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ERRATUM
Unfortunately, the last issue of TORTURE (Volume 5, Number 2 1995) contained a misprint on page 8 in the article Rape survivors. The sentence starting in the last line in the first column should read: "UNHCR, together with several international NGOs, help the refugees to meet their basic needs of food, water, clothing, and shelter."
EDITORIAL

THE SNAKE IN THE GARDEN OF EDEN

There is a report from the border area between Iran and Iraq in this issue of TORTURE. The account is based on an aid project following one of the most brutal regimes of our time. Some of the incredible violations by this regime were described in a report in 1992 from the United Nations Commission on Human Rights about the Violations of Human Rights by the Government of Iraq. In a short account of the attacks on the Shi’a population and its traditional culture, the Special Rapporteur stated: “Recent and continuing measures instituted by the Iraqi military forces against the population of the marshes (including Marsh Arabs, internally displaced persons and refugees, and army deserters) ... include the tightening of control over food destined for the area, the confiscation of boats, and the evacuation of all areas within three kilometres of the marshlands. Further reports indicate that military attacks have been launched against the Marsh Arabs between 4 December 1991 and 18 January 1992, resulting in hundreds of deaths. Animal and bird life have also been killed in large numbers, while the marsh waters themselves have been filled with toxic chemicals. The apparent recent and continuing nature of the policy aimed against this particular part of the Shi’a community is most disturbing.”

At the same time, there are some 600,000 Iraqis in refugee camps in Iran, the majority torture victims. This underlines the enormous need for the work carried out by Dr. Bayan Alhakim among the Marsh Arabs. Dr. Bayan Alhakim’s husband, Sahib Alhakim, is general secretary of the Organisation of Human Rights of Iraq; from his London office he has protested several times against Barzan Tikriti, Sadam Hussein’s half-brother, being Iraq’s member of the UN Human Rights Commission since 1983. Barzan has torture and several crimes on his conscience, including the disappearance of about 8000 Kurds since 1983. According to a documentary account in The Observer (26.07.92) “the religious leader Mohammed Bakr Sadr was killed with a nail through the head after Barzan burned off his clerical beard – laughing as he did so, according to eyewitnesses – and tortured him with electricity. His sister, Bint Huda, was stripped of her veil, raped and made to dance before her death.” The Observer can also recount some of Barzan’s other activities, which, apart from his high diplomatic post, include the management of large financial operations for the Baath party from his domicile in Switzerland. But till now Sahib Alhakim and his organization in London have failed to stop Barzan’s continued representation in the UN and his activities in Switzerland.*

Surprisingly, however, with respect to other crimes against human rights, it was announced on 26 July 1995 that Judge Richard Goldstone, the chief prosecutor at the UN International War Crimes Tribunal in The Hague, has taken out a summons against the Bosnian Serb leader, Radovan Karadzic, and his military commander-in-chief, General Ratko Mladec, accusing them of “genocide and crimes against humanity”. As well as these two, a further 22 people are accused based on extensive concrete examinations. The crimes comprise extensive and systematic murder, torture, rape, extremely humiliating treatment of prisoners, and the extermination of whole population groups because of nationality, ethnic origin or religion. The named civilian or military leaders are accused of having planned, ordered, or in other ways taken part in these crimes, or of having known that their subordinates committed them, without making any attempt to hinder them.

Whether or not the accusations of crimes against human rights in ex-Yugoslavia will this time lead to court procedures in The Hague, the international courts will in any case have enough to do to reveal the incredible and horrifying aspects of human behaviour. Be it in Iraq, at several places in ex-Yugoslavia, and among the members of several governments around the world.

H.M.

*ADDENDUM
According to the recent news, Barzan Tikriti has declared that he has defected and refuses to go back to Baghdad.
The story of medical involvement in torture

The fight against torture and the role of rehabilitation centres


Erik Holst, MD, Professor, President, RCT


Physicians are obliged by the various national versions of the Hippocratic Oath never to use their professional knowledge to harm their patients. This was reconfirmed in the Geneva Declaration of the World Medical Association 1948 (amended 1968 and 1983). This should preclude any involvement of physicians in the practice of torture, even in countries where torture takes place in violation of the Universal Declaration on Human Rights.

In spite of this it became clear in the early 1970s that physicians were directly and indirectly involved in practices that could only be classified as torture. This happened, for example, in relation to military operations against insurgents in Northern Ireland and Algeria. The physicians who were most at risk of becoming involved in the practice of torture were military doctors, police and prison doctors, as well as forensic medicine specialists, who might be called upon to cover up a lethal case of torture with a certification of death from natural causes.

Contribution from WMA

These experiences led to the adoption by the General Assembly of the World Medical Association of a special declaration on doctors’ participation in torture – the Tokyo Declaration of 1975.

The principles of this declaration are interesting in that to some extent they ask physicians to refrain from medical activities that under normal circumstances would have been an ethical obligation for them. For example, it requires physicians to refrain from involvement in force-feeding a detained person on hunger strike, if it is the expressed wish of a sane person who understands the consequences of this act to demonstrate his or her dissatisfaction with the situation in this way. However, it is recommended that the evaluation of the situation be shared with a colleague.

The General Assembly of the United Nations in 1975 adopted its Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and in 1982 adopted Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the Protection of Prisoners against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment with principles similar to those of the Tokyo Declaration, but which should govern not only physicians but also all other health professionals.

In between, the WMA in 1981 had been motivated by the introduction of pharmacological methods of capital punishment in the United States to issue a specific statement forbidding physicians from becoming involved in any form of capital punishment.

Contribution from UN

Later, the United Nations in 1984 adopted the Convention Against Torture, and established a Committee Against Torture with 10 members to oversee the implementation of the convention in countries signatory to this convention. It should be noted that the convention requires signatories to give appropriate training and information to all relevant professionals and personnel about their duty not to become involved in torture under any circumstance. Thus all Danish medical students and nursing students receive a minimum input in their training about torture and its consequences, and their special duties in relation to this group of patients.

Many countries have not yet implemented this part of the convention.

- and from EU

A regional effort in this area was undertaken in 1987 by the Council of Europe in its Convention for the Prevention of Torture, which also includes the right to international inspection of all places of involuntary detention in the 23 member countries of the Council of Europe.

The reports of the inspection teams are in principle confidential, containing recommendations to the respective governments aiming at the prevention of torture rather than taking the form of condemnation of past practices. However, most governments have now adopted the practice of making public the reports and recommendations of the inspection teams with the governments’ comments on the criticism and the actions taken or planned to remedy the shortcomings pointed out by the inspection team.

The Council of Europe has recently been expanded with 9 new members, i.e. former members of the Eastern Block in Central and Eastern Europe who are expected to ratify the convention as soon as possible, bringing to 32 the number of countries submitting themselves to international inspections of places of detention to which in the past only representatives of the International Committee of the Red Cross have had access.

On the initiative of the government of Costa Rica, the United Nations’ Committee on Human Rights is now considering an Optional Protocol to the Convention Against Torture which would globalize such a system of international inspections of places of detention.
The Statement of Madrid

It should be emphasized that physicians have a clear interest in and obligation to get involved in these activities. Physicians have special competence in detecting physical and mental consequences of torture. At present only one member of the UN Committee Against Torture is a physician, whereas several members of the Committee for the Prevention of Torture of the Council of Europe are physicians.

Realizing that the adoption and implementation of all these declarations and conventions and the actions of their respective monitoring bodies still did not put an end to torture and continued physician involvement in torture, even in a number of countries signatory to the convention, and that the majority of member countries of the United Nations had not even ratified its Convention Against Torture, the Standing Committee of Doctors of the European Community adopted the Statement of Madrid in 1987, urging national medical associations to take concrete action in a number of areas.

Public and professional sanctions against physicians involved in torture were first applied to Nazi doctors at the Nuremberg trials against war criminals after the Second World War. Attempts have since been made in a number of countries moving from repressive to democratic government to take disciplinary action against physicians who had been directly or indirectly involved in the practice of torture under the repressive regime, e.g. in Greece, Uruguay, Chile, and Argentina. Unfortunately, in most of these situations such physicians as well as other torturers have been protected by impunity legislation introduced prior to democratization.

Situation of today

It remains to be seen whether the International Court set up by the United Nations to look into human rights abuses committed in former Yugoslavia will succeed in bringing any physicians involved in torture during that conflict to justice.

It should further be considered an ethical obligation for all physicians to report cases of torture among their patients to appropriate national or international authorities with responsibility for the protection of human rights. Only in this way will they be able to avoid being considered accessories after the fact to the practice of torture. In principle such reporting should be considered as normal as reporting a case of suspected occupational disease. We know, however, that repressive systems have been able to scare physicians from performing their ethical duties in this respect, thereby adding to the silence surrounding the whole subject of torture.

