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EDITORIAL

ON THE OCCASION OF A 50th ANNIVERSARY

During the first months of the year, newspapers, news media, and public debate in much of the world have occupied themselves with the 50th anniversary of the end of the Second World War.

The anniversary suggests a historic distance. This has influenced the debate positively, with more openness and more factual reporting – a consequence of today's dwindling respect for the political and governmental interests tied up in the past. The trends to democracy, including the collapse of the Soviet empire, have also contributed.

The anniversary gave RCT/IRCT the opportunity to review its own development. It was the facts about the management and conditions of concentration camp victims – the systematic follow-up and care of their physical and, not least, psychological state – that led to the application of similar care for torture victims of later times, after their liberation. Thus, the basic documentation, especially in Denmark and Norway, about the situation of the concentration camp prisoners and the war sailors was the background for the work with the large contingents of refugees in the 1970s and later that was started by the Danish medical group under Amnesty International and that led to the creation of RCT in 1982. RCT became the first institution with the defined purpose of treating the sequela of torture, and also of examining the mechanisms of their formation, with the aim of improving treatment methods.

However, the anniversary was also an occasion for other reflections. The evil, the suffering, the destruction, the breaking down of what good forces had created – these were not weakened, not sufficiently toned down, in the clearing up after World War II. Some parts of the world may well have got more order and democracy. But state or government-sanctioned repression and evil, including torture as one of the worst weapons, continue to crop up in many countries, in 79 countries in 1994 according to Amnesty International.

Analyses of the evil of Nazism mention the crises of the national states, racism, and the breakdown of values. These factors are also behind the forces who want to secure their own power and interests by hindering resistance and the people's right to decide and influence their own future. In other words, by hindering democratic development. The target then was to control public opinion, to declare witnesses incapable of controlling their own affairs, and to break down or destroy those in charge of public opinion. At that time the means were to some extent different from those of today's government-sanctioned torture. The goals are to a large extent the same.

The many analyses and fine words of intent have not yet given us the means to effectively stop this banality of evil and to scare those responsible for government-sanctioned torture. Looking back on the history of RCT, the means that we have found against the evil that leads to torture are therefore still needed – even more as the evil continues to be made visible.

Our list of means comprises:

Openness – which weakens the evil regimes and strengthens their victims against isolation.

Knowledge – which hinders the assistants' eternal excuse of "only following orders".

Democratic governments' will to settle the crimes of the past, and to give moral rehabilitation to its victims.

Necessary treatment of psychological and physical conditions caused by torture.

And most important – economic resources.

H.M.
Rape survivors

Nepal district management of refugees

Sushila Sharma, counsellor*, Sangye Lama, social worker*, Shanta Ale, counsellor* & Jamuna Mahajan, yoga therapist*

CVICT introduction
The Centre for Victims of Torture (CVICT), established in December 1990, is a non-profit voluntary organization working with torture survivors and abused women and children in Nepal. CVICT’s interdisciplinary forum, which includes doctors, social workers, nurses, lawyers, and journalists, offers medical services and psychological and social support to all victims of organized violence, regardless of race, nationality, political ideology, or gender.

CVICT’s rehabilitation programme is supported by the European Union (EU), the International Rehabilitation Council for Torture Victims (IRCT), and the UN Voluntary Fund.

Paper background
Bhutanese Refugees in Nepal
Bhutan, a small Himalayan kingdom to the east of Nepal, has been home to several thousand Nepali immigrants for many years. Some had lived there for a few generations, the majority as small farmers. Their peaceful lives were suddenly disrupted in 1990 with the implementation of new immigration and citizenship laws by the Bhutanese government.

By a retroactive citizenship law, all who had settled in the country after 1957 were termed illegal settlers and were asked to leave the country immediately. The government also sought to impose a code of conduct on the general population. This code, which enforced, among other things, a rigid code of dress, was more in keeping with the culture and traditions of the ruling ethnic community, the Drukpas, which was very dissimilar to that of the Nepali-speaking population.

A political movement slowly began among the Nepali-speakers. Rallies and demonstrations were held to demand their rights. The government’s response was to crack down hard on all individuals who were connected with the movement. Random arrests were made, and many persons were imprisoned and tortured. Hundreds of innocent villagers were caught in between; they were forced to donate men and money to the struggle on the one hand, and were hounded by government forces for doing so on the other. A trickle began to leave the country in late 1990, but it soon became a mass exodus as army brutality increased and more people sought a safe haven for themselves.

Jhapa district in eastern Nepal became home for the hundreds of refugees fleeing from Bhutan. Today there are approximately 87,000 of them in eight camps established by the United Nations High Commissioner for Refugees (UNHCR). UNHCR, together with several Indian NGOs, help the refugees to meet their basic needs of food, water, clothing, and shelter.

Interviews conducted by His Majesty’s Government of Nepal (HMGN) and UNHCR indicate that the asylum seekers, who are almost all ethnically Nepali, fled Bhutan out of fear of harsh treatment by the local authorities.

Rape survivors
During initial medical missions organized by CVICT for the refugees in late 1991, many victims of rape were observed among them. Many of these women were suffering the psychological sequelae of rape, including severe depression and psychosis. For some women, the trauma of leaving home and country, and in some cases watching their near ones die, compounded further by the negative feelings associated with rape, had led to complete breakdown of the personality.

Living as they did in a culture in which the females are secondary citizens and in which virginity and chastity are prized, these women had received little social or emotional support. This fact, in addition to interviews with women groups in the camps, led us to believe that there were many women who had not spoken out, who were suffering in silence due to a misplaced sense of shame or guilt.

The perceived magnitude of their suffering and the rapid deterioration in the mental health of some of them pressed home the urgent need to extend help to these women. Though CVICT felt impelled to offer some form of support to them, lack of sufficient personnel made it difficult to have staff in the camps for long periods. In addition, the consensus was that local resources should be identified and appropriated to maintain the sustainability of the programme.

Women’s groups within the camps were already very active and, several discussions later, a proposal was formulated to train refugee women as helpers for female torture survivors.

With Oxfam’s1 pledge to support the project for a period of one year, it began in March 1992.

Programme
Training
As a first step to the programme, CVICT staff received an orientation in working with rape survivors from experienced psychiatrists, psychologists, and nurses. They also provided invaluable help in preparing the training manual.

Women from among the refugees were then identified and selected after individual interviews with CVICT staff, including a doctor, a nurse, and a social worker.

During five days of training by an all-women team, including a psychiatrist, social worker, nurses, and a lawyer, the women were oriented on rape and its physical and psychological consequences. The main objective of the training was to teach the women case work and counselling skills, particularly with rape victims. The need to maintain confidentiality
was repeatedly emphasized. To prepare them for their work, they were also taught self-defense exercises and report writing, and about legal provisions for rape survivors in the Nepali legal system. Role plays were used frequently to illustrate important concepts to the trainees and to give them the opportunity to experience what they were going to come up against in the field.

An evaluation after the training revealed that the trainees' attitudes towards rape victims and women's status as a whole had become more positive by the end of the training.

Work methodology

The trainees returned to the camps after the training, assigned the difficult task of identifying rape survivors and offering them support. They went from hut to hut in their respective camps inquiring discreetly. With time and the strict confidentiality maintained by the helpers, the women slowly began to trust them. As word spread within the camps, the number of women coming forward to ask for help increased.

The helpers first documented the case histories of their clients. If there was physical illness, they were referred to the medical services available in the camps. More serious cases were referred to the monthly supervision team from CVICT, which also included a female doctor. The helpers visited the clients regularly according to their needs for counselling and support. They also taught clients relaxation exercises and yoga to relieve stress and tension, and other physical ailments. Social support in terms of clothes and food for the women and their children was offered in a few cases when there was real need.

Files were maintained by the helpers for each client. These were checked regularly by CVICT supervisors on their monthly visits. Case presentations and discussions were held to help the women with difficult clients. Role plays were also enacted to evaluate counselling skills, and interviews were sometimes held with old clients to check their progress.

Out of this “befriending” service arose another, that of linking the women with the other services available in the camps, such as income generation, skills training, non-formal education, etc. All these programmes helped to fill the long hours of camp life and to prevent clients from constantly focusing on the rape, thus aiding their recovery.

Documentation

Until November 1994, 235 rape survivors had been identified by the helpers and provided with medical treatment, counselling, and psychiatric care. Of this total, 121 cases had been closed after full recovery; 113 women were still under CVICT care (table 1).

Nearly all the cases of rape had occurred in southern Bhutan between the years 1990 and 1992 (table 2). The perpetrators were mostly army personnel, with only a few civilian culprits. Only a very small percentage of women had been raped since settling in Nepal.

The ages of the victims varied greatly, ranging from 3 to 80 years. The majority were victims of multiple rape, having been raped by several soldiers in their own houses. Only a few had been raped in custody or jail (table 3).

### Table 2. Year of rape.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Timai</td>
<td>12</td>
<td>20</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>33</td>
</tr>
<tr>
<td>Goldhap</td>
<td>6</td>
<td>6</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>14</td>
</tr>
<tr>
<td>Beldangi I</td>
<td>12</td>
<td>16</td>
<td>9</td>
<td>-</td>
<td>-</td>
<td>37</td>
</tr>
<tr>
<td>Beldangi II</td>
<td>10</td>
<td>13</td>
<td>17</td>
<td>14</td>
<td>2</td>
<td>56</td>
</tr>
<tr>
<td>Beldangi ext.</td>
<td>1</td>
<td>6</td>
<td>8</td>
<td>2</td>
<td>-</td>
<td>17</td>
</tr>
<tr>
<td>Sanischare</td>
<td>5</td>
<td>34</td>
<td>17</td>
<td>5</td>
<td>3</td>
<td>64</td>
</tr>
<tr>
<td>Khudunabari</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>49</td>
<td>98</td>
<td>57</td>
<td>23</td>
<td>8</td>
<td>235</td>
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### Table 3. Description of rape incidence.

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<th>Place of incidence</th>
<th>Type of rape</th>
<th>Perpetrator</th>
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<tr>
<td></td>
<td>Single rape</td>
<td>Multiple rape</td>
</tr>
<tr>
<td>Home/</td>
<td>Out-</td>
<td>Custody</td>
</tr>
<tr>
<td>camp</td>
<td>door</td>
<td>jail</td>
</tr>
<tr>
<td>Army</td>
<td>151</td>
<td>27</td>
</tr>
<tr>
<td>Police</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Civilian</td>
<td>23</td>
<td>7</td>
</tr>
<tr>
<td>Unspecified</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>176</td>
<td>35</td>
</tr>
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</table>

Three women of one family, mother 55 years old, daughter 16, and daughter-in-law 30, were stripped naked in front of the male members of their family. They were forced to dance, beaten, and then had chilli poured over them. The soldiers finally raped them while the rest of the family, including a five-year-old, watched.

One woman, 34 years old, was alone at home with her retarded son when the soldiers came at night. They beat her when she resisted their assault and poured hot oil down the right side of her head. After they had finally raped her, they shot her in the shoulders. The entire right side of her face, including the ear, is now badly scarred.

One young girl, aged 15, was taken by soldiers to their barracks where she was raped repeatedly over a period of one week.

Though most of the families had been supportive of the victims, in a few cases the husband had not accepted the wife back. In others, the women had refused to return to their husbands, primarily due to a general fear of men and secondly due to resentment against their husbands for not protecting them in their time of need.

Despite the fact that most of these women had been raped by several men, only a few of them had received medical care. None had undergone tests for VDRL, HIV, or pregnancy. Common physical problems included excessive bleeding, infections, vaginal discharge, and epigastric pain. Six women who had become pregnant as a result of the rape delivered babies, while two chose to terminate their pregnancies.

All the women were suffering from psychological sequelae of rape such as feelings of fear, shame, guilt, anxiety, and depression. They felt dirty and wanted to clean themselves regularly. Some displayed a fear of men and of being alone. Many suffered nightmares. The common reaction was of guilt or self-blame.
Monitoring and evaluation

The number of clients who soon came out with their stories of horror and rape was a clear indication of the need for such a service in the camps. Many of the women had not talked with anyone about the rape, and it was a relief finally be able to do so without fear of being condemned.

All the clients showed signs of progress over the year. Psychological problems such as nightmares, fear of men, sleep disturbances, sexual disinterest, etc. decreased markedly. A young girl, silent and sullen on the first visit, was able to talk and smile when the supervisors interviewed her a second time. A few young girls went on to marry after they had received counselling for a while. Physical complaints like backache, lower abdominal pain, joint pains, etc. were also perceived to have decreased with the use of relaxation exercises and yoga. Gynaecological problems were also addressed. A few women required surgery, while others received treatment for minor problems. However, irregularities of menstruation and minor infections persisted despite treatment. This could possibly be due to nutritional and other deficiencies in the camps.

Many clients have enrolled in the adult literacy programme and the Oxfam knitting project in the different camps. Some have joined the women's groups, others work as community health visitors. Many have been enrolled in skills training and income generating programmes, established in the camps for victims of violence.

A survey by a UNHCR consultant on “Victims of Violence in the Bhutanese Refugee Camps”, conducted in May-July 1993, stated that it seemed to be of benefit to most of the women who use(d) the service.

Conclusion

Female torture survivors had not been included in the programme initially. However, when some of them began to appear the helpers were encouraged to offer them help too. The consensus was that many rape survivors preferred not to be labelled as such, identifying themselves as torture survivors instead. The experiences and sequelae of torture survivors were also quite similar to those of rape victims.

