology. He is now a senior lecturer in psychology at London University. He acts regularly as a consultant to police forces in England and has appeared as an expert witness in many criminal cases.

His main interest, which has involved him in intense research work into unclear and complicated criminal cases, is the "false confession". Why do suspects make such statements during the police interrogations, and why do some not change their testimony when in court while others do?

Rules on tape-recording of any police interrogation, instituted in the 1980s in the UK, were meant to secure the right of the individual in any minor or major case and to improve the quality of questioning. However, "talks" under pressure at the informal level are not necessarily recorded. Once the confessions have been given to the police, the likelihood of conviction when the case goes to court is greatly enhanced, even if the confession is disputed at the trial.

The author's own research of more than 200 cases who alleged that they had given false confessions reveals that a combination of several circumstantial factors is most common. The two major components are the nature of the interrogation and the psychological vulnerability of the accused.

The concept of perjury is not particularly taken into account in this book, but it is one of the latest disclosures of techniques used by some police forces. A recent report (Mollen Commission Report) on perjury in the New York police has demonstrated that the motivation by the police was "bolstering the units' performance record". This police performance has already led to the coining of a new word, "testilying". Pressure from the public on the police to perform better anywhere in the world is well known and is felt as a natural demand in a democratic society for the sake of our personal security.

However, in many other areas, a fact-finding talk is conducted between two persons, in which one of them has the upper hand. Clearly, there are differences between being interviewed voluntarily and involuntarily, but the basic elements in the talk are the same.

Whenever an attempt is made to collect information in a structured manner, the result is never a dialogue between two equals. During such an attempt, one person intrudes into another's personal sphere, and professional skills have to be applied. A clear indication of the goal of the "talk" has to be given and understood by the interviewee in any situation, whether legal, clerical, or social, or even in a media setting.

This is not a book on police misconduct, but rather an analysis on a scientific basis of the facts concerning techniques of police interrogation and of the impact these may have on suspects.

The final recommendations are clear: that increased focus must be put on "objectivity" in police interrogations, and that the professional skills of the interrogators should be improved, allowing them to detect and acknowledge the vulnerabilities of suspects.

More research is required into false confessions and mistrials.

The book is highly academic, but is obligatory reading for any professional who is dealing with fact-finding interviews or rehabilitation of persons who have suffered after being under interrogation or exposed to similar situations. It includes a wealth of references from the increasing literature in this forensic field.

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Helping children in war


This manual is intended for parents and teachers in communities where children are daily subjected to the stresses of war. The aim of the manual is to provide parents and teachers with simple and practical advice.

The first part provides basic information about the reactions of children living in a situation of armed conflict, and the second illustrates this general advice in a range of concrete situations.

The necessity to assess the children's own understanding of the situation they are facing is emphasized throughout the book.

Although anxiety, depression, and aggression are seen in children at any age, the ways these feelings are expressed can be quite different for children in different age groups. Pre-school children often regress to earlier developmental stages. Schoolchildren are better able to understand the meaning of their experiences, and they use their fantasy to try to cope with reality. Adolescents understand more fully the consequences of war, and are therefore very vulnerable. They do not use play or fantasy like smaller children, but must talk about their experiences. They can become self-destructive and show risk-taking behaviour, and the war experiences can force them into premature adulthood.

Parents and teachers can help children by creating a "therapeutic" environment in the home and at school where the child is listened to, is given the opportunity to speak about horrible experiences, has questions answered truthfully and fear attended to, and is given plenty of encouragement. Three basic steps are described for parents to follow when dealing with a child who has been exposed to violence.

In the second part of the book, the author illustrates how the advice can work by giving examples of concrete situations. Following a short case description in which the problem is presented, advice is given on how to deal with it. Specific problems include a small child clinging to her mother, a school child wetting his bed at night, a small child who refuses to go to bed, a school child showing aggressive behaviour. Advice is given for parents...
BOOK REVIEWS

and teachers separately, and the necessity of talking with the child is stressed throughout. School activities are important in providing stability and structure, and the teacher has the opportunity of giving information about normal reactions and helping the children to gain control of their feelings through essay-writing or drawing.

Parents and teachers are instructed in how to look for specific problem behaviour that calls for referral to competent professionals, and how to take action.

The manual is written in a simple and clear language, making it very appropriate for adults, who under those circumstances often find themselves in a situation of crisis. It thus fully lives up to its intentions. Although it is intended for parents and teachers, it also provides valuable information for counsellors and para-professionals dealing with families in war. In the case of professionals, the manual could be a valuable tool in teaching and supervising counsellors, helping them to adapt their professional knowledge to working circumstances very different from their original training. It is important, though, to be aware of the fact that advice given in a manual intended to be used cross-culturally might not always be satisfactory in a particular culture. Culturally appropriate rituals for mourning could, for example, be very important in helping children to cope with grief.

Edith Montgomery
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NEWS IN BRIEF

New members elected for the two torture committees

The members of the United Nations Committee against Torture (CAT) are the following:

Mr. Hassib Ben Ammar
Tunisia
Mr. Peter Thomas Burns
(Vice-Chairman)
Canada
Mr. Fawzi El Ibrashi
(Vice-Chairman)
Egypt
Ms. Julia Iliopoulos-Strangas
Greece
Mr. Ricardo Gil Lavedra
Argentina
Mr. Hugo Lorenzo
(Vice-Chairman)
Guatemala
Mr. Alexis Dipanda Mouelle
(Chairman)
Cameroon
Mr. Mukunda Regmi
Nepal

Mr. Bent Sørensen
(Rapporteur)
Denmark

Mr. Alexander M. Yakovlev
Russian Federation

The members of the European Committee for the Prevention of Torture (CPT) are the following:

Mr. Nicolò Amato
Italy
Mr. Jón Bjarman
Iceland
Mr. Tonio Borg
Malta
Mr. Leopoldo Torres Boursault
Spain
Mr. Constantin P. Economides
Greece
Ms. Ingrid Lycke Ellingsen
Norway
Mr. Günther Kaiser
Germany

Mr. Love Kellberg
Sweden
Ms. Pirkko Lahti
Finland
Ms. Nadia Gevers Leuven-Lachinsky
The Netherlands
Mr. Rudolf Machacek
Austria
Mr. José Vieira Mesquita
Portugal
Mr. Petros Michaelides
Cyprus
Mr. Claude Nicolay
(President)
Luxembourg

Mr. Arnold Oehry
Liechtenstein
Ms. Gisela Perren-Klingler
Switzerland
Mr. Safa Reisoglu
Turkey
Ms. Nora Staels-Dompas
(2. Vice-President)
Belgium
Mr. Bent Sørensen
(1. Vice-President)
Denmark
Mr. Stefan Terlecki
United Kingdom
Mr. Ivan Zakine
France
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.