Furthermore, physicians have an ethical obligation to offer relevant physical and psychosocial treatment to victims of torture among their patients. This requires also the willingness of physicians to make a proper medical examination, including psychological assessment, of all cases when torture may be suspected. The problem is that this group of patients in most cases are silent about their torture experience, feeling humiliated in the extreme and, strangely enough, feeling guilt and shame, because they were broken both physically and mentally in the process of torture. They may also have been told never to talk about the experience, and that nobody would believe them anyway.

Practical efforts

So physicians working among special risk groups such as refugees from repressive systems and detained persons in such systems should be especially sensitive to this problem and not just assess somatic fitness or disease in these populations.

Special treatment and rehabilitation centres have been set up to offer the most relevant services to these patients or survivors, as they should more properly be called. The first such centre was set up in 1982 in the city of Copenhagen, Denmark, on the initiative of Dr. Inge Genefke, a Danish neurologist. This centre offers somatic and psychosocial treatment and rehabilitation to torture victims among refugees coming to Denmark.

Since then similar centres have been established in many other countries receiving refugees from repressive systems, but also – and increasingly – in countries that have moved from a repressive to a democratic system, and where the needs of former victims of political repression can now be recognized, and appropriate services and programmes offered from programmes and centres that are trusted by this understandably rather cautious group. So as a general rule such services are offered by independent non-governmental institutions.

In 1992 the International Rehabilitation Council for Torture Victims adopted the Declaration of Istanbul in connection with its Fifth International Symposium on Torture – a Challenge to the Medical Profession. This declaration was a strong appeal to the United Nations to take firmer action against torture and became an official document of the UN Commission on Human Rights and of the Fourth Preparatory Committee Meeting in the process leading to the World Conference on Human Rights held in Vienna in June, 1993.

The Vienna Declaration

At least in part due to this effort, the World Conference included a special section on Freedom from Torture in its final document: The Vienna Declaration and Action Programme on Human Rights. This section was included in the Action Programme rather than among the Principles that have already been sufficiently established in the past.

The section on Freedom from Torture stresses the need for effective implementation of the Principles of Medical Ethics and the need for introduction of the subject of torture in the training of all health and other professionals who are involved with detainees of every kind. Further, the Vienna Conference condemned legislation giving impunity to torturers as violators of human rights.

Finally, the Vienna Declaration and Action Programme on Human Rights stressed the obligation to provide legal redress and economic compensation, as well as physical, mental, and social rehabilitation to victims of torture and their dependents.
More rules to guide the anti-torture work of the UN?

The developing ideas of combating torture and rehabilitating torture victims

Henrik Døcker

The international endeavours to combat torture — well, the fight against that evil — cannot point to clear victories in reducing its use. More than one third of the countries of the world are listed as perpetrators of torture according to Amnesty International, and the number has not been decreasing lately.

As eastern Europe gradually abolished the use of torture and closed the odious prison camps, as well as torture cells — now being shown to visitors as curiosities of the past — various new and bloody armed conflicts, and even concentration camps, have appeared on the international scene.

The civil wars, whether in ex-Yugoslavia, Somalia, Liberia, Angola, Rwanda, or elsewhere, brought new misery to the world — and complicated the Human Rights work of the United Nations. The world body used a number of years in setting Human Rights standards, until it developed control mechanisms and preventive measures. But the internal wars could not be stopped or even hampered by international humanitarianism.

The Special Rapporteur on Torture, Professor Nigel Rodley (UK), one of several of the so-called thematical rapporteurs (on disappearances, arbitrary and summary executions, arbitrary arrests, etc.), stressed a vital point in this respect in his 1993 report, which summarized the work of his office.

He asked for specific guidelines as to whether his mandate should include acts committed by parties to an armed conflict. It has been suggested by the Indian Government that the Special Rapporteur should also deal with the harmful effects of terrorism. Should he for instance be guided by the view of the member state concerned?

Professor Rodley, who in 1993 succeeded the first torture rapporteur (Professor P.H. Kooijmans, who is now former Foreign Minister of The Netherlands), hereby touched on difficult questions of definition. One could imagine India's interests coming under strong international scrutiny with respect to its adversaries in Punjab or Kashmir; the government in New Delhi has been blamed continuously for its use of torture on the Sikhs and Muslims.

Could torture be fought effectively in war-torn countries?

The question posed by Professor Rodley is, however, a wider one. He believes that it is intentional that the resolution 1993/48 of the UN Human Rights Commission omitted mention of violent actions committed by armed groups as Human Rights violations. He thereby draws attention to far-reaching perspectives of the humanitarian work of the UN and the debatable distinctions between international law in peace and war.

"The Commission would not wish to dignify the perpetrators of criminal violence by describing them as Human Rights violators, or (...) addressing them as though they had the authority that falls within the international legal protection of Human Rights," he observed.

The rapporteur knows perfectly well that torture by any party in a conflict is prohibited, whether in peacetime or in a civil or international war. But his work is much more delicate, not to say complicated, in wartime. The question is whether the UN bodies have any chance at all when fighting has not been stopped. And, furthermore, whether the resources that are spent by, for instance, the UN Human Rights Commissioner and the rapporteurs are worthwhile in situations of great danger and where there is little prospect of improvement for the Human Rights.

Nigel Rodley also spoke at a public hearing of the European Parliament in Brussels in December 1993. He said that it had not yet been decided whether the UN should set up a preventive torture mechanism similar to the one created by the Council of Europe in Strasbourg. Perhaps one should aim at regional preventive committees that could visit police stations or prisons in the member countries in order to examine the places where a torture risk exists. The European Committee has done much useful work, recorded in the many reports that have been voluntarily published by a number of governments that had been criticized. Many improvements in prison conditions have consequently followed.

What the Council of Europe's Torture Committee can do

The European Parliament — part of the European Union (EU), which was formerly known as the European Community (EC), now consisting of 15 European countries — gave 2 million ECU in 1993 to the international rehabilitation work for torture victims. Various centres for the treatment of torture survivors had requested 17 million ECU altogether.

Responding the Chairman of the Foreign Affairs & Security Committee of the European Parliament (Mr. Enrique Bárón Crespo, Spain), Professor Bent Sørensen (Denmark) acknowledged that the European Torture Prevention Committee (abbr. CPT) had only one weapon, i.e. a public statement. It had hitherto only been used in December 1992 when the Committee, after three visits to Turkey, had seen no reduction in the use of torture.

That statement, in fact a publication of several pages, was the outcome of a visit by the Committee during which the delegation (of which Professor Sørensen is a member) found torture instruments in Ankara and Dyrabbakir. A publication despite Turkish protests. As stressed by Professor Erik Holst (Denmark), President of RCT, Copenhagen, and Executive Vice-President of IRCT, physicians have a clear interest,
and feel an obligation to be involved, in the endeavours to
globalize the above-mentioned system of international in-
spection of places of detention.

At the hearing in Brussels, Professor Holst also asked how
physicians can be effectively protected from being directly or
indirectly involved in torture or other cruel, inhuman or de-
grading treatment or punishment.

**Ice cubes - a new torture weapon**

Dr. Inge Genefke, Medical Director of RCT, stressed that
torture victims/survivors, treated at the many centres all over
the world, are not regarded as patients, but as very normal
people who have normal reactions. “It is normal to be
anxious and depressed, shameful, and feel guilty after being
exposed to such a horror as torture,” she said.

All these endeavours have practical aspects as well. Ac-
cording to Professor Veli Lök (Turkey), pathological changes
caused by torture can be proved more than two months later.
Thus, thanks to recent scientific methods, squeezing the
scrotum of a young man could be detected after 70 days.
However, this is an area that is full of new problems, because
the police change their methods, thereby making it more dif-
ficult to detect whether torture has been used. Tests on pigs
proved changes in the deeper layers of the tissue following
electric torture.

In some countries police are putting detainees among ice
cubes, while in others the cubes are put in their hands. This
would cause some changes in the fingers, but they are very
difficult to spot. Medical research does not give up. “We are
competing with them,” Dr. Lök assured. Bone scintigraphy is
one of several methods which are of vital importance for tor-
ture victims who want to take their torturers to court. Many
Turks now try to get compensation through the courts –
by way of the European Human Rights Convention and the Eu-
ropean Human Rights Court in Strasbourg. The first victims
have received compensation through that European system.

**Bad conscience and weak will by many governments**

As put by Maria Piniou-Kalli, Greek medical doctor in
charge of the Athens Medical Rehabilitation Center for
Torture Victims: “Torture is a crime against humanity (...) 
vioence is bred and perpetuated by [the torturers] not being
punished (...). Immunity leads to the generalization of the
use of violence and arbitrariness (...): it leaves indelible marks
on the people who have suffered. Attribution of justice is not
to be identified with revenge, but with truth.”