As the number of refugees in the camps increased, CVICT received a proposal from UNHCR to train more women in the new camps to work with female rape and torture survivors. A total of 51 refugee women were trained over the period of 1½ years. 27 are still working.

As of March 1994 there has been a change in the organizational set-up of the programme. CVICT signed an agreement with UNHCR to start a community-based programme for the rehabilitation of all torture survivors in the camp. The rape survivors' programme has also been incorporated in this. The programme now has a three-tiered approach with the helpers working at the grass roots level, health workers in clinics in each camp at the second level, and a supervisor and doctor at the office near the camps.

Refresher courses for the helpers were held in June 1994. These sought to improve their skills by reviewing past experiences and working on solutions to the problems faced by them.

Supervision is still being continued to ensure that the helpers are able to put their skills into practice. Evaluation is also ongoing to monitor the quality of the services that the clients are receiving. However, a large part of that task has already been taken over by the supervisor in the community. It is hoped that, except for training needs, this programme will continue to become self-sufficient and self-empowering.

This low-key programme has offered us a great learning opportunity. The success of the programme was probably due to the involvement of the community, particularly of women with similar experiences of exile and trauma, rather than direct involvement from “professionals” who would have been more intimidating. This model of “befriending”, together with medical treatment and other services, is probably more appropriate to our cultural context than “psychotherapy”, which is a foreign and strange concept.

Note

1. OXFAM, Oxford, England, supports over 2,500 projects in 70 countries with refugees, displaced persons, torture victims, and minority groups as target groups.

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Selected list of publications

received in the IRCT International Documentation Centre

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<th>Author(s)</th>
<th>Title</th>
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<tr>
<td>Kriener som torturoverlever</td>
<td>Aarnes, Trude</td>
<td>In: Jordsmorbladet ; vol. 95, no. 1. - 19950000. - p. 2</td>
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<td>Torture as a medical problem</td>
<td>Vest, Peter; Beijholm, Sven</td>
<td>In: Schweizerische Zeitschrift für Militär- und Katastrophenmedizin ; vol. 71, no. 4. - 19940000. - p. 115-119</td>
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<td>Indelible scars: a study of torture in Nepal</td>
<td>Guragain, Gopal; Lama, Sangev; Khan, Tarik Ali</td>
<td>In: Centre for Victims of Torture, Nepal ; vol. 19940000. - 81 p. : ill.</td>
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<td>Genecke, Inge</td>
<td>In: RAHAT's medical journal ; vol. 1, no. 3. - 19941100. - p. 8-15. - ISSN: 1023-6805</td>
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<td>Guajardo, Alejandro</td>
<td>In: Reflexion ; vol. 7, no. 22. - 19941200. - p. 18-19 : ill.</td>
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<td>Trade in organs and torture</td>
<td>Sottr, Eric</td>
<td>In: SOS torture ; vol. 1994, no. 45-46. - 19940300. - p. 4-11</td>
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Lost innocence

Nellie Smeliers

[Summary of a thesis for the degree of Master of Arts written under the guidance of Dr. P. Stouthuysen at the Free University of Brussels.]

The cruelty and inhumanity of torture chambers, concentration camps and mass killings are often beyond comprehension, yet they take place all over the world. "Who are these people?" "How could anybody be so cruel?" In trying to find the answers to these questions the realization grew that torturers are just ordinary people and that anyone could, given certain circumstances and the appropriate training, become a torturer. A disturbing awareness, with implications yet to be fathomed out.

Torture: a state crime

Man is often described as aggressive and violent by nature. Our history, which is one of bloodshed, seems to prove this. The emergence of states, however, brought about a pacification of society and showed that violence could be controlled. Sadly, it also brought about a new kind of violence, namely political violence and state terrorism. The state monopoly of arms, which was originally meant to keep order and peace within a society and protect it from foreign attacks, turned out to be the most important political power-base. Several governments and states, losing legitimate control, started to use the army, police, secret services, and all kinds of other military or para-military organizations such as specialized units and death squads to win, keep or increase their power. Coercion, repression and violation of the three most fundamental human rights, namely articles 3, 5 and 9 of the Universal Declaration of Human Rights are often the consequences. The conclusion of PIOMS, an organization which conducts research on root causes of human rights violations, is that 'Political murder, torture and disappearance are three manifest violations of these basic rights. They form a fatal triangle because they usually occur together. They are the ultimate tools of repressions'.

Torture, just like disappearances and political killings, has several functions. Until the nineteenth century it was used as a legal instrument to extract information from the suspect. Dubois argues that torture has its roots and finds legitimation in ancient Greek civilization. "The ancient Greek word for torture is "basanos". Firstly, it means a touchstone used to test gold for purity; the Greeks extended its meaning to denote a test or trial to determine whether something or someone is real or genuine. The use of torture as punishment was also widespread. Public and cruel executions were meant to bring about justice and show the public what would happen to anyone who trespassed the law. Beccaria pleaded strongly against torture in his book "Crimes and punishments" (from 1784): torture, he said, was a barbaric practice. This thinking played an important role in the outlawing of torture. This, however, was not the end of the use of torture. The Jacobins who came to power after the French revolution were the first to use torture on a massive scale as a means of state terror. Nowadays we can distinguish the four commonest reasons for the use of torture.

People are tortured in order to obtain information. Information about their own alleged crimes and possibly crimes of those involved with them. Sometimes people who are known to be innocent are tortured in order to obtain false statements and prepare them for a show trial. Another important reason can be to eliminate political opponents and sometimes even try to brainwash them or win them over to the other side. Torture, as well as political killings and disappearances, is furthermore very effective in spreading fear and preventing anyone from trying to oppose the system. These reasons can be combined, or they may change as the regime changes.

Torture and other gross human rights violations, such as disappearances and political killings, are part of the political system; they are institutionalized, and as long as the outside world pays no attention to them, they sadly seem to work. In far too many countries all over the world they are the rule, rather than the exception. The main conclusion, important to us and our research now, is that the torturer is above all a product of a system. He is a member of a specific, often militarized organization, and has to undertake a special training programme, and then receive orders from above to torture, often from the government itself: orders which, from a strictly national point of view, are legitimate, and which the soldier or policeman must obey, regardless of his own opinion. The torturer therefore cannot be seen outside the context in which he is placed, outside the environment and society which brought him forth.

The features of the organization

The militaristic organizations, whether applying torture or not, all have some very special and typical characteristics. The clear hierarchy, harsh discipline and strict duty to obey are well known. Recruits learn to accept new rules and other norms, which make it clear to them that this is another world. Often they have to give up their individuality and personality and learn that they merely exist as a member of the group, the army, the police, the squad ... The uniform is probably the most typical feature of what Finer noticed, namely that "The army is separated and segregated from society ... The barracks becomes the world". Stohl and Lopez distinguished four ideologies which are typical for militaristic organizations, namely authoritarianism (which signifies the importance of an authority and obedience), militarism, national security (nothing can and should be more important), and patriarchy, 'the socialization of boys ... as cultural males, ... an explicit rejection of those characteristics associated with frail and womanly aspects of human beings: sensitivity, pity, emotionality, tenderness'.

All these features and ideologies create a very specific climate in which the recruits feel a strong pressure to comply, afraid to be seen as a traitor or, even worse, as a weakling. The social environment is such that the young men tend to act according to this ideal type of manly hero, the macho, and push all their personal doubts and weaknesses aside. They tend to concentrate on the strong positive motivations to comply: earning respect, being a member of something big, something important, fighting for something better, some-
thing holy almost. All this is especially true for those who are members of a mass-movement. A lot of people find security, a goal and friendship in such a movement. Political conviction is often less important than mere attraction to the movement and leader. People tend to stop thinking for themselves and do whatever is asked from them.

We had broken with everything: nothing could any longer impress us except our Father and his idea ... The holiness of his idea ... and he found believing disciples ... That meeting was more like Divine secret. (A member of the SS)²

All these features contribute to a specific climate in which people feel the urge and pressure to comply and obey. Most important of all, however, is the training. All military training prepares recruits to obey any order, to be hard and, if necessary, to maim and kill the enemy. As an example here we will take the training of the recruits of the special persecution unit ESA in Greece under the colonels' regime from 1967 to 1974. This is the best known example of the education of a future torturer, described and analyzed by Mika Haritos-Fatouros.

The training of a torturer: an example

The recruits for the elite corps of the ESA were selected from all the new soldiers who had been recently drafted. Physical force, the correct attitude and unquestioning obedience were the criteria. All those who showed signs of weakness or being emotional were left aside. The special training of the selected group was extremely harsh and cruel. They were cursed, beaten and humiliated. At all times they had to show their loyalty, faith and strong character by enduring all beatings and executing all orders. Recruits were for example often forced to get up in the middle of the night and start jumping up and down with heavy bags on their shoulders or had to crawl on their knees to the canteen, eat their own berets and make love to their kit-bags. They were told that they had to learn to love pain. Fatouros said about the education that: 'To teach obedience to the authority of violence and to the authority of the irrational, the method of overlearning was widely applied. Obedience without question to an order without logic was the ultimate goal'°

After this basic training programme the best recruits were selected and the actual training to become a torturer started. First of all they were asked to bring food to the prisoners, later to attend torture sessions and once in a while "asked" to participate. Meanwhile the recruits were tortured themselves by officers and other superiors. Whenever they did not hit the prisoner hard enough they were in danger of being hit themselves. Fear ruled because they were constantly aware of what could happen to them too. Petrou, one of the torturers, later stated that at KESA (the education centre) you were trained not to think as an ordinary human being anymore. The recruits were made to be people without any will of their own, mere instruments who obeyed all orders. Why? Because ... (Petrou) 'You never thought you could do otherwise', Gibson and Haritos-Fatouros therefore concluded that 'There is a cruel method in the madness of teaching people to torture. Almost anyone can learn it'°. Almost anyone ...

The frightening conclusion is that social and psychological pressures seem to be so strong, the fear so intense, that anyone can be forced to maim, kill and torture a fellow human being. Psychological mechanisms start to work so that people learn to adapt to the situation. They start to see torture as nothing extraordinary and maim and kill without any visible strain or emotion. These dangerous mechanisms "defend" people from the awareness of what they are really doing.

The psychological mechanisms

Some of the most important psychological mechanisms were distinguished by Kelman and called authorization, routinization and dehumanization. The first is the conviction that one was not responsible for the consequence of one's own actions. The superiors were responsible, their only responsibility was to obey. The sense of morality changed. By routinization, Kelman meant that even an act of torture can become merely routine. People learned to be indifferent to others. They successfully learned to eliminate empathy, which can be defined as 'A cognitive awareness and understanding of the emotions and feelings of another person'.

When you do it [torture] you are in that condition of "conscience narrowing" and strangely obsessed to get information. So you inflict pains, maim and kill to get what you want. (Rhodesian squad leader)⁸

The importance of this routinization is especially clear when we hear perpetrators and torturers talk about the first time they witnessed torture. Most of them remember this as an extremely unpleasant moment, but then they get used to it. Staub: 'Once perpetrators begin to harm people, the resulting psychological changes make greater harm-doing probable. ... People learn by doing - they learn to be cruel and sadistic'⁹

I can only say that when you first start doing this job, it is hard ... you hide yourself and cry, so nobody can see you. Later on you don't cry, you only feel sad.

You feel a knot in your throat but you can hold back the tears. And after ... not wanting to ... but wanting to, you start getting used to it. Yes definitely, there comes a moment when you feel nothing about what you are doing. (Valenzuela Morales, working for the Chilean secret service)¹⁰

The third mechanism Kelman distinguished was dehumanization. Torturers learned to see their victims as no longer human anymore. "Beasts", "worms", and the German term "Untermensch" are some typical examples of how the victims were termed and seen by their perpetrators.

Organization of the work

The work was so organized that people could avoid awareness of what was really happening: euphemisms were used to describe the torture, torturers used nicknames and thus could almost slip into another personality. When someone had to be executed several people shot at the same time so that responsibility could be spread. Specialists even worked out methods to make the killing more "humane" ... which meant less of a burden for the perpetrators. The psychological problems of members of the famous "Einsatzgruppen" in the Second World War are well known. Gas was considered a better method, since the men could not stand wading through the blood any longer, ... some had gone mad. And as a last resort the superiors always made sure that enough alcohol and sometimes even drugs and medicine were available ...

The most important factor though is that everything was so organized that torture and killings became normal, nothing extraordinary, merely a job. The notes in a diary of a member of the Khmer Rouge prove how easily some seemed
to distance themselves from their "crimes of obedience", just as a bureaucrat can forget his daily dull work:

- July 1, 1977
  A day largely devoted to executing the wives of workers previously executed.
- July 6, 1977
  127 persons executed.

Obedience: a crucial factor

According to Creilstein there are three types of torturers, the zealot, who truly believes in what he is doing, the professional, who tortures because he wants to do a good job and make a career, and the sadist, who enjoys torturing. Most importantly, all torturers are obedient; they torture because they get the order to do so: it is their job and they, for whatever reason, feel compelled to do so. They are asked, urged and otherwise forced to obey. All torturers can therefore be described as obedient followers. A notorious example of a man who was not a torturer, but a so-called "Schreibtischtäter" (armchair perpetrator) was Adolf Eichmann, a man whom we could label as almost obsessively obedient. His trial in Jerusalem in 1961 showed the world that Eichmann was not a sadist, nor a criminal by nature, but merely an obedient bureaucrat. Psychologists who examined him were struck by this: they could only conclude that Eichmann was normal: 'More normal, at any rate, than I am after having examined him'. His crimes came from the motivation of desperately wanting to "be good", do what he is supposed to do, have respect for superiors and be obedient. The world was struck by this "banality of evil", as Hannah Arendt described it. Milgram's obedience experiment had an even more disturbing outcome.

Milgram asked subjects to give another person an electric shock whenever he gave a wrong answer in the so-called learn experiment, which was really an obedience-experiment. It turned out that 65% of the people were prepared to give electric shocks up to 450 volts, to their fellow human beings. Some did this under great strain but were unable to disobey, others were indifferent: 'It was a job, wasn't it?' People seem to be prepared to do almost anything as long as the order comes from a legitimate authority. 'On command, citizens torture without any anger or rage, but also without guilt or remorse' was Milgram's conclusion. Furthermore, 'this behaviour', he explained, 'is normal human behaviour'. Two factors play a key role. First of all the fact that 'When people are asked to carry out actions incompatible with fundamental standards of morality – relatively few people have the resources to resist authority'. Kelman and Hamilton agree: 'Legitimate authority creates the obligation to follow rules, regardless of personal preferences or interests'. The second factor is that 'Once they have taken the initial step, they are in a new psychological and social situation in which the pressures to continue are powerful'. Thus, they justify their earlier actions ... breaking off means admitting to earlier wrongdoing ... The psychological pressure to obey an order is genuine.

Conclusion

In conclusion it could be said that torturers and other perpetrators are just ordinary people, however cruelly and inhumanly they may act. It is just that they are surrounded by an extremely coercive climate and have, often in pure self-defence, learned to distance themselves from their acts, to hide and ignore their ordinary and natural empathetic feelings. They have changed the world around them, changed reality in order to save their own ego from inner rejection and intense feelings of guilt and self-accusation. It is a dangerous ability and characteristic of man, but one we probably all have.

The autobiography of Rudolf Hoess, camp-commandant of Auschwitz, is revealing. Known to the outside world as an extremely cold and absolutely-unemotional and cruel man, he too seemed to struggle with his inner feelings, but his blurred sense of duty and responsibility made him hide exactly those feelings which could and should have stopped him from doing what he did ...

I myself dared not admit to such doubts. In order to make my subordinates carry on with their task, it was psychologically essential that I myself appear conformed of the necessity for this gruesome order. I had to exercise intense self-control to prevent my torrent of doubts and feelings of oppression from becoming apparent. I had to appear cold and indifferent to events that must have wrung the heart of anyone possessed of human feelings. I might not even look away when afraid let my natural emotions get the upper hand. I had to watch coldly while the mother with laughing or crying children went into the gas chambers. My pity was so great that I longed to vanquish from the scene: yet I might not show the slightest trace of emotion. I had to see everything – I had to do this because I was the one to whom everybody looked. (Rudolf Hoess).

References

11. Hawk D. Introduction to Khmer Rouge prison documents from the S-21 (Toul Sleng) extermination centre in Phnom Penh.
Prevalence of exposure to organized violence among refugees from Kashmir

Morten Larsen, MD*, Hans Petersen, MD*, Maiken Mannstaedt, MD* & Gunnar Skytt, MD*

Abstract
Since 1989 there has been an armed conflict in Indian-held Kashmir between Indian security forces and militant Muslim resistance groups, and grave human rights violations against civilians have previously been reported. In this study we want to assess the extent of exposure to human rights violations among refugees from that area.

Some 10,000 people are living in 10 refugee camps near Muzaffarabad.

In November 1994 we visited refugee camps for Indian Kashmiris near Muzaffarabad in Pakistan-controlled Kashmir. We performed the interviews and examinations in the camps with assistance from 2 interpreters.

A structured interview form was used. Those who told of marks after torture or maltreatment were physically examined.

We interviewed 94 representative heads of families (all males) from 4 camps. 2/3 of them (group A) fled their home village in 1989-92, while 1/3 (group B) fled in 1993-94.

The extent of killings, torture, maltreatment and arrests of members of the family before their escape was measured. In addition torture forms and torture sequelae were noted.

Exposure to torture among the interviewed men was 67% in group A and 77% in group B. Exposure to maltreatment of families with children was 32% in group A and 45% in group B. The overall family exposure to killings and/or torture was 89% in group A and 84% in group B. There were no significant differences between the two groups in the frequency of exposure to various forms of organized violence.

Conclusions: Our results showed that the refugees had been heavily exposed to human rights violations, those recently escaped to the same extent as the others.

Key words: Kashmir; Refugee camp; Torture; Killings.

Introduction
Since 1947 the national attachment of Kashmir has been the subject of conflicts between India, Pakistan, and groups wanting an independent Kashmir. There has been an armed conflict in Indian-held Kashmir for the past five years. Indian security forces are fighting against armed resistance groups, some claiming independence for Kashmir, others wanting union with Pakistan.

A large number of severe violations of human rights have been reported, e.g. torture, terrorist shooting of civilians, custodial death, arson of sections of towns or villages, disappearances and rape. Most of these violations are attributed to the Indian security forces. A number of Kashmiris have fled Indian-held Kashmir and are now living in refugee camps in Pakistan-controlled Kashmir.

Physicians for Human Rights/Denmark visited Kashmir several times during 1993 and 1994. Srinagar, in Indian-held Kashmir, was visited in April and June 1993. We examined a number of torture survivors and victims of arbitrary shooting and we collected data on human rights violations from local lawyers and doctors. A summary of the report from the mission in June 93 has previously been published.

In June 1994 we visited Pakistan-controlled Kashmir. We interviewed and examined 55 persons in refugee camps near Muzaffarabad who had fled from Indian-held Kashmir, and we reported on torture and other violations against adults.

We also examined and reported on Kashmiri children who had been exposed to torture and maltreatment. During that mission we examined selected groups of people and therefore could not assess the extent of exposure to human rights violations among the refugees from Indian-held Kashmir. To remedy that, Physicians for Human Rights/Denmark revisited refugee camps near Muzaffarabad from 14-18 November 1994.

Material
Some 2300 families from Indian-held Kashmir live in 12 camps in Pakistan-controlled Kashmir. Most of them arrived during 1990-1992. During the past 2 years, only about 50-60 families have arrived each year. We interviewed 94 heads of families, who were divided into group A and B (table 1).

Group A comprised 63 of the 87 (72%) families that were housed in the 2 small camps of Domishi and Hirkothi. Some

<table>
<thead>
<tr>
<th>Table 1. Number and composition of examined families, profession of family head and year of migration.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group A</strong></td>
</tr>
<tr>
<td>No. of families</td>
</tr>
<tr>
<td>No. of adults</td>
</tr>
<tr>
<td>No. of children</td>
</tr>
<tr>
<td>Head of family – profession</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Year of migration – no. of families</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

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heads of families were not interviewed, mainly because they were away visiting relatives in other camps. All the group A families had fled during 1989-92, 61 of them in 1990.

Group B comprised 31 families, all housed in 4 camps, 27 of them in the two relatively large camps of Brakhot and Hatten, and the remaining 4 in the above mentioned camps of Domishi and Hirkotli. The group B families had all fled during June 93-September 94. They comprised about 40% of the refugee families who were registered as coming from Indian-held Kashmir during that period.

The family pattern in groups A and B was more or less the same, i.e., on average about 3 adults and 2\(\frac{1}{2}\) children per family; about 90% of both groups were farmers.

Methods

To obtain a picture of the exposure to human rights violations among the refugee population we decided to focus on individual families by interviewing the heads of the families.

On arrival at the camp, we informed the inhabitants, in particular the elders, about the intended interview and examination. It was stressed that participation was voluntary and that the results would be published. The interviews took place via interpreters.

The interview form included questions about reasons for emigration, about detention, maltreatment and torture of the interviewed person and his family, and about deaths within the family caused by violence.

The persons who stated that they had scars and/or other sequelae of torture were examined. Scars and marks were measured and described. Remarkable scars were photographed.

We wanted to give a representative description of the exposure to violence among the refugees, but for practical reasons it was not possible to examine all households in all camps. We therefore decided to interview all heads of the families in two small camps, since we were told that the refugees had been exposed to the same extent in all the camps.

In addition, we decided to examine families who had fled within the previous 1\(\frac{1}{2}\) years, and compare their statements with those of families who had fled Indian-held Kashmir during the first years of the conflict. In this way we would be able to describe a possible recent change of conditions in Indian-held Kashmir.

Results

Table 2 shows the extent of killings, torture, maltreatment, and arrests in the families of groups A and B. Table 3 shows remarkable clinical findings.

We were informed about 28 named torture centres and approximately 20 defined torture methods, of which we shall mention only a few. Chili and/or salt put in the eyes, nose or wounds. Beatings with barbed wire. Forced abduction of the legs until dislocation or fracture of thigh bone. "The Roller" used on the back; a sort of large rolling-pin that can cause severe traumatization of skin and muscle tissue. The two latter torture methods have previously been described from India\(^6\),\(^7\).

Sexual violation of women was indicated in several interviews, although we did not systematically ask about this delicate subject. In 1 case, rape was reported; in 2 cases, the interviewed men said that female members of the household had been separated from the men during house searches and had been alone with the soldiers for a while; finally in 2 cases, it was mentioned that female members of the household were "teased" by the Indian soldiers. The interpreter explained that this could mean anything from verbal assaults to rape.

Case

A 36-year-old farmer who fled with his family in January 1994. He reported that he had been in prison for a month just before the flight. He was burnt with cigarettes, and boiling water was poured over his lower legs. In a forced prone position, gravel was strewn over his back and a pole rolled over it ("The Roller"). He also underwent electrical torture to his forearms and wrists. He had two wives; the younger, aged 19, died in June 1993 after being beaten by army troops at home. His second wife and two children, 12 and 10 years old, were beaten and kicked while the house was searched. His brother, brother-in-law, and nephew were imprisoned in January 1994; their fate is unknown.

Examination showed numerous linear scars running longitudinally on the upper part of the back, 0.5-1.5 cm long and 2-3 mm wide. There were several round, dark scars on both lower legs 0.5-1 cm in diameter. Both shins showed several lighter, oblong, irregular linear scars. There was a 3 x 6 cm scar on the right forearm, and a 0.5 x 2 cm scar at the left wrist.

Comments: testimony of torture, of arbitrary violence against children, fatal violence against a woman, imprisonment and disappearance of relatives. The location, number, and appearance of the scars on the back were remarkable, entirely consistent with the testimony. The circular scars on the lower

<table>
<thead>
<tr>
<th>Table 2. Results – the numbers indicate the number of family heads who confirmed the posed questions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group A</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>A. Killed first degree relatives</td>
</tr>
<tr>
<td>B. Torture of family head</td>
</tr>
<tr>
<td>C. Maltreatment of family head</td>
</tr>
<tr>
<td>D. Arrest of family head</td>
</tr>
<tr>
<td>E. Overall family exposure to killings, torture and/or maltreatment – A, B and/or C above</td>
</tr>
</tbody>
</table>

NS: No Significant difference between the two groups.
legs were consistent with burns from cigarettes. The other scars were nonspecific, but their number was striking.

**Discussion**

It has previously been documented that Indian Kashmiris in general, and refugees from Indian-held Kashmir living in camps in Pakistan in particular, have been exposed to torture and other kinds of violence by the Indian security forces. Therefore we have not evaluated in depth all the statements about torture of the groups examined in the present series. Our programme did not include obligatory physical examination. When the interviewees mentioned that they had scars and marks from torture/maltreatment, we compared their history about torture with the objective findings. In all cases the findings were consistent with the histories. Most findings were unspecific but some scars and marks were remarkable, and most of them indicated very severe and unnatural traumatization, far from every day events. The 3 cases with deformities involving the nails seem to be highly specific and are beyond much doubt due to torture as described; it has not been possible to locate photos of such nail deformities in the accessible medical literature. The many remarkable findings indicate that the torturers in Indian-held Kashmir do not care whether they inflict “specific” lesions on the victims. The observations described in the present study are thus additions to the previously reported evidence of torture in Indian-held Kashmir.