“The UN Rapporteur on Torture in 1993” made 84 urgent
appeals to 31 governments concerning roughly 400 individu-
als with regard to fear of torture, and 42 letters concerning
500 cases of alleged torture. 20 countries provided the Rap-
porteur with replies on about 250 cases submitted during
1993.

The Special Rapporteur appreciated the spirit of coopera-
tion of many governments, but their political will to improve
Human Rights conditions (not to say to abolish torture) was
weak. The persistence of torture is expressive of that.

The many flat denials, and references to unspecified in-
vestigations and legal procedures that have already been
compromised showed that many states camouflage their bad
conscience rather than try to change anything. Professor
Rodley is rightly disappointed – and so is that part of the
world which actively combats the use of torture.

**Notes**

1. Question of the Human Rights of all Persons subjected to any form
   of Detention or Imprisonment, in Particular Torture and other
   Inhuman or Degrading Treatment or Punishment. Report of the
   Special Rapporteur (Economic and Social Council of the United
2. Dócker H. India’s torture and abuse of Sikhs. Torture 1994; 4:
   78.
3. Petersen HD, Wandall JH. Evidence of organized violence among
4. “Summary records of presentations made at the Public Hearing
   on the Fight against Torture and the Role of Rehabilitation Cen-
   tres”. Brussels, 20 and 21 December 1993. The proceedings from
   the hearing contains 10 contributions in either French or English,
   and an introduction in Spanish.
5. 1994-statistics not available when this was written.

**Selected list of publications**

**received in the IRCT International Documentation Centre**

**Physiotherapy to torture survivors**

**Health and human rights seminar**

**Torture**

**Torture**

**Torture in Israel**

**Towards an epidemiology of political violence in the third world**
- Zwi, Anthony ; Ugalde, Antonio. - In: Social science and med-
cine ; vol. 28, no. 7. - 19890000. - p. 633-642. - ISSN: 0277-
9536

**Chiweshe nurse-counsellor programme**

**Assessment of the consequences of torture and organized vio-
ence**

**Kim**
- uddrag af dagbog og breve skrevet fra hans syttende
From the Garden of Eden to a tortured desert

An interview with Bayan Alhakim, human rights fighter and medical doctor for the Marsh Arabs

Niels Astrup, Journalist

Believed to be the descendants of Sumerian fishermen, they have made these waterways their home. Much like the Indians of Lake Titiaca, they have used reed for building their houses, mosques and boats, used the waters for fishing, cultivating rice and keeping herds of water buffaloes. It is a way of life that has not changed much during the centuries.

But for the Marsh Arabs, the last 15 years have been a period of great anguish. First, starting in 1980, the prolonged and bloody trench warfare between Iran and Iraq for almost a decade. Then, in the period following the Iraqi defeat in the Gulf War, a reign of terror let loose in the region to quell an armed dissent.

Today, hundreds of thousands of people in the marshes pay dearly for having listened to — and believed — the advice of former US president George Bush, who in March 1991, at the end of the Gulf War, called on the people to overthrow “The butcher from Baghdad”. In cities all over the south, Iraqis, mainly belonging to the Shiite branch of Islam, rebelled against the regime in Baghdad — hoping for military assistance from the United States. The help never came, the uprising faltered, and thousands of refugees, together with deserters from the Iraqi army, sought refuge in the marshes and tried to continue their resistance from there.

In a meeting with local elders and clan leaders some time later, Watban Takriti, a half-brother of Saddam Hussein, vowed to settle the problem of the marshes once and for all. What he meant was made clear to Shyam Bhatia, a British journalist working for The Observer, who visited the marshes in the company of a group of resistant fighters, commonly known as the mujahedin.

On the first night of his stay, Bhatia himself was a witness to the indiscriminate shelling of the reed islands. An artillery grenade hit one of the reed islands, transforming the dry grass into bright orange flames and creating panic among the inhabitants. “Whoever fires these grenades”, Bhatia wrote, “does not know exactly where they land. But because the huts along this rapid stream are so close to one another, the Iraqis know full well that they are going to kill or maim a few people and scare the survivors, that is also their aim.”

But the plan to “solve” the problem of the marshes once and for all has assumed an even more sinister dimension. Since early 1992, Iraqi engineers and soldiers have been busy creating a 560 km so-called “third river”, designed to divert the waters of the two legendary rivers and drain the marshes, thereby destroying the traditional livelihood of the Marsh Arabs. Plans and satellite photos, taken from captured Iraqi engineers, show beyond reasonable doubt that this ultimate plan is proceeding on a war footing. According to Dr. Bayan Alhakim, approx. 3/5 of the marshes have been drained by now.

Other captured documents reveal the master plan of the Iraqi military. The army should ensure that no outsider enters the marshes. Everyone found in abandoned villages...
will be treated as an enemy. And, further, the inhabitants are not allowed to travel further than 3 km from their villages. Finally, the army should carry out routine house-to-house searches in the area. If the food supplies of the families exceed government limits, the people should be taken for questioning and be accused of supplying the rebels.

As a result of the shelling, the draining, and the persecution by the army, thousands of people have fled to the Iranian border, continues Dr. Bayan Alhakim. Most of the refugees now live in camps a few miles inside the border and are able to hear the constant shelling of their old homes.

“To me,” Dr. Bayan Alhakim finishes the interview, “there is absolutely no doubt that torture has become a widespread tool in the efforts of the regime of Saddam Hussein to destroy the culture of the Marsh Arabs. I have been able to examine dozens of women and have documented that torture and rape are widespread in detention centres of the Iraqi army. Several of the women I have examined had disfigurements that resulted from prolonged periods of suspension. It really is a genocide.”

**Dr. Alhakim’s account of the sufferings of Iraqi women**

Dr. Bayan Alhakim met many Iraqi refugee women during two visits to the Iran-Iraq border. In October 1993 and May 1994, to give medical advice to victims of Saddam Hussein’s regime who fled from Iraq before and after the crushing of the popular uprising in March 1991, during the aftermath of the Gulf War.

*The case of Um S*

Um S is married to a doctor. Both of them were working in Kerbela Hospital when they fled Iraq during the crushing of the popular uprising in March 1991. Now they are living in a refugee camp where both work in the clinic of the camp serving Iraqi refugees. Um S assists her husband in the pharmacy; he is the only doctor serving in that refugee camp.

Um S herself was imprisoned and sentenced to death by the Iraqi regime when she was 16 years old. At that time she was a student in a secondary school at Basra in the south of Iraq. Because of her age, her sentence was reduced to live imprisonment, and then to 15 years. She then spent 3 years in the prison after being released because of an amnesty. During the 3 years she spent in detention and imprisonment she was subjected to various types of torture.

She was arrested in October 1980 in Basra on her way back from school because she is from a religious family. She was taken to the governor of Basra, who intimidated her, then transferred to Basra Security Headquarters where she spent more than one month and was subjected to various types of torture. She was beaten on her back and all over her body and face. As a result, she bled from her nose and mouth on many occasions.

They used to take her to see other detainees tortured in front of her, and to see others hanging by their hands and legs from the ceiling. She herself was sometimes hung from a window with her hands tied behind her back.

She was then transferred to a room not more than 4 x 4 feet where she spent seven days in solitary confinement; she was tied to metal bars and prevented from going to the toilet for four days. The torture session lasted daily from 2 p.m. to 2 a.m.. Three of her uncles and 38 other relatives were arrested at the same time. She was tortured in front of her uncles. They hanged her up and put cautery electrodes on her fingers and toes. One of her uncles lost his sanity when he saw her in such a condition.

One of the huts where the refugees live on the Iran-Iraq border.

Dr. Bayan Alhakim standing (left) with a refugee woman in a refugee camp in Himmet, on Haswizah Marsh on the Iran-Iraq border. November 1994.
The security forces then arrested eight other classmates. She only remembers the names of some of them: K and Z who also lost her sanity when she was forced to take off all her clothes. Um S also saw one girl from Kut governate raped. Other girls from Al Amara were arrested with Um S. A lady who came to visit her family in Baghdad was arrested because she was carrying some religious books. This lady was subjected to all sorts of torture such as beatings and hangings from a ceiling fan.

She also saw imprisoned men kept in hessian bags with tied tops; these bags were opened once a day for food.

In Basra she was interrogated by the colonel An naqeeb Mehdi from Al Hindiyah City. An eight-year-old boy was also with her. Another girl who was related to Um S was also detained, and another, a student in the Agricultural College, was raped in front of her.

The virginity of a girl from Basra was removed by the security men by use of a rubber tube, and two other women, one of them 35 years old, had their virginity removed by introducing the neck of a bottle forcibly inside them. "They threatened to do the same to me if I did not confess", Um S said. Other ladies whom she knew had a bottle introduced into their back passages by force; they are now incontinent of faeces.

In Baghdad detention she met a girl who was pregnant and who gave birth to a girl. They took the newborn baby; the parents were executed. Um S stayed in the security headquarters in Baghdad for eleven months, then she was tried in a so-called "Revolutionary Court" headed by Mr. Muslim Al Mehdi from Al Hindiyah City. An eight-year-old boy was also with her. Another girl who was related to Um S was also detained, and another, a student in the Agricultural College, was raped in front of her.

The case of M

This patient is 65 years old, from Al Amara city, diabetic. Her big toe was amputated because of her uncontrolled diabetes while she was in Iraq. M was taken hostage in 1990 while she was in Iraq because her four sons were convicted as deserted soldiers. She was arrested and detained for 6 months. During that time the security men broke into her house and destroyed all her furniture and other house contents, fridge, cooker, etc. by a bulldozer. They then knocked the house down! M fled Iraq during the uprising in March 1991. She now lives in the Ansar refugee camp, on the Iran-Iraq border.

Dr. Sahib Alhakim's list of Iraqi torture methods

The list comprises 59 methods; several that are known in other contexts are omitted here:

- Al-Mangana: clamp-like instrument which is placed over the toes and tightened
- Extracting finger and toenails
- Applying pressure to the eyes through blindfolds
- Suspension by handcuffed wrists or ankles from a rotating fan in the ceiling, and beating during rotation
- Forcing the victim to step into a bath full of water through which an electric current is running
- Fixing the head in a cabinet with intense ultra-violet rays, which burn the eyes
- Placing the half-naked victim in a heated closet full of steam, then reducing the temperature drastically
- Pouring water over the nose and mouth of the victim, causing near suffocation
- Throwing the victim a distance of 2-3 metres from a type of ejector-chair
- Mutilation of the body, including gouging out the eyes, cutting off the nose, ears, breasts, penis, axing the limbs, peeling the skin or cutting it open with a sharp instrument, hammering nails into the body; threats of such mutilation
- Sitting on a paraffin heater. The victim is tied sitting on a flat top paraffin heater. The heater is turned on and the victim begins to burn and agonizes from the pain
- Burning of the beard. This is used on bearded religious people as in the case of Mohammed Baqir Al Sadr
- Breaking the nose with a steel bar
- Ordering the detainees to kick each other in the head
- The women are sexually assaulted and raped. If it is to extract confessions from her husband, this is done in front of her husband
- Torture of children. This occurs in order to extract information from the parents. The children are summoned and are beaten and assaulted in front of their parents. If the parents still refuse to give any information, then the children will be killed in a variety of ways in front of their parents. An example of this occurred when the wife of an opposition figure was brought in with her baby son to be tortured. The father refused to give any information. One of the torturers heated an iron rod until it was red hot and put it over the tummy of the baby until it was kicking and screaming from the pain
- Confinement in metal cylinders. The detainee is put in a long metal cylinder, the width of a man and is locked up in it. He cannot sit down and must remain standing
- Nailing the ears to a wall while sitting or standing. If the victim is standing, he has to remain in that position. If he tires and wants to sit or fall, his ears will be torn.
Let us speak for the dead and protect the living


P. Srikrishna Deva Rao*

Torture is a wound in the soul so painful that sometimes you can almost touch it, but it is also so intangible that there is no way to heal it. Torture is anguish squeezing in your chest, cold as ice and heavy as a stone, paralyzing as sleep and dark as the abyss. Torture is despair and fear and rage and hate. It is a desire to kill and destroy, including yourself. Adriana P. Bartow

No violation of human rights has been the subject of so many Conventions and Declarations as torture, all aiming at total banning of it in all forms. But in spite of the commitments made to eliminate torture, the fact remains that torture is more widespread now than ever.

A large number of agencies, police, para-military forces, executive or judicial magistrates, scientists, politicians, and doctors are directly or indirectly involved in the process of torture. Amnesty International's report on Torture, Rape and Deaths in Custody in India, 1992, castigated the Indian police, saying that "Torture has become a daily routine practice in India". It also criticized the entire criminal justice system operating in India, including the doctors who share the responsibility for the institutionalization of torture in the police process.

Torture or the killing of a person in police custody is the direct and visible form of torture. The direct or indirect participation of doctors in covering up torture by issuing incomplete or falsified autopsy reports or death certificates, deliberately omitting medical information, amounts to an invisible form of torture. By participation knowingly or unknowingly, their misuse of medicine has aided in legitimizing the brutality, and the use of medicine as a punitive weapon of the state. Keeping silent about torture and being bystanders to it only serves to condone its practice as a means of political and social control.

The following describes some cases in which doctors were bystanders and a party to the conspiracy of silence by deliberate omission of medical information, or by falsifying autopsy reports. Medical and legal aspects of torture are examined, including the conditions under which the violations occur, and what the medical community can do to check this trend.

**Torture process**

The torture process begins with the arrest, the stigma of which survives even if the person is released after only 24 hours. The family structures are shaken as a result of the victim's sudden arrest and indefinite detention. From the moment of arrest, the detainee is defenseless; he has no control over his mental and physical integrity, and he is compelled to follow his captors' directives. The arrest and detention in a police station create a psychological impact on him; the resulting anxiety, fear, and stress cause mental pressure and trauma.

**Torture and law**

Practically every person who is taken to a police station in connection with some offence or other is subjected to torture. It may take several forms: physical violence on the body of the arrested person, sexual violence against women detainees, psychological torture, or, the ultimate, the death or disappearance of the victim. Custodial torture is an aggravated form of torture; it is of serious concern because what happens in police custody is not generally open to public scrutiny. The denial of open accessibility to the public is what makes these violations qualitatively different from others. Incidentally, doctors play a crucial role in the medical examination and treatment of all types of custodial violence.

Sections 330 and 331 of the Indian Penal Code (IPC) deal exclusively with the offence of torture. Voluntarily causing hurt to extort confession or information is an offence under Section 330 punishable with 7 years imprisonment and fine, and 10 years imprisonment for causing grievous hurt under Section 331. These sections include only the suffering of bodily pain, not mental pain. The arrested person, if brought before a magistrate, can request a medical examination under Section 54 of the Criminal Procedure Code (CPC). If the arrest is not shown in the record, and was based only on suspicion, then this provision does not help him. This provision has been incorporated in the CPC as a safeguard against torture, since the period between arrest and being brought before a magistrate is the crucial phase when torture takes place. The magistrate has a mandatory duty to ask the arrested person, when he is first brought before him, about complaints of torture. If there is any visible mark of violence on the body of the person, he should send him for medical examination. But unfortunately the magistrates just mechanically sign the remand orders, and this provision is observed more in its breach than in its observance. In the Bhagalpur blinding, when the prisoners were blinded by the police by piercing their eyes and pouring acid into them, the Supreme Court...
Court expressed its unhappiness at the “lack of concern shown by the judicial magistrates in not inquiring from the blinded prisoners, when they were first produced before the judicial magistrates and thereafter from time to time for the purpose of remand, as to how they received injuries in the eyes.” (AIR 1981 SC 932).

Rape is also used as an instrument of political repression. Rape in police custody is not a mere physical violation and injury. But the legal system defines and treats rape as an offence against property, not as an offence against a person. It is designed to protect a man’s female property (Sections 375 and 376, IPC). The victim of rape often sustains minor physical injuries: the emotional damage and psychological trauma are of greater severity than the physical event. It temporarily destroys the victim’s sense of self-determination and undermines her integrity as a person. As succinctly observed by the People’s Union for Democratic Rights (PUDR) in its report on Custodial Rape, “the social power that men have over women gets intensified with the legally sanctioned authority and power of policemen. Even the limited supportive mechanism that exists for women becomes less effective when the rapist is a policeman . . .” The significance of rape lies in the physical repugnance, the mental and emotional trauma, and its severe social repercussions. The woman ceases to be a person and a social being; she becomes merely a rape victim. The sense of moral outrage against rape, seemingly centred around the offence and offender, becomes inexcusably a judgement on the women. It all arises from social attitudes towards female sexuality and chastity.