Group A consisted of a sample of refugees who escaped from Indian-held Kashmir during 1989-1992. There was no reason to believe that the refugees had been “sorted” into different camps according to their injuries or exposure, and we were informed that there had been no special allocation procedures. Since we examined 72% of all the households in

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**Table 3. Remarkable clinical findings.**

<table>
<thead>
<tr>
<th>Described trauma</th>
<th>Clinical findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beatings and kicks or combined traumas</td>
<td>1 case of a deformed finger (5th right).</td>
</tr>
<tr>
<td></td>
<td>1 case of amputation of distal phalanx (1st right) covered by irregular scar</td>
</tr>
<tr>
<td></td>
<td>3 cases of irregular scars on lower leg with underlying deformity of the bone (e.g. fig. 3)</td>
</tr>
<tr>
<td></td>
<td>1 case of 2 missing teeth</td>
</tr>
<tr>
<td></td>
<td>1 case of scar on the skull with underlying 4 mm excavation of the bone</td>
</tr>
<tr>
<td></td>
<td>see – case</td>
</tr>
<tr>
<td>The “roller”</td>
<td>1 case of a 4 × 1.5 cm biconvex scar on the medial aspect of knee</td>
</tr>
<tr>
<td>Cuts/stabs with bayonets</td>
<td>1 case of a 4 × 0.2 cm scar on the dorsal aspect of the left hand</td>
</tr>
<tr>
<td></td>
<td>1 case of 2 triangular scars 4 × 4 mm on the dorsal aspect of right hand</td>
</tr>
<tr>
<td></td>
<td>1 case with a 0.3 × 12 cm scar below left nipple</td>
</tr>
<tr>
<td></td>
<td>1 case with numerous small, regular scars on both hands and forearms</td>
</tr>
<tr>
<td></td>
<td>1 case with an irregular L-shaped scar 2 × 4 cm above right eyebrow</td>
</tr>
<tr>
<td></td>
<td>1 case with a 1 × 3 cm scar on right thigh and a 1 × 2 cm scar on right calf</td>
</tr>
<tr>
<td></td>
<td>1 case with a 3 × 9 cm irregular scar on left calf; a 0.2 × 10 cm linear scar on left ankle; a 1.5 × 8 cm scar above right knee (fig. 1); a 0.5 × 5 cm scar on right foot; a 0.5 × 4 cm scar on the scalp; a small scar on left thumb</td>
</tr>
<tr>
<td>Strike with an axe</td>
<td>Extrication of the right foot (injury treated in a surgical clinic)</td>
</tr>
<tr>
<td>Burns with cigarettes, fire or electrical devices</td>
<td>1 case of 3 small round scars on left arm and leg</td>
</tr>
<tr>
<td></td>
<td>1 case with 6 round 1 cm big scars on left shoulder and both knees, and 1 round 2.5 cm big scar above the navel</td>
</tr>
<tr>
<td></td>
<td>1 case with a 5 × 5 cm irregular atrophic area on left elbow</td>
</tr>
<tr>
<td>Insertion of a steel rod</td>
<td>1 case of a 12 mm circular scar on the lateral aspect of left lower leg</td>
</tr>
<tr>
<td>Insertion of pins under the nails</td>
<td>3 cases of longitudinal deformities of one or two nails involving the matrix (e.g. fig. 2)</td>
</tr>
</tbody>
</table>

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**Fig. 1.** Scars on leg – allegedly from bayonet thrusts.

**Fig. 2.** Longitudinal deformities of the nails of the 4th and 5th fingers of the left hand – allegedly from pins forced up under the nails.
the 2 camps, they should be a representative sample of refugees from the first years of the ongoing conflict.

Group B comprised approximately 40% of the households that arrived at the camps during the past 1½ years. In our opinion, this participation rate indicates that the examinées were representative of the refugees from that period (June 1993-September 1994). We had no access, however, to the lists of arrivals and could not therefore evaluate the "response rate".

It is clear from our findings that almost all the families had been exposed to ill-treatment, torture, and/or killings before their escape from Indian-held Kashmir. These findings agree with the information from previously published reports concerning this area, describing widespread torture and a large number of arbitrary killings and custodial deaths. The figures of our study could be compared with figures from Denmark, where 55% of male refugees living in camps were found to be torture victims. This may indicate a generally high prevalence of exposure to organized violence among refugees from conflict areas, who have no other possibility of refuge than a temporary camp. We are not aware of other similar surveys carried out in refugee camps describing prevalence of exposure to torture.

There were a large number of households, 32-45%, in which children were said to have been maltreated. This agrees with a previous report concerning maltreatment and torture of children under the age of 15 years inflicted by the Indian security forces. We regard children as representing the civilian population, and their exposure to maltreatment reflects a systematic terrorization of civilians.

Some interviewees suggested that women from the household had been exposed to sexual violation. Our examination procedures did not allow exploration of these suggestions, one of the reasons being that this subject is very much taboo in the Muslim society. Therefore we assume that the information we received about sexual violations to women represents minimum figures on the matter.

There were no significant differences between groups A and B in the frequency of exposure to various forms of organized violence. We were told that the decrease in the number of refugees registered over the last couple of years was a result of strengthened border control by the Indian security forces. Our results therefore do not indicate a recent improvement in the human rights situation in Indian-held Kashmir.

Conclusion

Refugees from Indian-held Kashmir living in refugee camps in Pakistan-controlled Kashmir have been heavily exposed to human rights violations. Our results are in agreement with other reports underlining that civilians are highly affected by the ongoing conflict, and they do not indicate a recent improvement of the situation in Indian-held Kashmir.

References


TORTURE Volume 5, Number 2 1995
Trauma in Mozambican refugees

AP Reeler*

During 1992-1993, AMANI initiated a series of training workshops in all the refugee camps within Zimbabwe. This was in response to the recommendations of an international workshop held to discuss services to Mozambican refugees. These workshops were facilitated by the Commissioner for Refugees, and the results were summarized in a series of reports, forwarded to the Commissioner for Refugees. The consolidated findings have been described elsewhere.

The findings indicated a high prevalence of psychological disorders in adult Mozambican refugees (62%), with a substantial proportion reporting some previous experience with organized violence (25%). These findings paralleled findings with other refugee populations, and are not surprising.

The training programme indicated that health, social, and community workers were capable of detecting, assessing, and managing such psychological disorders, but it is apparent that the training programme did not result in a sustained service delivery programme.

The present report emanated from a new initiative by AMANI and Intercountry People's Aid (IPA) to offer rehabilitation services to the victims of organized violence within the remaining Mozambican refugees. There was a more explicit focus on the victims of violence, on psychological traumas as opposed to psychological disorders generally.

A training programme for the health staff of IPA was organized between 26-30 September 1994, and follow-up is continuing, but the programme has been curtailed to a large extent by the rapid repatriation of the refugees to Mozambique.

Workshop process

Unlike previous workshops, the Tongogara workshop (1994) focused on both clients and caregivers. One full day was given to an exploration of burnout, vicarious traumatization, and care for caregivers. This involved experiential exercises, focused discussions, and a minimum of didactic input. This took place on the first day, and seemed to generate much insightful reflection among the participants.

The remaining three days were given over to the detection, assessment, and, to a lesser extent, the management of psychosocial trauma. All participants were given copies of a manual that had been used in previous workshops, but had been substantially modified. The teaching involved both didactic input and practical exercises, and two series of screening exercises were carried out, one in the refugee community, the other in the outpatient department of the primary care clinic in the camp. Despite the small numbers, the results of the screening exercises were interesting; they are given in more detail below. Overall, the workshop seemed a useful exercise, and was enjoyed by the participants. A need for continued follow-up and further training was identified by the participants, and this was to be arranged by the two major participating organizations, AMANI and IPA.

Results of screenings

As indicated above, two separate screening exercises were conducted. In the community exercise, homes were chosen at random from amongst the homes in the camp, while in the PHC exercise, consecutive patients attending OPD were screened (table 1).

<table>
<thead>
<tr>
<th></th>
<th>Cases</th>
<th>Noncases</th>
<th>Percentage prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community screening</td>
<td>5</td>
<td>9</td>
<td>37%</td>
</tr>
<tr>
<td>PHC screening</td>
<td>8</td>
<td>5</td>
<td>62%</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>14</td>
<td>48%</td>
</tr>
</tbody>
</table>

As can be seen from these results, the prevalence in the community setting was considerably lower than that obtained at the OPD setting. The rate obtained at the clinic was higher than in 1992 (54%), which may have some importance.

Various other forms of data were taken from the screening and the interview, and these are summarized in tables 2 and 3.

These results (table 2) show some differences from 1992. The present sample is older, with far less education and fewer having worked. There are more women, with more relationship difficulties (divorce and widowhood), and larger families. Most of these indices suggest greater social adversity, and also indicate a group with little social buffering or support.

As can be seen from table 3, the clinical data show a group with multiple symptoms, severe symptoms, and high suicidal

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Table 2. Demographic characteristics of Mozambican refugees.

<table>
<thead>
<tr>
<th></th>
<th>1994 (n=13)</th>
<th>1992-1993 (n=65)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>30%</td>
<td>46%</td>
</tr>
<tr>
<td>Female</td>
<td>70%</td>
<td>54%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean years</td>
<td>45.1</td>
<td>40.9</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Single</td>
<td>0</td>
<td>8%</td>
</tr>
<tr>
<td>Divorced</td>
<td>10%</td>
<td>11%</td>
</tr>
<tr>
<td>Widowed</td>
<td>30%</td>
<td>21%</td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean number</td>
<td>5.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean years</td>
<td>0.9</td>
<td>3.0</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worked</td>
<td>20%</td>
<td>14%</td>
</tr>
<tr>
<td>Never worked</td>
<td>80%</td>
<td>86%</td>
</tr>
</tbody>
</table>

Table 1. Prevalence of psychological disorders in Mozambican refugees.
Table 3. Clinical characteristics of Mozambican refugees.

<table>
<thead>
<tr>
<th></th>
<th>1994 (n=13)</th>
<th>1992-1993 (n=65)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>Mean number</td>
<td></td>
</tr>
<tr>
<td>SRQ-20 (Total)</td>
<td>Mean score</td>
<td></td>
</tr>
<tr>
<td>SRQ-20 (Anxiety)</td>
<td>Mean score</td>
<td></td>
</tr>
<tr>
<td>SRQ-20 (Depression)</td>
<td>Mean score</td>
<td></td>
</tr>
<tr>
<td>Suicidal risk</td>
<td>Mean score</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.1</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td>12.1</td>
<td>11.8</td>
</tr>
<tr>
<td></td>
<td>4.5</td>
<td>4.6</td>
</tr>
<tr>
<td></td>
<td>6.1</td>
<td>5.4</td>
</tr>
<tr>
<td></td>
<td>4.1</td>
<td>3.7</td>
</tr>
</tbody>
</table>

risk. There is comparatively higher reporting of depressive symptoms. The data in table 4 show markedly higher Social Adversity scores than the 1992 sample, with a much larger number reporting previous experience of organized violence, and more than double having some adverse life event during the previous 6 months, most relating to the deaths of relatives and family.

Table 4. Social adversity and other features in refugees.

<table>
<thead>
<tr>
<th></th>
<th>1994 (n=13)</th>
<th>1992-1993 (n=65)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social adversity</td>
<td>Mean</td>
<td></td>
</tr>
<tr>
<td>Life events</td>
<td>Entrances</td>
<td>Exits</td>
</tr>
<tr>
<td>Violence in history</td>
<td>Percentage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.5</td>
<td>2.5</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>70%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>43%</td>
<td>26%</td>
</tr>
</tbody>
</table>

If the cases who report an experience of repressive violence are separated out, as described in table 5, it is evident that several report symptoms indicative of PTSD, and one reports symptoms of what could be described as "vicarious trauma". One person indicated having an experience of organized violence, but was unwilling to give any kind of detail, and so was excluded from this subsample.

Interpretation of results

These results have to be treated with caution due to the very small sample size, but they are interesting, especially when they can be compared with a previous sample from 1992. Generally, the 1994 sample shows both increased severity of symptoms and greater social adversity, both factors which are linked to poor prognosis if untreated.2

The severity is indicated by higher mean scores on the SRQ-20 (12.1 in 1994, 11.8 in 1992), while social adversity is indicated by a variety of different measures. Social adversity was 2.6 in 1992, 3.5 in 1994. Life events indicated more recent losses, almost double the 1992 rate, and all the demographic features, which are an indirect measure of social adversity, indicated that the problems were greater: the group was made up of older women and generally had less education, less experience of employment, and a higher incidence of relationship difficulties.

A very high number of persons (43%) reported an experience with organized violence in Mozambique, much higher than the previously reported rate (25%). From the clinical information, these persons would probably receive a diagnosis of Post-Traumatic Stress Disorder; all were severe, and all would require treatment. Furthermore, the rate of persons attending the clinic was much higher than the rate obtained in the community, which suggests that these persons are troubled by their symptoms and actively seek help.

The fact that their problems are being expressed somatically leads to an exclusively medical and physical focus, and to inappropriate treatment. However, it is interesting that the clinic is such a focal point for attempts to solve the problems, and corroborates findings from the primary care setting in the Zimbabwean community.6

Most of these patients expressed reservations about repatriation, and fears about renewed war were frequent. Several patients had been excluded from repatriation due to their medical condition, although it was not clear from their clinic cards what precise medical condition had been diagnosed by the clinic staff. This reinforces the view that psychosocial aspects of refugee work requires a higher emphasis than is the case at present.1

Conclusions

The results corroborate earlier work with Mozambican refugees, and demonstrate the importance of screening refugees for psychological disorder. They also indicate the need to be aware of the consequences of organized violence: nearly 50% of this sample reported an experience of violence, mostly the witnessing of violence. Not all of the cases report symptoms of PTSD, which underlines the need to consider carefully the value of the PTSD concept in refugee work, and more generally with the victims of organized violence.

On a practical note, the results suggest that the population left in the refugee camp is a cause for concern, and it may well be that the most vulnerable are being left to repatriate last. It may equally mean that the most vulnerable are finding ways to avoid repatriation to a still insecure situation, and several expressed a wish not to have a repetition of the previous experiences that led to their becoming refugees. In

Table 5. Summary of refugees reporting previous experience with repressive violence.