What is of great concern in all custodial crimes is not justification of body pain, but the mental agony of a person in the four walls of a police station, whether it is the arrest, or physical assault or rape in police custody – the amount of stress and trauma a person experiences is outside the purview of the law. The Indian legal system has overlooked the complex and neglected area of the victim’s emotional problems. Especially in rape, the stresses and emotional trauma of the victim only begin with the case of physical assault by the rapist. The medical examination will be of even more importance in cases of Encounter Deaths, wherein all the minimum safeguards are flouted. It is also strange to note that in both these cases, the victim has to lodge a complaint, then it will be followed by investigation. Apart from custodial death, when an inquest by the magistrate is mandatory under Section 176 (CPC), all the other custodial crimes are investi-

<table>
<thead>
<tr>
<th>No.</th>
<th>Name of judge</th>
<th>Name of victim</th>
<th>Date of inquiry</th>
<th>Brief facts</th>
<th>Inquest</th>
<th>Postmortem report</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>K. A. Muk-</td>
<td>Ahmed Hussain</td>
<td>30.03.1978</td>
<td>Deceased was brought to police station without any charge against him. His wife Pemee-jaboo was raped and severely beaten. After leaving the police station he complained of severe pain in the body and chest and died on the way to the hospital</td>
<td>5 external injuries</td>
<td>Coronary thrombosis</td>
<td>Doctor minimized the external and internal injuries and maximized condition of heart to show that he died as a consequence of “Coronary Thrombosis” and not as a consequence of homicide</td>
</tr>
<tr>
<td>2.</td>
<td>M. Sreeramu-</td>
<td>M. Anjaiaj</td>
<td>06.09.1986</td>
<td>Deceased was taken into custody on suspicion of involvement in a theft case. According to police he died of chest pain</td>
<td>Injuries on thighs, abdomen, ribs, navel, shoulders, chest, ear and buttocks</td>
<td>Contusion of heart</td>
<td>Postmortem report was sent after more than four months. Doctor did not disclose the contents of the postmortem report for nearly 5 months obviously with ultimate motive to help the accused (the police). It is gross negligence on his part</td>
</tr>
<tr>
<td>3.</td>
<td>B. Rama Rao</td>
<td>David Raju</td>
<td>23.09.1986</td>
<td>Deceased was an exconvict and escaped from jail while undergoing trial. Later he was caught and brought back to the police station, where he was chained by his legs to the doorframe of his cell</td>
<td>Suicide by strangulation</td>
<td>Asphyxia due to strangulation</td>
<td>Tortured to death; action recommended against doctors who despite 10 injuries on the body suppressed the truth</td>
</tr>
<tr>
<td>4.</td>
<td>K. Venkata</td>
<td>G. Rama-</td>
<td>28.07.1987</td>
<td>Deceased was brought to police station on suspicion of his involvement in a theft case; he died next day</td>
<td>Five external injuries and ante-mortem swelling above penis</td>
<td>Died due to poisoning</td>
<td>Tortured to death; action recommended against doctors for suppressing the truth</td>
</tr>
<tr>
<td>5.</td>
<td>P.V. Ranga</td>
<td>D. Venkata-</td>
<td>15.09.1986</td>
<td>Deceased was illegally detained on the suspicion of dacoity and tortured. When his condition deteriorated, he was thrown outside on the road</td>
<td>Conducted by police in contravention to Sec. 176 of Criminal Penal Code</td>
<td>Pneumonia</td>
<td>When an exhumation order was issued, the body was missing. Lapses by police and doctor in suppressing the truth</td>
</tr>
</tbody>
</table>
gated and tried in accordance with general criminal procedure. It is also surprising to note that the Law Commission of India in its 113th Report on Injuries in Police Custody, in the wake of the Supreme Court’s observation to amend the law on custodial deaths in 1985 (Ram Sagar Yadav vs the State, AIR 1985, SC 416), never recommended any special procedure to investigate these crimes. Interestingly, the National Police Commission, in its first report in 1979, recommended a mandatory judicial inquiry into all these cases.

**Doctors and torture**

In all cases of custodial crime, the victims or the deceased are eventually examined by the doctors for its cause or treatment, or for medico-legal investigation. In fact, many doctors in India have given detailed and honest accounts of injuries and their causes inflicted on men and women brought in by the police for treatment or examination. Some doctors, however, do not appear to withstand pressure from the police to provide postmortem reports that conceal the truth. Postmortem reports, when they are not doctored, sometimes reveal the telltale marks.

The medical examinations and opinions, both ante- and postmortem, have special relevance for the investigations of these incidents, and placing responsibility for them. In the absence of any direct, independent evidence, which is inherent in most of these cases that take place within a police station, the medical evidence helps to determine the injury or death, and the manner of their causation, and helps to corroborate or disprove the version.

Several judicial inquiries have pointed out the lapses on the part of the doctors. Justice Muktdhar made scathing remarks about doctors in the infamous Rameejab case in Hyderabad in 1978, when a woman was raped in the police station and her husband was tortured to death. “It is sad to note that a department which has been established to bring out the truth is manned by officers of questionable integrity who could suppress or distort the truth to accommodate criminals. The earlier the Department of Forensic Medicine gets rid of such officers, the better it will be for Indian citizens.”

In the Guntaben case, when a young woman was gang-raped by policemen in January 1988, the Commission appointed by the Supreme Court found that there was evidence against 8 policemen and two doctors whom it named. Disciplinary action was started against the policemen for participating in the rape, and against the doctors for its cover-up. The case of Dayal Singh, who was a chowkidar (‘Watchman’) in New Friends Colony, Delhi, is exemplary. He was picked up in connection with a theft, and found dead a day later in custody. His body was taken to the All India Institute of Medical Sciences (AIIMS) for a postmortem. The doctor who performed it confirmed the police diagnosis of tuberculosis. But the Resident Medical Doctors’ Association of AIIMS took up the case, and a second postmortem was conducted by a team of senior doctors. They found that Dayal Singh had died as a result of injuries he received in the police station, not from tuberculosis. Table 1 points out the observations made by five Commissions of Inquiries into custodial deaths in Andhra Pradesh.

The proof of the large number of physicians who participate in torture is alarming. It is now pertinent and necessary to examine what the medical community can do to end torture, to aid its victims, and to restore the moral and ethical integrity of the profession.

**Chilean experience**

The Chilean Medical Association started a nationwide campaign in 1984 to educate physicians and the public about its firm opposition to torture. It has sharpened its own code of ethics, and has held disciplinary hearings against physicians who had been charged with complicity in torture. The Chileans are not alone in this endeavour. The medical associations in Argentina, Brazil, Uruguay, and South Africa have also investigated, and in some cases suspended, members who had covered up acts of torture.

What needs to be done?

- To abolish torture we must devise an anti-torture campaign among the medical community.
- Doctors should document evidence of torture, conduct autopsies in a fair manner, and help the victims to obtain redress. It is an ethical obligation of all doctors to report cases of torture.
- The medical association should issue an official directive condemning and banning these practices, and should prescribe strict ethical rules and guidelines in this regard; strict measures should be taken for their violation.
- The law should be amended so that every accused person should be medically examined on arrest; injuries, if any, on his person should be entered into the record.
- Training about torture, its sequelae and treatment, rehabilitation of torture victims, and medical ethics should be part of the medical education curriculum.
- Doctors who have been involved in cover-up operations should be made personally liable, and should be proceeded against under Section 166 of the IPC. The responsibility for filing such charges should be taken up by the Indian Medical Association.

**References**

Forensic considerations concerning survivors of torture with craniocerebral trauma and postconcussive syndrome

Sepp Graessner, MD*

In everyday practice, whenever we are required to establish traces of torture in refugees and applicants for political asylum, we find ourselves confronted with problems which can probably be resolved only against the background of international cooperation. European “harmonisation” of asylum law, with all its asylum-preventing consequences, calls for a concerted European effort to ensure forensic evidence of torture traces and long-term sequels.

Our medical expertise, based on long experience, is quite often downgraded in hearing procedures and administrative courts, since a direct causative relationship between torture actually suffered and detectable traces may be hard to establish and is burdened with different degrees of probability.

To speak plainly, we were not present when the events took place, a claim which cannot be made by all medical doctors and psychologists in many a country. So we have to rely on circumstantial evidence, the evaluation of which becomes easier and harder, at the same time, with growing experience.

Ethical considerations

If our judgement is taken seriously, it is likely to impose on us the pressure of contributing to decisions about persons being granted asylum or being deported. Hence, we become directly involved in the asylum seeker’s destiny. Is this what we want? Would this expert duty be compatible with the principle of “nil nocere” (Never cause damage)? How much responsibility and effort are required for positive evidence without visible traces? Are we the most suitable persons for emotional disburdening of investigators and judges?

Since we cannot tolerate political, religious or ethnic aspects to interfere with our relationship with the patient, we cannot tolerate problematic legal issues to be quasi-pardoned by medical and psychological know-how, since they are devoid of a humanitarian dimension in themselves.