<table>
<thead>
<tr>
<th>Client</th>
<th>Type of violence</th>
<th>Current concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>46-yr-old female</td>
<td>Not direct. Mother witnessed decapitation of father/husband</td>
<td>Recent deaths of 2 children. Fear of bewitchment</td>
</tr>
<tr>
<td>29-yr-old male</td>
<td>Witnessed aftermath of massacre</td>
<td>HIV infected</td>
</tr>
<tr>
<td>60-yr-old female</td>
<td>Witnessed massacre of own family</td>
<td>Resisting repatriation</td>
</tr>
<tr>
<td>56-yr-old male</td>
<td>Witnessed killing and torture of relatives and family</td>
<td>Worried about own health and family security</td>
</tr>
<tr>
<td>65-yr-old female</td>
<td>Witnessed killing of close family, father killed by landmine, escaped because of own handicap (crippled)</td>
<td>Fears about repatriation</td>
</tr>
</tbody>
</table>

(presenting) Complaints

either event, this is a population that will require active clinical intervention, and the results suggest that psychosocial assistance should be equally important in both later and earlier phases of the refugee experience, and particularly important in vulnerable groups, such as victims of organized violence and the elderly. It may additionally be important to ensure follow-up in host countries, since it is unlikely that clinical interventions can be timed to coincide easily with reapatriation dates.

Few of these refugees report direct violence, and it is clear that "high war zone stress" can be a significant precipitant of clinical disorder. This underscores more strongly the need to provide psychosocial assistance to areas suffering from war and extended civil strife.

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Practices against governmental sanctioned torture

Bent Sørensen, MD, DMSc*

I. United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)

The United Nations paid attention to torture as early as 1948. Article 5 of the Declaration of Human Rights says:

No one shall be the subject of torture or cruel, inhuman or degrading treatment or punishment.

This proved to be a good formulation. The wording has not been changed apart from the omission of the word “cruel” in Europe. Article 5 was interpreted as a right, which perhaps should not necessarily need special attention. It was thought that torture was something terrible that belonged to the past and would not reappear.

But the practice of torture continued, and in 1975 the United Nations published the Declaration Against Torture – also words, but at the same time the UN wanted to work to create a Convention. This succeeded, and on Human Rights Day, 10 December 1984, the UN General Assembly, without voting, passed the Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment.

"Without voting" means that all the nations agreed on the content of the convention (otherwise voting would have taken place) – whether a nation will follow the convention is up to the nation itself. By 10 December 1994, the 10th anniversary, 85 UN member states had ratified the Convention. The Convention was put into effect on 27 June 1987, when it had been ratified by 20 countries.

The definition of torture

Article 1 gives a definition of torture:

For the purposes of this Convention, the term “torture” means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

Today, seen with NGO-eyes, this may seem quite a narrow definition. Thus, it must be a question of severe pain or suffering – physical or mental (but mental suffering is included). The torture should be inflicted intentionally and with a pur-

pose – thus, for instance, ordinary police violence in connection with arrests is not torture. The torturer must be a public official or someone who acts on public orders. It is thus only a question of government-sanctioned torture. Actions of resistance movements or terrorists are not covered by the Convention, nor is violence within the home.

In this connection: The definition was made at the beginning of the 1980s when the world looked quite different. However, the definition was approved by the then Eastern and Western powers, and by the present North and South. The definition is thus universal in the very best meaning of the word – a situation that no member state denies, and which in my opinion is much preferable to a wider definition that would not be universally approved.

No excuse whatsoever

Article 2 requests the member states to refrain from torture. Paragraph 2 states very clearly that no behaviour can justify torture:

No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture.

This is a particularly important article for member states in these days of terrorism and fight against terrorism. No state can refer to "the rule of necessity". Apart from this, torture has never in the history of mankind solved a political problem.

Paragraph 3 of the article is also of paramount importance:

An order from a superior officer or a public authority may not be invoked as a justification of torture.

The language is clear; it prohibits unambiguously "due obedience".

Obligations of the member states

Articles 3-16 and 19 impose several obligations on the member states. Article 3 states:

No State Party shall expel, return ("refouler") or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture.

As far as I know there are about 15 million refugees in the world; many of these are torture victims, and some of them will risk torture if they are "refouled".

Article 3 is thus highly relevant at present and gives, if it is used, good protection for refugees who risk being tortured.

Articles 4-9 describe in detail the obligations of member states to bring torturers to court without delay and to punish them, even if the crime took place outside their own country and involved foreigners. Torturers are thus outlaws. It is a question of "universal jurisdiction".

Article 10 is here quoted in full:

1. Each State Party shall ensure that education and information re-
NEWS FROM CAT AND CPT

garding the prohibition against torture are fully included in the
training of law enforcement personnel, civil or military, medical
personnel, public officials and other persons who may be involved
in the custody, interrogation or treatment of any individual sub-
jected to any form of arrest, detention or imprisonment.
2. Each State Party shall include this prohibition in the rules or in-
structions issued in regard to the duties and functions of any such
persons.

Most people probably agree that in the long run education is
the best means to obtain any goal — including the prevention
of torture. Article 10 of the Convention is very fortunately
formulated in this respect: it is the duty of the State to ensure
that the problems of torture are fully incorporated (quite a
strong UN-expression) in the rules for several professions
— including the medical.

Article 11 states:

Each State Party shall keep under "systematic review" interrogation
rules, instructions, methods and practices as well as arrangements for
the custody and treatment of persons subjected to any form of arrest,
detention or imprisonment in any territory under its jurisdiction,
with a view to preventing any cases of torture.

A very important article. How many states have such rules at
all? How many states have made a review? And, if they have,
how many have done it systematically? It is now the obligation
of the member states.

Articles 12-14 deal with persons who have been tortured.
They should have the right to have their cases brought to
court immediately. Possible witnesses must be protected, and
if the person is found to have been exposed to torture he
should have access to what is called the three “M”s of the
rehabilitation process:

Moral = redress
Money = compensation
Medical = full rehabilitation.

Article 15 prohibits the use in court of a confession made
under pressure.

The Committee Against Torture, CAT

Previous initiatives against torture resulted in words more
than in results. To improve this situation, the Convention
created a Committee Against Torture (CAT) to see to it that the
rules of the Convention are introduced in the national laws,
and to make sure that the same rules are implemented in
practice.

The members of the Committee are elected for a period of
4 years by a secret ballot among those member states who
have ratified the Convention. According to the Convention:
The Committee shall consist of ten experts of high moral standing
and recognized competence in the field of human rights, who shall
serve in their personal capacity.

CAT meets twice a year for a 2-week session in Geneva.

The controlling mechanism

The member states are obliged to produce an initial report at
the ratification of the Convention, and thereafter a periodical
report every fourth year. The reports should describe how the
rules of the Convention have been implemented in the do-
mestic laws and in practice.

Before a member state makes its report, the CAT-
members usually receive some information about the country
from various NGOs, including Amnesty International. The
presentation of the report takes place at public meetings to
which NGOs, individuals, and the press (including TV, if
desired) have access. The country sends a delegation to pres-
ent the report. As a rule the members of the delegation are
high officials, sometimes even ministers, often from the min-
istries of foreign affairs, internal affairs, and of justice, and
from the prison authorities. CAT poses some questions. The
delegation replies, and thereafter CAT will meet behind
closed doors to formulate its conclusions, which will be
presented at an open meeting. CAT’s statements usually
consist of an introduction, followed by sections on positive
aspects, matters of concern, and recommendations. The con-
clusions are printed in the CAT annual report, which is sent
to the UN General Assembly.

Individual member states can make good use of the public
meetings of CAT. NGOs and the press can use the meetings
to start a public debate and thus help to have the CAT rec-
ommendations carried out. At any rate, it allows the country
concerned to create awareness of the problem of torture —
perhaps the most important condition to abolish this
plague of the Century.

Communications

At the ratification of the Convention the member states can
decide whether they also want to ratify Articles 20-22; almost
half of the states have done so.

Article 20 states:

If the Committee receives "reliable information" which appears to it
to contain "well-founded indications" that torture is being "sys-
tematically" practised in the territory of a State Party, the Committee
shall invite that State Party to co-operate ...

Such discussions take place behind closed doors and may re-
sult in a visit to the country concerned. When the discussions
have been finished, CAT can decide to publish the results.
This has happened in one country, Turkey, where CAT re-
vealed the practice of systematic torture.

Article 21 gives a country the right to complain about an-
other country. This article has not yet been used.

Article 22 gives individuals the right to communicate with
CAT about violations of the Convention — from Article 3
onwards. These discussions are also confidential, but fin-
ished cases are published and included in the annual report,
anonymously with respect to persons, but not to countries. It
may be mentioned that CAT has dealt with two complaints
of violations of Article 3 (return to a country where the com-
plainant would risk torture) — in both cases to the advantage of
the complainants, both of whom avoided extradition.

II. The Council of Europe’s Convention
for the Prevention of Torture and
Inhuman or Degrading Treatment
or Punishment (CPT)

Lenin said: “Trust is good, control is better.” The relation-
ship between UN’s Committee Against Torture (CAT) and
the European Committee for the Prevention of Torture
(CPT) may be characterized in this way.

On 26 December 1987 the European Council opened the
European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment for signature. The Committee held its first meeting in November 1989. A few years later all 23 original members of the European Council had ratified the Convention, and by the end of 1993 all 23 countries had been visited.

After the fall of the Berlin wall, more and more of the Central European states have become members of the European Council, and Russia is expected to join during 1995. At the beginning of 1995 Bulgaria, Hungary, Poland, Slovakia, Slovenia, and Romania had ratified the Convention.

The CPT

CPT seems to be different from CAT in all respects.

Each member country elects one member to CPT. The members of the Committee shall be chosen from among persons of high moral character, known for their competence in the field of Human Rights or having professional experience in the areas covered by this Convention ... The members shall serve in their individual capacity, shall be independent and impartial and shall be available to serve the Committee effectively (Article 4).

The present Committee has a variety of competences, including: lawyers, prosecutors, judges, ambassadors, psychologists, psychiatrists and other doctors, some politicians, a priest, and prison specialists.

The CPT mandate differs considerably from that of CAT since it really has only one mandate, expressed in Article 2:

Each Party shall permit visits, in accordance with this Convention, to any place within its jurisdiction where persons are deprived of their liberty by a public authority.

Furthermore, member states are obliged to cooperate with the Committee and to give all the information requested by the Committee.

The visits

In practice the work of the Committee consists of inspection visits. A Visit Delegation is formed, usually consisting of 4-5 Committee members, supplemented by 1-3 experts, as well as interpreters.

At the end of a year, governments are informed which countries can expect to be visited during the following year. Two weeks before the start of the visit, CPT informs the country about the time of the visit and the composition of the delegation. At the same time, meetings with relevant ministries/ministers are suggested. Three days before the delegation begins its work, it gives notice by fax of the names of the institutions to be visited, and it requests from them the relevant statistics, maps, etc. At the same time the delegation stresses that it has the right, without notice, to visit all the institutions it might want to.

The member states have given the Committee extensive power and trust since:

The Committee may interview in private persons deprived of their liberty, (...) The Committee may communicate freely with any person whom it believes can supply relevant information.

After the visit, the secretariat and the delegation will write a report, based on the found facts, with recommendations and possibly questions to the government. The report is presented to and approved by the whole Committee before it is sent to the country concerned.

Everything is done confidentially. The whole work is based on the two "C"s:

Confidentiality and Co-operation.

To my knowledge, it is the first time in the history of the world that several states have given permission to foreign, independent inspectors, not representing their own countries, to visit their closed institutions and to talk with everyone in private.

It has proved a very fruitful procedure. CPT has started a valuable dialogue with the governments. The recommendations have been followed to a large extent, or the governments have given CPT convincing reasons for not doing so.

However, CPT does not visit a country once only. According to Article 7:

the Committee shall organise visits to places referred to in Article 2. Apart from periodic visits, the Committee may organise such other visits as appear to it to be required in the circumstances.

It is just a question of an ongoing dialogue.

CPT has only the "means of coercion", described in Article 10.2:

If the Party fails to co-operate or refuses to improve the situation in the light of the Committee's recommendations, the Committee may decide, after the Party has had an opportunity to make known its views, by a majority of two-thirds of its members to make a public statement on the matter.

CPT has only done so once; in December 1992 we published a statement on Turkey (see the annex of the Third Annual Report).

What has been published?

The member states can suggest to CPT that the reports and possibly the responses to them are published. This is of course welcomed by CPT, and this procedure has now become almost the rule. Of the 23 "original" member states, 20 have published the reports and usually also their responses.

CPT writes an annual report on its activities (November and December 1989 were included in the report covering 1990). Furthermore, some of the reports have additional supplements: the first report included an article that compared the work of CPT with that of the Court and Commission of the European Council; the second report included a special article on the work of police stations, and the third on medical aspects in prisons.

The published reports and corresponding answers by governments are available at CPT's office in English and French, the two official languages of the European Council (and never in other languages). Personally I would like to recommend readers to study the report on their own country, and the Third Annual Report for medical readers.

Future issues of Torture will include "News from CAT" and "News from CPT" - similar to the one on CAT. However, according to the above, and especially the confidentiality rules, this information will mainly be limited to facts.

TORTURE Volume 5, Number 2 1995
United Nations Committee on Torture:

Concern on Chile, Peru, Libya and Morocco

*Satisfaction with three other countries examined at the thirteenth session of the Committee*

*Henrik Döcker*

The United Nations Committee set up under the Convention against Torture and other cruel, inhuman or degrading Treatment or Punishment examined two South American, one former Communist, two North African countries, and two European dwarf states during its thirteenth session in Geneva, November 1994.