In addition, we are called upon to add a touch of humanity to the merciless strategies of asylum rejectors, e.g. in a situation in which we are explicitly asked for our expert opinion by judges, social workers, and lawyers. It is from our own experience that we are aware of the psychological pressure of being confronted with an individual who has gone through destructive torture.

Experience obtained from recourse claims after the Nazi holocaust has clearly revealed a need not only for pathophysiological and psycho-anamnestic examinations and, if possible, for evidence, but also for due attention to examiners’ and therapists’ experience and representation of that experience in public. Causative evidence is expected from us by virtue of our professional principles even in cases in which a complexity of injurious influences is involved. We simply cannot accept what has been and still is everyday practice in compensation proceedings in court, where long-term sequels of imprisonment and torture used to be attributed to pre-existent dispositions, previous diseases or genetic preformation1 to dismiss claims which would appear to be absolutely justified against the background of average common sense and even without professional knowledge. Similar experience has been recorded from countries liberated from dictatorial regimes.

We feel strongly that late sequel of torture should be dissociated from demonisation, stigmatisation and clinification, and should rather be interpreted as adequate responses to a severe, obscure trauma. Hence, for any assessment of such late sequels, we should proceed from the triggering damage, and our judgement should be related to the trauma proper.

Any use of psychiatric criteria of diagnosis would produce contradictory findings2.

Criteria of appraisal

It is easier adequately to evaluate the damaging forces involved in the first place, and their consequences, if we succeed in obtaining a precise description of the torture method used; this quite often takes a long time of confidence building contacts.

A distinction may be made between four stages with which to appraise the biography of an asylum seeker, the torture suffered, and the long-term sequels of the torture:

1. low consistency of the description of the torture experience, as well as of resulting complaints and long-term sequel
2. adequate consistency of description, complaints and detectable traces
3. high probability ...
4. close-to-certain probability ...

This approach to differentiation is primarily due to our inadequate cultural, methodological, linguistic and forensic knowledge.

Definition

This paper concerns a subject which so far cannot be evaluated with full consistency unless the violence inflicted on the head and nape of the neck, together with subsequent complaints, is actually reported to us and we have at our disposal some preliminary methods of detection and verification. We present our views openly, despite their preliminary nature, because they relate to a frequent complex of torture and long-term sequels.

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14050 Berlin
Germany
Numerous patients at this therapeutic centre suffer from cognitive disorders (reduced information processing, impaired intellectual capability, lowered concentration, impairment of short-term memory as well as reduced response time, attentiveness and judgement). They also suffer from headache and sleep disorders after exposure to violent beating on their head with different frequency, pushing their head against walls and doors or after having been suddenly dropped onto stone flooring from suspended positions and with arms bound. Postconcussive syndrome (PCS) is assumed, according to the literature, in cases in which symptoms are protracted over years, as a result of brain contusion. The aetiology of PCS is controversial and under discussion.

I want to emphasize that in this past complex of complaints has too often been incorporated under the diagnostic pattern of post-traumatic stress syndrome, without sufficient effort to find out whether and to what extent brain injury due to violence should be considered.

**Approach**

We selected 20 male patients who contacted our centre in 1992 and 1993. They had suffered many blows to their freely movable head during imprisonment and torture. The number of blows was estimated by the patients at 10-100+, mostly while the patients were blindfold, i.e. they could not see so they could not evade the blows. Repeated episodes of unconsciousness were reported by all 20, lasting from 15 min to several hours. Clues as to retrograde amnesia were not obtainable, since in most cases torture was resumed after they woke up. The blows had produced variable numbers of head lacerations which we would diagnose with high probability as results of maltreatment. This was relatively easy when other traces of torture were present, e.g. skin scars, fractures of extremities, mutilations or damage of sense organs. Skull fractures were not reported. Imaging techniques did not provide any clue as to previous skull fractures. Violent interrogations had been continued for one week to two years. One to 13 years had elapsed from torture to first contact with our centre.

Some of the patients had been imprisoned for several years and had gone through periods of starvation or had participated in hunger strikes. All had been exposed to several forms of torture, one of which was blows to the head. No safe distinction was possible between contusion and hyperventilation as the cause of clouding of consciousness. Forced breathing from fear or during screaming was reported by all patients. Some of them had hyperventilated deliberately to resist demands for betrayal made on them by their torturers.

All the patients were examined for neurological changes, one or more EEGs being applied to each. They had to undergo a simple test for memory and concentration (Luria Memory Word Test, Rey Auditory Verbal Learning Test). Brain CT or MRI was used in some cases.

None of the examinations was conducted with this report in mind. All interviews and examinations were part of diagnostic procedures that would be used on any average health-insured patient in Germany.

There was no control group for reference, since we felt that it would not make sense to set up a group that was comparable for major parameters, such as origin, age or educational background. Foreigners living in Germany and coming from the same countries of origin as our patients would at least have in common with the latter the trauma of exile.

The patients' countries of origin, estimated numbers of blows to the head, some symptoms, and the estimated, memorised incidence of unconsciousness are listed in table 1, where + stands for presence of the symptom. Cognitive impairment is defined as protracted impairment of everyday life in exile, while cephalgia describes the occurrence of one or several attacks of pain per week, each lasting more than five hours. The heading sleep disorders refers to problems in falling and staying asleep, with an average sleeping time of 3-6 hours. All symptoms were spontaneously reported by the patients, i.e. without leading questions. Some symptoms had been present for more than five years.

**Table 1. Country, number of blows, and sequelae.**

<table>
<thead>
<tr>
<th>Patient country</th>
<th>Estimated blows to head</th>
<th>Cognitive impairment</th>
<th>Cephalgia</th>
<th>Sleep disorders</th>
<th>Unconsciousness (subj.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iran</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. ........................&gt;100</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>5</td>
</tr>
<tr>
<td>b. ........................&gt;100</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>7</td>
</tr>
<tr>
<td>c. ........................&gt;100</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>5</td>
</tr>
<tr>
<td>d. ........................30</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>2</td>
</tr>
<tr>
<td>e. ........................&gt;100</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>12</td>
</tr>
<tr>
<td>Ex-Yugoslavia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. ........................50-100</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>3</td>
</tr>
<tr>
<td>g. ........................30</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>3</td>
</tr>
<tr>
<td>h. ........................20-30</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>4</td>
</tr>
<tr>
<td>Syria</td>
<td></td>
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<tr>
<td>j. ........................&gt;100</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>2</td>
</tr>
<tr>
<td>k. ........................50-100</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>5</td>
</tr>
<tr>
<td>Lebanon</td>
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<tr>
<td>l. ........................50-100</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>2</td>
</tr>
<tr>
<td>m. ........................10</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>4</td>
</tr>
<tr>
<td>Kurdistan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n-p. ........................50-100</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>3-5</td>
</tr>
<tr>
<td>q-u. ........................&gt;100</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>2-8</td>
</tr>
</tbody>
</table>

+ = presence of the symptom.  

Table 2 shows the results of the neurological and neuropsychological examinations and special tests. Only one patient exhibited positive findings in response to all the diagnostic methods. While all the patients complained about similar symptoms, the diagnostic approaches were contradictory to each other from one examination to another. Hence, no absolutely reliable method can be given for detection of post-traumatic alterations in the brain of torture survivors.

Table 2 seems to support the assumption that imaging techniques cannot be regular diagnostic tools for our category of patients. The same view was expressed by specialists who stressed that brain contusions that had occurred in a somewhat remote past would rarely be detectable by means of CT or MRI. The positive CT findings reflected arachnoidal cysts in the temporoparietal region on the right side. An aneurysm was suspected in one case. MRI is supposed to be superior to CT for our patients, according to the literature. It is hoped that further improvement of MRI will make a major contribution to detection of glial scars in white matter.

EEG appears to be more suitable for the correct detection of diffuse disorders in cerebral function and circumscribed focal lesions, though repeated recordings are necessary for higher probability of diagnostic and prognostic information. Positive findings were recorded from some 60% of our pa-
tients. In 45%, the abnormal findings were localised in the temporal brain regions. Diffuse disorders of brain function with relatively good prognosis were present in 55%. Fair consistency may be claimed for our findings on the assumption that blows of rotational force are primarily capable of inflicting damage on the temporal areas of the brain. Concerning differential diagnosis, the EEG findings of the Zubek group have to be taken into account. They found the following, persisting changes in long-term experiments with patients who had undergone sensory deprivation:

1. increasing retardation of the alpha-band during the period of deprivation
2. increased theta-waves in the temporal areas.

Considering the fact that many of our patients during detention experienced sensory deprivation for months or sometimes years, it seems conceivable that the EEG changes we found were even more persistent than those found by Zubek et al. After an experimental deprivation period of two weeks, they still found the a.m. EEG-effects ten days later, while detecting at the same time motivation losses in the test persons. Biase and Zuckerman attributed the subsequent cortical deactivation to the concurrently measured increase of autonomic arousal.

To date, damage to the CNS after torture-related sensory deprivation has not been seriously researched.

**Discussion**

Many authors have suggested that the kinds of symptom discussed in this paper tend in most cases to recede after two years, as a result of treatment or spontaneously. Only few authors claim chronicity of PCS. The persistence of symptoms, however, has led to the assumption that chronic PCS cannot be ruled out in torture survivors who have suffered frequent blows to their head. It has to be admitted, on the other hand, that isolated consideration of only one injury can be problematic. Numerous torture survivors have been exposed to many different ways of abuse, including solitary confinement and associated permanent fear, electric current, and humiliating forms of punishment. For example, we have no detailed knowledge yet of electric torture and its impact on cerebral function. With regard to excessive blows to the head, we can think in one direction only, and this might lead us to a dead end.

A methodological problem is implied in the neuropsychological tests. Most of them are not available in the patients' native languages, or only in Roman characters, with which most of them are hardly familiar. That is why the strings of words according to Rey were used on some patients to delineate their memory and concentration disorders, while five words according to the Luria Memory Word Test were used on others (house, forest, cat, night, table). They were translated and, consequently, turned out to be a self-test for the attending medical doctor. These words were recalled after some time (delayed verbal recall) until they were flawlessly repeated twice by the proband. They were again recalled at the end of the therapeutic session for determination of the extended verbal recall. The results are merely of an orientating nature and must be evaluated with limitations. They cannot be rated as a high-accuracy neuropsychological test battery.

Development of PCS to chronicity is another problem of importance. Is it correct that people with such a syndrome find themselves entrapped in a lasting maelstrom of complaints, communicative disorders, and overwhelming desire to get better. We were rather under the impression that, for example, our Iranian patients after years of hardship in exile, reflected in social and familial tensions, were overcome by depression and resignation. Personal initiative and political commitment were waning, marriages broke up, and professional capability was lost. Self-image and world image were damaged. The conclusion might be drawn that PCS entailed not only protracted physical complaints but also chronic social and communicative disorders which could be offset over certain periods of time. The same view was expressed by Tomlin and Liberto, who developed rehabilitation programmes to cope with the above disorders.

Cognitive disorders that, according to our claims, result from blows to the head and have an intracerebral substrate not yet identifiable, lead to discouraging disorders in social and communicative contexts. They become visible and conspicuous in those contexts and make the patient seek treatment. These complaints continue to molest the sufferer, although several years have elapsed after the original trauma and although a neurotic development because of not getting better physically in exile is of low probability. The same complaints continue to act even on those who have long been recognised as applicants for political asylum. No matter whether a psychological background is predominantly assumed for such cognitive disorders or direct damage to the brain – it cannot be ruled out that neuronal degeneration and glial scars may have a detrimental impact also on the psychological processes in a torture survivor. This postulation at least calls for thorough questioning of the patients and detailed reconstruction of their torture experience. Nevertheless, it would be wrong to underestimate the consequences of blows to the head and simply to include subsequent symptoms in the diagnostic pattern of PTSD. Torture is a highly complex traumatic experience in which CNS-perceived pain is of cardinal importance. There is a growing number of scep-

<table>
<thead>
<tr>
<th>Patient</th>
<th>Neur. examin.</th>
<th>EEG</th>
<th>CT</th>
<th>MRI</th>
<th>Neuro-psychol. examin.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a...........</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>b...........</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>c...........</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>d...........</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>e...........</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>f...........</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>g...........</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>h...........</td>
<td>-</td>
<td>-</td>
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<td>-</td>
<td>-</td>
</tr>
<tr>
<td>j...........</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>k...........</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>l...........</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>m...........</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>n...........</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>o...........</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>p...........</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>q...........</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>r...........</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>s...........</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>t...........</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>u...........</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+</td>
</tr>
</tbody>
</table>

+ = positive finding.
- = no positive finding.
tics who rate PTSD as insufficient or irrelevant to torture survivors.

The following points may be made with reference to the findings so far obtained from research on minor head trauma and the consequences of boxing, taking into due consideration that these findings are still preliminary and thus of limited consistency:

- torture survivors who had suffered massive blows to the head all exhibit symptoms which tend towards chronicity
- the categories of DSM-III do not appear to be adequate for our patients
- there are diagnostic approaches towards a more accurate definition of PCS
- several methodological problems closely associated with ethical principles for treatment of extremely traumatised patients remain to be resolved. If torturing techniques were really capable of causing lasting damage to cerebral function, this would have an effect on the self-image and self-perception of torture survivors
- attending therapists would have to accept the insight that certain types of damage escaped therapeutic intervention and were to be tackled merely by alleviating strategies.

The author wishes to thank Dr. Frank De Beukelaer for evaluation of the EEG recordings, and Ms. Leyla Schön, librarian at the TCTVB, for her support.

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Torture in Bhutan

Krishna Adhikary, MBBS*

Torture has been used by governments throughout the history of man and Bhutan is not exempt to it. Many refugees, particularly those who were imprisoned or detained experienced torture. The number of people who experienced some sort of violence at the hands of the government forces amount to more than 2.5% of the total refugees in the camps.

The majority of torture survivors are between 15 to 45 years old. 24.6% of the total reported male victims were sent to jail later.

The most common forms of torture were beating and kicking. Severe beating was often inflicted at the time of arrest, in order to extract information or force the signing of a confession. Bamboo canes, wooden sticks, iron rods, electric wires, belts, whips, rifle butts, bayonets, roots of trees and thorn branches were usually used to beat the detainees. Exposure to extreme temperatures, cramped accommodation, and suspension were also common. Other forms of common torture: washing facilities, inadequate medical facilities, isolation and blindfolds. Most of the victims who were imprisoned were kept handcuffed with their hands tied with rope or shackled.

Females were very rarely (only 3.9% of total female victims) kept in jail. The most common and serious form of torture for female cases was rape. 53.4% of the total female cases registered reported to have been raped. The Bhutanese army were involved in 83.8% of the incidents. Many of the female victims of violence were beaten randomly, and pushed around when they protested against the arrest of their husbands and sons. Almost all of these incidents took place at home or outdoors.

Table 1. Year of torture incident.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Torture</td>
<td>3</td>
<td>178</td>
<td>170</td>
<td>74</td>
<td>16</td>
<td>9</td>
<td>450</td>
</tr>
<tr>
<td>Rape</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>47</td>
<td>96</td>
<td>57</td>
<td>23</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>225</td>
<td>266</td>
<td>131</td>
<td>39</td>
<td>21</td>
<td>685</td>
</tr>
</tbody>
</table>

Table 2. Description of Perpetrators.

<table>
<thead>
<tr>
<th>Perpetrator</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Army</td>
<td>385</td>
<td>11</td>
<td>396</td>
<td>88.0</td>
</tr>
<tr>
<td>Police</td>
<td>40</td>
<td>2</td>
<td>7</td>
<td>9.3</td>
</tr>
<tr>
<td>Local authority</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>1.6</td>
</tr>
<tr>
<td>Civilian drukpa</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0.7</td>
</tr>
<tr>
<td>Not specified</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>0.4</td>
</tr>
<tr>
<td>Total</td>
<td>433</td>
<td>17</td>
<td>408</td>
<td></td>
</tr>
</tbody>
</table>

Table 3. Methods of torture common in Bhutan (as studied in 95 men who were tortured).

<table>
<thead>
<tr>
<th>Torture method</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe beatings and kicking</td>
<td>95</td>
</tr>
<tr>
<td>Handcuffed or tied</td>
<td>78</td>
</tr>
<tr>
<td>Forced labour</td>
<td>52</td>
</tr>
<tr>
<td>Legs shackled</td>
<td>47</td>
</tr>
<tr>
<td>Solitary detention</td>
<td>44</td>
</tr>
<tr>
<td>Paraded naked in front of other prisoners</td>
<td>43</td>
</tr>
<tr>
<td>Exposure to extreme cold</td>
<td>38</td>
</tr>
<tr>
<td>Cramped confinement</td>
<td>37</td>
</tr>
<tr>
<td>Leg clamps</td>
<td>35</td>
</tr>
<tr>
<td>Forced to imitate animals</td>
<td>26</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>26</td>
</tr>
<tr>
<td>Upside down on head</td>
<td>15</td>
</tr>
<tr>
<td>Suspended upside down</td>
<td>14</td>
</tr>
<tr>
<td>Submersion in water</td>
<td>11</td>
</tr>
<tr>
<td>Needles/pins under fingernails</td>
<td>11</td>
</tr>
<tr>
<td>Beaten on genitals</td>
<td>10</td>
</tr>
<tr>
<td>Cut or slashed</td>
<td>9</td>
</tr>
<tr>
<td>Strangulation</td>
<td>6</td>
</tr>
<tr>
<td>Made to clean toilets with hands</td>
<td>6</td>
</tr>
<tr>
<td>Submersion in water</td>
<td>5</td>
</tr>
<tr>
<td>Needles/pins under fingernails</td>
<td>4</td>
</tr>
<tr>
<td>Beaten on genitals</td>
<td>3</td>
</tr>
<tr>
<td>Hair pulled out</td>
<td>3</td>
</tr>
<tr>
<td>Put in pit</td>
<td>2</td>
</tr>
<tr>
<td>Taking of blood</td>
<td>2</td>
</tr>
<tr>
<td>Forced signing of confession</td>
<td>90</td>
</tr>
</tbody>
</table>

Table 4. The most difficult torture experience by the victim.