Though some hope of improvement was glimpsed from some of the country reports, the general picture of the extent of the use of torture worldwide is still grim. The Assistant Secretary General for Human Rights of the UN, Mr. Ibrahim Fall, reported that the UN Special Rapporteur, Mr. Nigel Rodley, in 1994 sent more than 120 urgent appeals on behalf of people allegedly tortured or threatened with torture, twice the number in 1993.

The reports from Chile, Peru, Morocco, and Libya, dealt with in November, gave reason for concern, since the power of the military and the police is still too extensive, and the rights of the citizens too weak. Two Lilliput states of Europe, Liechtenstein and Monaco, which have probably never had a single torture victim, received good marks, as did the new Czech Republic, which has adopted a definition of torture in its national legislation – after 40 years of torture-prone Communist dictatorship.

**Chile**

The Committee noted with satisfaction that the government of Chile was initiating a number of important changes, both in respect of proceedings and in substantive legislation, which would contribute to preventing the practice of torture. It also welcomed programmes fully to compensate those affected by violations of human rights. However, the Committee noted with concern the existence of a considerable number of accusations of torture and ill-treatment by various security forces, in particular by carabineros and the investigative police, which had not received an effective judicial response.

The Committee suggested a thorough overhaul of procedural rules, especially with respect to the power of detention by the police, and free access by the detainee to family members, lawyers, and doctors that he trusted. There should be an explicit waiver of rules, such as automatic obedience, that were not in conformity with the Convention. The security forces should be subject to the civil authorities, and all vestiges of the military dictatorship should be abandoned. With the former dictator, General Augusto Pinochet, still as chief of the Army, this is easier said than done!

**Peru**

Measures taken by Peru to comply with the UN Convention against torture had proved inefficient in the prevention of acts of torture, the Committee concluded. Peru also did not satisfy the Convention’s requirements regarding the prompt and impartial investigation of all complaints of torture. On the other hand, the Committee took note of the intense campaign for promoting respect for human rights carried out by the military and the security forces. The Committee also noted other developments such as allowing prosecutors to visit places of detention in zones under a state of emergency and the setting up of new organs for rights protection.

The Committee recommended revision of the procedures relating to terrorist offences, with the aim of establishing an efficient trial system while preserving the independence and impartiality of the courts and eliminating incommunicado detention and “faceless” judges. It should not be forgotten that the guerrilla movement Sendero Luminoso, which frightened large parts of Peru for many years, is now crushed, according to the Peruvian government. There is therefore no reason for judges still to hide their faces with hoods at trials concerning terrorism. Military jurisdiction should be regulated so as to prevent the judging of civilians and to restrict the competence of military tribunals to military offences. Institutions such as the National Council and the Defender of the People should come into being, and prosecutors’ offices should be strengthened.

**The Czech Republic**

The Committee noted with satisfaction that the Czech Republic had adopted most of the protective measures indicated in the Convention and had developed its own institutions to give effect to its obligations. All the necessary democratic institutions and safeguards are now in place in the republic to ensure the implementation of the Convention. The expeditious and effective way in which the Czech authorities had dealt with allegations of abuses by police and prison officers, had set up a system of compensation and rehabilitation, and had initiated education on torture prevention was further praised.

**Libya**

The Committee noted with satisfaction that the terms of the Convention had been generally incorporated into the domestic laws of Libya, and, in particular, that Libya had defined a separate crime of torture. It was concerned, however, that incommunicado detention continued to create conditions that could lead to breaches of the Convention. It was also concerned that allegations of torture continued to reach it from
non-governmental organizations that had proved to be reliable sources in the past.

The Committee recommended that free access to a lawyer and doctor of choice, as well as to relatives, should be guaranteed at all stages of detention. The government should continue its fight against torture by sending a clear message to its police and prison officers, as well as providing educational programmes for them; and by ensuring that offenders were prosecuted in strict accordance with the law.

Morocco
The Committee expressed its appreciation for Morocco's efforts at constitutional and legal reform with a view to harmonizing its system of justice with the provisions of the Convention. It observed that the Government's attitude demonstrated a willingness to achieve the conditions necessary for the protection and promotion of human rights and to prevent the practice of torture and cruel, inhuman and degrading treatment.

While welcoming some recent events in Morocco, such as the creation of a Ministry of Human Rights, the Committee was, nevertheless, concerned over allegations of torture and ill-treatment received from various non-governmental organizations, as well as over practices noted in various places of detention. It was also concerned about certain shortcomings in the prevention of torture and in the investigation and prosecution of cases of ill-treatment. That situation created an impression of relative impunity for those responsible, which was prejudicial to the proper implementation of the Convention, it stated.

The Committee recommended that Moroccan legislation provide for the punishment of all forms of torture so as wholly to cover all elements of the definition of that offence. It also called for the systematic and effective monitoring of places of detention so as to provide optimum protection for detainees. Morocco was encouraged to continue its efforts to undertake further reforms in penal legislation, with particular regard to the administration of the penitentiary system and the allowable extension of custody.

The Committee urged serious investigations into allegations of torture made by the police. It also made recommendations for the reinforcement of training and education in human rights for public officials, and adequate compensation for victims of torture. Morocco should also submit in writing information not provided during this session, notably in connection with allegations of disappearances made by various international organizations.

A case about Canada and Pakistan
The UN Committee also dealt with a case from an individual, a Pakistani who convinced the Committee that Canada violated art. 3 in the anti-torture Convention when it decided to deny him asylum and send him back to his homeland. The Committee thus accepted an allegation from the Pakistani student, Tahir Haseen Khan, that he would be in danger of being tortured upon his return since he was a local leader of the Baltsitan Student Federation.

He has twice been tortured by Pakistani police and military, and since he was scheduled to appear before a court charged with political activities, he fled in 1990 to Canada. He had fought for political rights for the inhabitants of Baltsitan — a part of Kashmir, which is nowadays completely militarized. The Committee notes that there is evidence in Pakistan of widespread torture of political dissenters and common detainees.

Khan has a copy of an arrest warrant against him for organizing a demonstration and for criticising the Pakistani government. Moreover, the President of the Baltistan Student Federation has advised him not to return for fear of torture. This man also has evidence that supporters of independence for the northern areas and Kashmir have been targets of repression.

Consequently the student, who is a professional cricket player, was not returned. A letter from the Montreal-based Hopital Saint-Luc last summer confirmed that the marks and scars on the complainant's body were consistent with the alleged torture.

Committee members
The Committee was established on 26 November 1987. Its main tasks are to make general comments on the reports submitted by states and to inform the other states parties and the UN General Assembly in that regard.

The Convention against Torture and other cruel, inhuman or degrading treatment or punishment has been ratified by the following 94 States: Afghanistan, Albania, Algeria, Antigua and Barbuda, Argentina, Armenia, Australia, Austria, Belarus, Belize, Benin, Bosnia and Herzegovina, Brazil, Bulgaria, Burundi, Cambodia, Cameroon, Canada, Cape Verde, Chile, China, Colombia, Costa Rica, Croatia, Cyprus, Czech Republic, Denmark, Ecuador, Egypt, Estonia, Ethiopia, Federal Republic of Yugoslavia (Serbia and Montenegro), Finland, France, Georgia, Germany, Greece, Guatemala, Guinea, Guyana, Hungary, Israel, Italy, Jordan, Latvia, Libya, Liechtenstein, Luxembourg, Malta, Mauritius, Mexico, Monaco, Morocco, Nepal, Netherlands, New Zealand, Norway, Panama, Paraguay, Peru, Philippines, Poland, Portugal, Romania, Russian Federation, Senegal, Seychelles, Slovak Republic, Slovenia, Somalia, Spain, Sri Lanka, Sweden, Switzerland, Togo, Tunisia, Turkey, Uganda, Ukraine, United Kingdom, United States, Uruguay, Venezuela and Yemen.
The following 35 States have recognized the competence of the Committee to receive and consider claims from one state party that another state is not fulfilling its obligations under the Convention, and from individuals from a state party claiming to be victims of a violation: Algeria, Argentina, Australia, Austria, Bulgaria, Canada, Croatia, Cyprus, Denmark, Ecuador, Federal Republic of Yugoslavia (Serbia and Montenegro), Finland, France, Greece, Hungary, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, New Zealand, Norway, Poland, Portugal, Russian Federation, Slovenia, Spain, Sweden, Switzerland, Togo, Tunisia, Turkey, Uruguay and Venezuela. In addition, the United Kingdom and the United States have recognized the competence of the Committee to receive claims from another state on Convention violations only.

**Membership and Officers**

The States party to the Convention have elected the following experts to serve in their personal capacity on the Committee: Hassib Ben Ammar (Tunisia), Peter Thomas Burns (Canada), Alexis Dipanda Mouelle (Cameroon), Fawzi El Ibrahi (Egypt), Ricardo Gil Lavedra (Argentina), Julia Lliopoulou-Strangas (Greece), Hugo Lorenzo (Uruguay), Mukunda Regmi (Nepal), Bent Sørensen (Denmark) and Alexander M. Yakovlev (Russian Federation).

The officers are: Chairman, Alexis Dipanda Mouelle (Cameroon), Vice-Chairmen, Fawzi El Ibrahi (Egypt), Peter Thomas Burns (Canada) and Hugo Lorenzo (Uruguay), and Rapporteur is Bent Sørensen (Denmark).

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**CENTRE PRESENTATION**

**New centre opened in Honduras**

A new centre was opened in Tegucigalpa, Honduras, on 23 February 1995—El Centro de Prevencion Tratamiento y Rehabilitacion de lasVictimas de la Tortura y sus Familiares (CPTRT) "Ole Vedel Rasmussen".

In giving the centre this name, a great honour was bestowed on Ole Vedel Rasmussen for the amount of work he has done, particularly in Central America, where he is staying at present as medical consultant with the IIDH (Instituto Interamericano de Derechos Humanos). But it also acknowledges IRCT for the support it has given to the creation of the centre. It should also be mentioned that the centre owes its existence to the initiative and courage of several other people.

For the first six months, the Centre was financed by PRODECA (Programme De Dinamarca Pro Derechos Humanos Para Centroamerica Costa Rica) (DANIDA).

The Centre began to function on 13 January 1995, and before its official opening, 16 persons had already sought treatment. They had all suffered severe torture—removal of nails, falanga, and capucha, a special form in which inner ear tubes are pressed against the face to prevent breathing while the ears are beaten (telefono).

The clients presented the classical symptoms, mainly psychological with anxiety and depression, but also physical sequelae from broken arms and removal of nails, etc.

The Centre is staffed by two doctors, a psychiatrist, a nurse, a social advisor, a psychologist, and a secretary.

One of the clients travels 300 kms for treatment.

Leo Valladares, ombudsman, was present at the inauguration. He published a book in January 1994 about 184 people who disappeared during the previous 13 years. Some of the corpses were found at secret burial places during the first months of 1994.

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*The CPTRT Centre is situated in Tegucigalpa in Honduras.*
El Nadim Center for the Management and Rehabilitation of Victims of Violence

Suzan Fayad, Director*, Abdallah Mansour, Principal Psychiatrist*, Aida Seif El Dawla, Psychiatrist* & Leila Hussein, Executive Director*

In August 1994, El Nadim Center for the Management and Rehabilitation of Victims of Violence celebrated its first birthday. The first year of its existence witnessed a number of activities that added to the building up of the centre's organizational capacity and the scope of its structure and activities.

Who is working at El Nadim
The centre is staffed by two full-time psychiatrists, an executive secretary, an administrative resource person, and a cleaner. An accountant has been involved in organizing the accounts of the centre. A lawyer has been contracted to deal with any legal issues that relate to the status of the centre itself and its relation with the different authorities, though not involving the clients. The centre is open six days a week from 17.00 to 22.00. Decisions are made collectively by the staff at El Nadim. There is an evaluation meeting every month.

How do we get our clients
Clients are usually referred by other organizations, though some refer themselves. Sources of referral have included personal contacts, lawyers, a number of friends and contacts, and recently a newly established legal aid centre for human rights. In some cases clients could not come to the centre themselves, either because it is far from their residence or because their physical condition did not allow for mobility. Members of the staff visited those clients in their homes and arranged for a management plan that in the majority of cases involved further investigations and in some cases involved referral for legal aid.

Who are our clients
Clients of El Nadim are men, women, or children who are survivors of violence, or families which have been traumatized by violation of their members. To date, El Nadim has been visited by 55 clients.

What forms of violence
Clients seen by El Nadim have been survivors of torture, domestic violence, rape, and child battering.

What service is provided at El Nadim
Management is tailored according to every client. In four cases an emergency crisis intervention was required and a member of El Nadim went to the client immediately. In cases where there has been physical trauma, or when investigations are required, referral to other specialities is made by the centre, and follow up is maintained. In a number of cases, admission to hospital was recommended by the psychiatrist, and the client was followed up in hospital. Lines of therapy basically involve psychotherapy, and in cases of need the prescription of medication. Family therapy has been part of the management of a number of cases. Whenever this is possible key persons in the life of the client are involved in the rehabilitation process.

Expenses of investigations and hospital admissions have been covered by El Nadim when the client could not afford to do so, which is mostly the case. In some cases a token sum of money was given to victims who could not sustain themselves for medication and transportation.

El Nadim’s work with children’s and women’s institutions
Work with children’s institutions started early in the project and followed a general survey of the organizations present in the district where the centre is located. Close cooperation was established with an orphanage where El Nadim participated in counselling for children and staff members who work with children. El Nadim also received some individual visits from children at the centre. It organized a sports day at the orphanage and extra tutorial classes for school failures with an NGO that works on literacy and adult education. The link with the orphanage was useful for both the centre and the orphanage, but it reflected the difficulty in dealing with institutional violence against children, which is closely related to the social pressures on the children and the teachers themselves. The lack of an extended support network for such institutions makes the problem greater than can be covered by one type of centre.

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  Egypt

El Nadim Center for the Management and Rehabilitation of Victims of Violence is situated in Cairo in Egypt.
The other kind of institution was women’s houses, which provide shelter for raped women until they can provide for themselves. It is less easy to deal with these organizations. They are run by employees from the Ministry of Social Affairs, who are not open to suggestions on altering the approach to their guests. Women living there are kept under strong guard. The link with those institutions has not yet been structured, and has not gone beyond a number of visits and discussions with staff.

El Nadim has established a number of relations with NGOs based in popular areas of Cairo where the need was expressed for the service provided by El Nadim. These NGOs offered to host somebody from El Nadim at least once a week to listen to cases of violence. To date, this has been done on an irregular basis by the two psychiatrists. These areas offer a great potential for developing a network of psychiatrists, psychologists, and social workers who are ready to work in the field of rehabilitation from violence. Our next three years plan will focus a great deal on those potentials.

Resource unit
Our centre also has a resource unit, which holds literature on psychiatry, violence, torture and rehabilitation from torture, human rights activities in the field, and publications and brochures of similarly active organizations.

Liaison
El Nadim works in cooperation with a number of organizations, and in particular with a legal aid organization which offers free legal counselling and aid to survivors of violence who wish to go to court. El Nadim has contributed to the establishment of this centre through the donation of the Rebol Award that was given by an Egyptian human rights activist early in 1993.

El Nadim also works closely with an organization for the support of Sudanese victims of violence, established by a group of Sudanese refugees in Egypt. The relationship with the centre is one of friendship and cooperation, and their brochure declares that El Nadim is a support organization.

During the NGO forum at the UN Conference on Population and Development (ICPD), El Nadim, together with the New Woman Research Center (a feminist Egyptian NGO) participated with a testimony on violence against women in the Cairo Hearing on Women and Human Rights, which was organized by the centre for Women’s global leadership, USA.

Future plans
Our plans for the next phase involve an expansion of the work of the centre in time, space, and personnel.

1. The centre will be open during the morning as well as the afternoon. The mornings will mainly be given to receiving referrals from the legal aid centre or other organizations that work during the day. The availability of the centre is important so that the clients are not burdened with having to travel twice from their homes to the support units, whether legal or psychological. The afternoons will be allocated to sessions of psychotherapy, team meetings, and settling administrative matters.

2. The expansion in space will involve a number of popular areas in the form of clinics that will be hosted by already existing NGOs. Those NGOs expressed their need for the Nadim service to be transferred to their districts at least once per week to start with.

3. The expansion in personnel will involve a GP, who will function from the centre in follow up of the different investigations and medical referrals of clients, and a number of individuals who will be recruited from the different areas to support the work of El Nadim. Before going into the field, the recruited staff will attend daily at El Nadim centre for two weeks to become familiar with the activities of the centre and the different approaches and problems that are likely to face them in the field. A monthly meeting of El Nadim extended network will discuss problems, questions, and possibilities for the promotion of the work.

4. The next few years will also involve a programme of research that will attempt to identify a map of violence in Egypt, and the different psychological profiles of victims of violence in Egypt.

5. The team will attempt to formulate a general management outline, derived from the experience of El Nadim. We feel the need to exchange our experience and have now received requests from other centres in the Arab region to help them in training and in rehabilitation of victims of violence and their families.

Through its correspondence, El Nadim is now a member of:
- The International Society for Health and Human Rights
- The section on Torture and Psychiatry, World Psychiatric Association
- The Amnesty Survey of Medical and Psychiatric Services for Victims of Human Rights Violation.
Medical aid for victims of repression now available in Estonia

Heino Noor*

A new medical institution, the Estonian Centre of Medical Rehabilitation for Victims of Torture (MRT), opened its doors in Tartu, Estonia. The new centre is meant to provide medical and social aid for those who have undergone organized violence by repressive organizations and who subsequently suffer health problems.

Repressive organizations have committed unrecoverable genocide in Estonia, especially during the Soviet occupation. The survivors of this genocide need help here and now. So far they have only received general medical aid. However, torture and oppression have caused new and previously unknown health problems. These new problems need not necessarily develop into illnesses on their own, yet they continuously influence the personality, and by that the stability of society as a whole.

Every case of human trauma is followed by a psychological reaction, which is as a rule temporary. Nevertheless, a lasting and intensive traumatic situation may result in both mental and physical post-traumatic stress. Post-traumatic stress can last for years, and, in the case of continuing traumatic influences, it can become chronic. It is characterized by an extensive sense of fear and anxiety, nervousness, depression, low spirits, and trouble with adaptation, compulsive thoughts, disorders of memory, sleep and behavior, self-destructive conduct, alcoholism, and suicide. Post-traumatic stress, when diagnosed early, can be treated effectively.

MRT was founded under the aegis of and with direct assistance from IRCT, a Danish-based international organization for rehabilitation of torture survivors. MRT is a non-political institution that observes the following guidelines, elaborated in our practice:

- a victim of repression is a person who has been subjected to deprivation of human rights, and organized violence: arrest, eviction from home, deportation, forced expatriation, manhunt, torture, physical and mental maltreatment, deprivation of education, active re-nationalization, persecution on religious grounds, execution, etc. An unborn baby can be the victim of torture even in its mother’s womb. All of the above was extensively practised in Estonia during the Soviet occupation.

- torture is mental or physical suffering imposed on a person by an individual or group. Torture is used to scare, terrorize, extort testimonies, and to silence and blackmail individuals. Soviet power used torture in Estonia at length, to reshape and repress individuals, to dismantle their identity, and to eliminate possible leaders. The deformations in the nation’s mental condition may last for a long time, even after the fall of the Soviet state.

The penal and civil codes of the Soviet Union and its member "republics", Estonian SSR included, lacked any mention of torture as a form of criminal behaviour. MRT is presently striving towards establishing various forms of torture as criminal offences.

MRT is receiving Estonia-residing clients, regardless of their nationality and citizenship. We also offer psychological aid for survivors of various disasters and catastrophes. We maintain strict anonymity of our clients when asked to do so.

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The Estonian Centre of Medical Rehabilitation for Victims of Torture (MRT) is situated in Tartu in Estonia.
Countertransference in the treatment of PTSD


An art-therapist works with an 18-year-old male refugee from Kurdistan, whose parents have been killed. This therapist has been preoccupied for some time with themes of aggression and death. After a few sessions in this therapy, she knows for certain that the 18-year-old lad has been a killer himself – although he never told her about it.

Is this a case of knowledge, gained through intensive empathy, or is it a case of countertransference problems in a therapist? Does the therapist have problems of her own in the area of aggression, trauma, or victimization? Or is there some sort of intensive process of induction going on between patient and therapist, raising anxiety levels in the therapist beyond toleration, blurring boundaries between reality and fantasy? These are important matters for further therapy and interventions, which have to be considered in supervision.

This book is about such aspects of the patient-therapist relationship in the treatment of PTSD, or rather of extremely traumatized patients. Especially since the second half of the 1980s a number of articles have been published that highlight aspects of these problems; the reason was that, in dealing with extreme traumatization, traditional ideas and opinions in psychotherapy, other clinical work, and research were no longer sufficiently valid to explain what was going on in the patients, therapists and therapies. This book tries to understand why, and to explain how. It is an extremely lucid and well-written book, a masterpiece of its sort, a must for every therapist in this field.

The authors/editors are well-known and experienced clinicians and researchers in the area of psychotrauma. In part I (the book has 4 parts) they build, in a few chapters, a theoretical scaffold, based on a broad psychodynamic frame of reference. They discern two main types of countertransference reaction in treating psychotraumatized victims:

1) avoidance, and 2) overidentification (here we may find a parallel with numbing symptoms and intrusive symptoms in the victim, I think).

There are a number of core psychological dimensions which underly these countertransference reactions, such as affect, defence, coping modes, impact of role boundaries and theoretical rationalizations. Moreover, these reactions may be of a more general, normative character (everybody would have them) and of a more personal kind, depending on one’s own history and personal build-up, as may be the case in the example of the art-therapist and the young Kurdish man.

In this way, the two main types are worked out in a number of sub-types.

Apparently this theoretical scaffold has helped the contributors of the other parts of this book to arrange their material. The “scaffold” also has a high heuristic value, helping researchers and therapists to identify phenomena in this field.

Part II deals with countertransference in the treatment of victims of sexual, physical, and emotional abuse.

Part III deals with countertransference reactions in work with victims of war trauma, civil violence, and political oppression. For the readers of this magazine, chapters 9 and 10 will be most interesting, dealing with the treatment of southeast Asian refugees (Kinzie) and treatment under state terrorism (Agger and Jensen), respectively. There are also chapters on war veterans (Maxwell and Sturm) and World War II resistance fighters (Op den Velde et al.) in Holland.

Part IV is some sort of rest collection: managing emotional reactions in rescue workers (Raphael and Wilson), trauma in the workplace (Dunning), and an important chapter on countertransference, trauma, and training (Danielli). This chapter gives insight into Danielli’s workshop for therapists working with Holocaust survivors. This is one of the few chapters in which concrete directions are given for direct work of exploration and identification of therapists’ reactions. In the last chapter, the editors review the conceptual model; they emphasize the importance of empathic strain in these therapies, and of “stretching” the empathy, i.e. to enhance the capacity for understanding and managing countertransference reactions and use them as sources of insight about the dynamics of the therapeutic relationship. Only in this way will a safe-holding environment be built up, which is, as the authors say: a necessary critical therapeutic structure, a safe sanctuary, in which the work of recovery occurs.

As I mentioned, this is a very good book. It explains the exceptional importance of the quality of the therapeutic relationship and the usefulness of countertransference reactions, if properly identified and manageable. The safe-holding therapeutic environment has to be secured by several protective measures, such as supervision and teamwork; a team, in its turn, should be a safe-holding environment for the therapists.

However, if a team is so important (and I think it is), it might have been reasonable to include a special chapter on teamwork and teambuilding, and the role of countertransference reactions in team conflicts.

This book is written predominantly from the point of view of “cure” people, with therapists and therapies as a main target. It might be useful to hear more about the positive but also sometimes negative interactions between the “care” and “cure” systems and the role of countertransference reactions in their interplay (professional envy is notorious in this respect).

One last remark: the book requires slow reading, not least because it evokes personal thoughts about past and ongoing therapies. It might be wise to read it together with a colleague, or to use it in a treatment team as a book to be studied bit by bit in the course of a semester.

Johan Lamen, MD psychiatry
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Refugee children: a basic handbook?


The ways in which local conditions affect intervention with refugee children and families are of particular interest. Different contributions show, for example, that nonprofessionals and paraprofessionals are used in different ways with Vietnamese and Mozambican refugees. Comparative data such as those presented in the chapter by McCallin are also useful. For example, in a sample of Mozambican women refugees in Zambia, 44% had witnessed a murder, and 40% had been threatened or humiliated with verbal abuse. However, amongst Salvadoran women refugees in Washington, DC, 22% had witnessed a murder, and 14% had been threatened or humiliated with verbal abuse, but 39% had been present when their home or neighbourhood was bombed. The traumatic experiences of refugees, and the contexts within which assistance is offered, must affect intervention efforts.

The diversity of contributions in this volume, in terms of both content and style, makes for interesting and informative reading. Because the contributions are so diverse in format, however, it is sometimes difficult to obtain an overview of how different projects and interventions in different parts of the world relate to one another. It would have been useful to ask participants at the seminar to contribute some basic information in a standard way so that an overview chapter could have been prepared. It seems a pity to have lost the opportunity to develop a global understanding of how work that focuses on the psychological well-being of refugee children operates. This criticism is addressed to a certain degree by the papers in the section on the response of the international community. However, no detailed consideration is given to the issues at the interface between local perspectives and experiences on the one hand, and international policies on the other. It is almost inevitable that there are differences in perspective; engagement with these differences can be very useful for reformulation of both local and international policies.

A further feature of the volume is that many papers overlap in terms of the basic introductory ground covered. For example, many papers present the basic tenets of widely-accepted principles of stress theory. In this respect, papers which on their own would be of value begin to appear somewhat repetitive in the context of the volume. Again, it would have been useful to have had some sense of how the papers sparked debate at the seminar, and the extent to which views and strategy plans were changed.

Perhaps what I am asking for, though, in suggesting more editorial intervention in the papers and a greater sense of the debates they have generated, is a very different book. The volume at hand has the advantage of a range of descriptions of services and policies from many perspectives, and it is to be welcomed as a basic handbook both for the practitioner and for the person wanting to have a sense of what is happening in the field.

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A book which is still necessary


In this little book, Amnesty International has collected international ethical "codes", declarations, conventions and texts, so that all within the health professions who work with human rights issues can quickly find an overview of the ethical rules within this field.

The book is divided into sections which refer to the place of origin, i.e. Amnesty International itself, the United Nations, the World Medical Association, the International Council of Nurses, the Geneva Conventions, the World Psychiatric Association, etc.

Each section starts with a short introduction about the organization in question, and the years of ratification of the declaration and revision(s). Then follows the text of the declaration, usually unchanged, though sometimes paragraphs are omitted when they are not immediately relevant to the subject. All important conventions and declarations are included, and of special interest to readers of TORTURE are for instance the Tokyo Declaration, the UN's Principles of medical ethics, Nurses and Torture, the UN's Convention against torture, etc. and Amnesty International's 12-point programme for the prevention of torture. Room should perhaps have been found for a short description of the European Council's Convention for the Prevention of Torture since it fulfils an important task with inspection of prisoners' conditions. The UN Commission for Human Rights is considering introducing such a system of inspection globally.

There are an impressive number of declarations and conventions, etc. that condemn violations of human rights, including torture. Considering the alarming and growing ex-

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tent of these violations, one may well ask how important all these declarations really are.

One weakness of the conventions is of course that, apart from the UN “Convention Against Torture” and the Geneva Conventions, they are not legally binding for the countries concerned. Their effect is through their moral authority and the international consensus. On the other hand, it is important that an ethical condemnation, for instance of torture, is set down in print, just as health personnel who may be under pressure to violate ethical obligations, can refer to these written rules in the international declarations and conventions. Finally, with these international declarations to hand, it is easier to put international pressure on countries which violate human rights. The many NGOs that do the practical work against violations of human rights are of the opinion that the international conventions and declarations are important as a support in their daily fight, for instance against torture. Therefore, even if it is not possible to measure the direct effect of the international conventions, there are many suggestions that they are an important and necessary, though not sufficient, weapon against violations of human rights. Unfortunately, Amnesty International’s little book is still necessary today.

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TORTURE WORLDWIDE

Torture by Palestinians in territories occupied by the Israeli authorities

Henrik Döcker

Collaborators in the Occupied Territories: Human Rights abuses and violations. 239 pages. Published by B’Tselem (The Israeli Information Center for Human Rights in the Occupied Territories).

Torture is perpetrated not only by states and governments, but also, occasionally at least, by guerrilla groups and insurgents. This is little talked of in books and reports, but the sketchiness of the information is probably due to the little use of torture by partisans. Not many prisoners are kept in the rural areas of their activity, or wherever they are active, and circumstances only occasionally call for torture. Killing is often easier.

Amnesty International condemned this privately exercised torture several years ago, but for many years quite a few Human Rights proponents in the world tended to hold governments solely responsible. Probably with a view to the small prospects of any change in the behaviour of private organizations or armies, which are bound by no international obligations.

B’Tselem investigated hundreds of cases concerning Palestinians suspected of collaborating with the Israeli authorities during the Intifada – the insurrection against the Israelis between December 1987 and November 1993. Based on data from the Israeli Ministry of Defence, they concluded that 35-40% of those killed were employed by the Jerusalem Government or were involved with the Israeli administration, while the remainder had no connection with the government.

B’Tselem found that a great variety of interrogation methods were used: injury with sharp objects, infliction of burns with hot irons or by dripping boiling plastic, rubber, or plastic bags onto various parts of the body, suspension, setting persons on fire, and amputation. Members of the Red Eagle in Nablus, in their interrogations, dripped boiling tar onto suspects’ bodies, suspended them by their feet, and cut off fingers and ears.

The Palestinian organizations, which seek political recognition and consider themselves legitimate representatives of the Palestinians in the territories, have argued that the killing of collaborators (sometimes after torture) is the only available alternative to institutional incarceration. (Since the publication of the book in January 1994, Yasser Arafat has established himself as head of the Palestinian West Bank authority in Jericho).

B’Tselem strongly rejects these attempts to justify killing, torture, or cruel treatment. The broad definition of “collaborator” led to the killing of hundreds, solely because their behaviour was considered immoral. Although Israel does not bear direct responsibility for the torture and killing, its actions and omissions in a number of aspects contravene its obligations under international law. (Some may be reminded of the massacres at Sabra and Shatilla camps in Beirut).

B’Tselem urged the government of Israel to stop using collaborators to carry out actions that violate Human Rights; Israel should also provide effective protection to Palestinians who are suspected of collaboration, and rehabilitate those who are attacked or exposed to threats. One wonders whether such appeals have any effect. A similar appeal to the British government concerning the IRA practice of shooting at the knees of suspected collaborators in Northern Ireland would hardly be considered realistic.
Street children in Guatemala

Violent crimes continue to be committed in Guatemala against street children by agents of the military and national police, as well as by private guards, without being prosecuted, according to Casa Alianza, a branch of the New York based Covenant House.

Since 1990 the organization's legal aid office for street children has initiated 188 lawsuits against authorities, resulting in only seven indictments in only four of the cases.

Among the convicted, two police officers have had their sentences commuted and remain free. The following suits against authorities have been initiated:

- Murder: 26
- Assault (including torture): 46
- Abuse of authority: 60
- Kidnapping: 15
- Illegal arrest: 13
- Death threats: 7
- Intimidation: 6
- Sexual assault: 4
- Physical abuse: 4
- Rape: 4
- Threats and coercion: 3
- Aiding and abetting in the use and sale of inhalants: 1

The accused comprised 282 officials and civilians:

- Uniformed National police officers: 90
- Plainclothes National police officers: 11
- Private police officers working under the authority of the Government Ministry: 18
- Military police officers: 20
- Private guards: 9
- Army officer: 1
- Civilians: 27
- Unidentified persons: 106.

New WPA Section on torture and psychiatry

During the last EC meeting of the World Psychiatric Association in Geneva, 6-8 December 1994, a Section of Torture and Psychiatry was accepted on an ad hoc basis. The Section is to be ratified during the next General Assembly in the WPA World Congress, Madrid, August 1996.

Structure of the section

A number of distinguished colleagues have been invited to join in the founding of the Section on Torture and Psychiatry. It was noticed with pleasure that all have replied positively. The list of Section Committee members thus includes the following: Arno Adamsoo, MD, Estonia, Eugene B. Brody, MD, USA, Aida Ela Dawla, MD, Egypt, Suhan Foyad, MD, Egypt, Inge Genefke, MD, Denmark, Semyon Gluzman, MD, Ukraine, Assen Jablensky, MD, Australia, Jannes Jaranson, MD, MA, MPH, USA, Marianne Kastrup, MD, Denmark, Diana Kordon, MD, Argentina, June Lopez, MD, The Philippines, Lars Weiseth, MD, Norway, and Thomas Wenzel, MD, Austria.

The following Section officers have been appointed: Chairperson, Inge Genefke; Vice Chairperson, Marianne Kastrup; Secretary, Thomas Wenzel; Treasurer, June Lopez.

The intention is to enlarge the group of Section Committee members with a limited number of experts. Furthermore it is intended to establish a group of general Section members, comprising colleagues with an interest in the field of torture and psychiatry.

Activities

One of the aims of the Section is to organize symposia at the WPA regional meetings. At the most recent regional meeting in Buenos Aires in March 1995 the Section organized a symposium entitled "Torture as a challenge to psychiatry". Professor Diana Kordon, Argentina, was in charge of this first venture of the Section.

A WPA regional meeting will take place in Prague 20-23 September 1995. It is our hope that several Section members will be able to participate in the Prague Symposium, which has been entitled: "Mental Health Programmes for Torture Survivors", and that an opportunity will be given to have a business meeting of the Section. The focus of the Section Symposium in Prague will concentrate on Eastern European countries, and it is our hope that representatives from these countries will be the main speakers. Approximately 1½-2 hours have been allotted for the symposium. The programme for this meeting is presently being finalized.

Communication

The secretary of the Section is planning to pass on information to all Section members in a quarterly newsletter.

New Health and Human Rights Network

VAST joins C.N.H.H.R.

VAST (Vancouver Association for Survivors of Torture) and a number of other centres for survivors of torture have formed the Canadian Network for Health and Human Rights. The idea for a national network arose out of some informal links between three Canadian organizations working with survivors of torture in Montreal (RoVO), Toronto (CCVT), and Vancouver (VAST).

The goals of the Network are to facilitate interaction between groups and individuals, to provide a stronger base of support to service providers, and to form a more coherent and powerful voice to advocate on behalf of survivors. VAST will be hosting a meeting of the National Network, to be held in Vancouver, in May 1995.

For further information on the Network, please contact:

VAST

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Canada

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NEWS IN BRIEF

New department for treatment of torture victims in Cape Town

The opening of the Nyanga Office of the Trauma Centre for Victims of Violence and Torture, Cape Town, on Wednesday 12 April 1995 was well organized and gave positive public interest in the work of the trauma centre.

Erik Holst, Vice President of IRCT, was invited to take part in both the ribbon cutting and the planting of trees to mark the inauguration of the new office.

International Human Rights Partners Award

In spite of arrests, firebombing and persecution by the Turkish government, the Human Rights Association and Human Rights Foundation of Turkey are struggling to promote the rights of Turkish citizens under international law, particularly those of the Kurdish people.

This year, the International Human Rights Partners Award is given to the Human Rights Association of Turkey and Human Rights Foundation of Turkey.

FROM THE MEDICAL LITERATURE

Children — war and violence

[Ottawa : Ferne Atkinson, 635 MacLaren Street, Ottawa, Canada K1R 5L1], (1994) (71 pp.).

The topic of children who are caught in war and violence is very important, so this bibliography is a very welcome publication.

The present volume short-changes itself in several ways, however. The most important is the lack of a preface/introduction, which leaves the user with no knowledge of the thematic, chronologic, geographic or other limits of the bibliography or how it relates to other bibliographies in the field.

In Children, war and violence: a bibliography you find your way via the list of contents. This lets you know that the collection is thematically arranged under headings such as: torture, refugee studies, intra-familial violence, alphabetically ordered by author within each grouping. There are also geographical access points: Cambodia, South America, etc. These comprise the first 25 pages. The references are to both books and articles.

In this “classified guide” the bibliographer has basically chosen one placing for each entry, with a few double-placings. This saves space but should be compensated for by several indices (e.g. author, title) or by cross-referencing, neither of which is present.

Some of the larger groups or topics are: treatment, mental health, violence and children’s health and refugee studies; the volume will undoubtedly serve as a useful guide for many professionals and especially paraprofessionals within these fields. The lack of points of access can be overcome by the relatively limited number of pages (71).

NEW PUBLICATION FROM IRCT

Diagnostic kit


Extensive use of electrical torture, together with the fact that the authorities in the countries violating human rights deny the use of torture, prompted the formation in 1975 in Copenhagen of an interdisciplinary group of scientists in order to develop methods useful for the diagnosis of electrical lesions. The group consisted of medical doctors, including dermatologists and pathologists, physicists, and one veterinarian.

Since electrical injuries were previously considered to be the result of concomitant heat development, the group, during the following 13 years, studied the possibility of distinguishing lesions caused by electricity from those caused by heat. The studies were carried out on biopsies obtained from exposed skin sites of fully anaesthetized pigs.

The finding of histological lesions that were diagnostic of electrical injuries in both experimental studies and human skin is described in a folder containing a video, two medical theses, and several articles.

Scientific proof of electrical torture is now possible by examining a small piece of skin from an area pointed out by an alleged torture victim as having been influenced by an electrical current. A positive observation proves the use of electricity. A negative finding, however, does not exclude possible exposure to electricity.

Practical information is also enclosed concerning:

- How to make the punch skin biopsy
- How to inform donors of skin punch biopsies
- Alizarin red S staining for calcium
- Biopsies placed in buffered formalin.

It is hoped that knowledge of the existence of methods for the diagnosis of electrical lesions might eventually prevent the use of electrical torture.

The folder and accompanying video can be obtained by contacting Ms. Natalie Parker, Secretary, the RCT/IRCT Department for Information and Education, tel: +45 33 76 06 00, or fax: +45 33 76 05 00.
SECOND ANNOUNCEMENT

VII International Symposium

CARING FOR SURVIVORS OF TORTURE
Challenges for the Medical and Health Professions

Cape Town, South Africa
15-17 November 1995

This is the 7th International IRCT Symposium focusing on torture as a challenge to the medical and health professions and following the most recent symposia in Buenos Aires 1993 and in Istanbul 1992.

The symposium is the first of its kind in South Africa and is organized in collaboration with the Trauma Centre for Victims of Violence and Torture in Cape Town which was inaugurated in 1993.

The symposium will feature a large number of plenary and paper sessions, discussions and skills sessions.

A limited number of fellowships are available especially for participants from the African continent.

The symposium will take place at the historic Breakwater Campus of the University of Cape Town. Preliminary programme and registration forms can be obtained from:

The Trauma Centre for Victims of Violence and Torture
Cowley House
126 Chapel Street
Cape Town 8001
South Africa
Tel: (27) 21 45 73 73
Fax: (27) 21 462 31 43

International Rehabilitation Council for Torture Victims (IRCT)
Borgergade 13
P.O. Box 2107
DK-1014 Copenhagen
Denmark
Tel: (45) 33 76 06 00
Fax: (45) 33 76 05 00
FORTHCOMING CONFERENCES AND SEMINARS

Boston, USA
2-6 November 1995

The Treatment of Trauma: Advances and Challenges

Further information:
The International Society for Traumatic Stress Studies
60 Revere Drive
Suite 500
Northbrook
Illinois 60062
USA
Tel: +1 708/480-9712
Fax: +1 708/480-9282

Gaza, Palestine
13-15 September 1995

Palestinians in Transition: Rehabilitation and Community Development

Second call for papers

Further information:
Gaza Community Mental Health Programme
P.O. Box 1049
Gaza
Palestine
Tel: + 972 7 865949
Fax: + 972 7 824072/823332

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RCT

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.

IRCT

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.