<table>
<thead>
<tr>
<th>Torture Method</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beating</td>
<td>26%</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>20%</td>
</tr>
<tr>
<td>Leg clamps</td>
<td>8%</td>
</tr>
<tr>
<td>Being forced to defecate before others</td>
<td>8%</td>
</tr>
<tr>
<td>Witnessing friends deaths</td>
<td>6%</td>
</tr>
<tr>
<td>Others</td>
<td>32%</td>
</tr>
</tbody>
</table>

Torture survivors from Bhutan are being treated in refugee camps in Nepal.

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Centre for the Victims of Torture (CVICT)
P.O. Box 5839 Maharajgunj, Kathmandu
Nepal
While the medical treatment for torture began only 15 years ago, the psychological and social treatment of torture victims is even further behind in providing adequate answers to ways and means of identifying, understanding and coping with the torture victim. The problems of torture victims are often compounded further by becoming refugees in a strange land. The normal support systems which sustained them in their country of origin no longer exists. The family, in most instances, has been disrupted and broken through death, separation, loss and divorce.

The community support system developed by our project aims at meeting the needs of torture and rape on two fronts.

**Individually**
Helping the person to cope with immediate health needs, as well as activities of daily living, shelter, food and clothing. Efforts are made to keep them occupied in some form of income-generating activities, adult literacy, reading practices, in-door games, etc. and to help them establish a routine for daily life.

**At group level**
Formulating a group support system which provides the person with the needed social support and enables them to share their problems. It is expected that in such a supportive environment they will be able to face their tragic circumstances and find the courage to go on.

The above is an excerpt from the article *Community based rehabilitation program for torture survivors in the refugee camps in Nepal* which was first published in *Journal of Nepal Medical Association* 1995;33:47-52.

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We believe that the process of naturalization is the great bar­
idea that it is possible to work with other approaches to the
indisputable truth; we therefore go about the work together
means of a political-ethical intention, and not of a technical­
through dogmas and present themselves as the holders of the

A. Theoretical considerations
Since its very beginning, the Project raised many questions, such as: Is the work with persons who have experienced vi­
ence a speciality in itself? We have learned from the critics of specialities and of the scientific institutions, which operate
through dogmas and present themselves as the holders of the indisputable truth; we therefore go about the work together
with the patients. Among other things, we learned that they
are the ones who faced violence and survived it: they are
warriors of life for life, rather than victims.

The practises carried out by the group were based on the idea that it is possible to work with other approaches to the
problem, using the therapeutic process. This means:
1. Investigate through several areas of subjectivity the inter­
actions1,2 that constitute desirable methods. That is, how
the ways of perceiving, thinking, feeling, living, and acting
in the world are socially and historically moulded and,
therefore, subjected to changes.
2. Build up possible intentions, i.e. the construction of de­
vices and strategies capable of bringing back to the scene
other desirable investments and other forms of relation­
ships and practices. In this sense, to be together with and
side by side with the patients in this process would mean
to be in search of active and productive relationships,
shown by analysis of the implication and by the use of
analysers3, instead of being linked to intimate networks
that take us back to the world of intra- and interpersonal
psychological fantasies.

We believe that the process of naturalization is the great bar­
errier to personal and group openings. In our practise we try to
work with a different proposal, i.e. try to find possibilities of
becoming unique, non-naturalized. However, it is only by
means of a political-ethical intention, and not of a technical­
scientific neutrality, that it is possible, in our opinion, to in­
terrogate these productions of social opacity, active produc­
tions of invisibility that result in a hidden assumption. The
higher the rate of transversality, and the possibility of identi­
fying institutional flows – means of production – the more
possibilities arise.

During each stage of the work, although knowledge is
being presented, yet constructed fundamentally on the basis
of the actual therapeutic event, new possibilities arise and are
investigated.

B. Considerations about the practical implementation
Let us take the story of a patient who lived in secrecy, fleeing
from the bodies of repression, who lost contact with his work,
his friends, his cultural activities. When he was in prison he
was deprived of sleep and rest, food and water, and of contact
with his relatives and friends, whose own lives were threat­
ened. He was humiliated, totally isolated and had to live with
loud noises, light and threatening animals, “parrot perch”,
electric shocks to several parts of his body, exposure to heat
(thermal shocks), injections of ether, beating and blows with
blunt objects, suffocation, and drownings. As a consequence,
his suffered temporary loss of vision, fainted, his hands,
fingers and face were crushed and he suffered trauma to his
skull. While in prison, he was offered medical help, but it was
never provided. He was tortured while his temperature was
high due to malaria.

How to deal with such a patient, who after this whole story
of torture started to show signs of epilepsy with convulsive
crisis and fainting? He was given strong psychopharmacologi­
cal drugs and was put in a psychiatric hospital. How can he
live a productive life if anxiety and depression, as well as his
wish to die, seem to be his only way of expression? One who
does not get a job, who does not have friends anymore, who
moved away from his family, who has lost some of his pre­
vious political contacts with little chance of finding new ones.

Could we say that his death wish manifests itself in the
pulsation of death, in some kind of masochism, of an omni­
potent fantasy, an immersion in the narcissistic world caused
by the impossibility of experiencing the “lack”, refusing to
understand that desire is the desire’s desire?

For us, to learn and create other relationships and ways of
living with the patient has meant going through the interac­
tions that gave rise to his symptomatology, to ally ourselves to
his desires for self improvement, to neutralize some “deadly”
processes that were not his but were active when he was de­
prived of his citizenship, of medical care, of being a part of
the group and of his history. We try to add to the components
that build up willpower and the coming events that give the
desire to live. If we do not interact with the “specialties” and
do not get far from neutrality, we become involved with
Human Rights, with the ethics of full citizenship, and with a
policy that benefits everyone. With this patient we share the
activities, experiences, meetings and other events of the
GTNM/RJ. We try to work without any closed ideas. We
know that this is an unfinished process of working, that the
analysis of the inner factors is permanent, and that the pro­
cess of construction is actually life itself.
This approach calls into question the notion of victimology. We believe that the construction of a status of victim sets in motion a move towards a political weakness together with a network of changes of the social violence into individual problems that favour isolation, expressed in solitary silence. In this silence, the “mentally sick person” and the “subversive” usually develops a “lack of good sense” (the former) – paradigm established by the medical-psychological order – and a “lack of political grounds” (the latter) – paradigm established by a political-legal order. Moral treatment is given to both.

The construction of totalitarian systems develops from a close relationship between psychiatry/mind and torture, not close by accident but as part of a strategy. If the “mentally sick person” is under ordinary care and is presumed unable to cope with social life, the “subversive” calls for exceptional laws and is considered unable to understand the requests coming from the establishment. Anyhow, these “losers” are always the ones who do not obey or refuse to acknowledge the microscopic meanderings within the legal power.

An equivalent notion of life as an alternative to death is something to be questioned either by the survivors or by all of us. Our survival is threatened by violence turning life into a mere state of being alive. The fight for life, however, is something else and absolutely possible. It is just a matter of turning it into a powerful, pleasant, and creative life.

C. Basic procedures

The doctors and psychotherapists who participate in the Project’s assistance team use the following procedures:

- evaluation and discussion of new patients and of patients who are already being treated by the other therapists (in the fortnightly meetings)
- screening, through group discussions and through the patients’ follow-up cards, referring them to any further necessary treatment
- when a suspicion of clinical or psychiatric symptomatology arises, the patient is referred to the appropriate professionals
- psychiatric treatment is given by one of the mentioned doctors. After tests and/or evaluations, the most appropriate treatment is given
- patients with symptoms of clinical disease or who have suffered physical trauma are referred to the public health networks (those with which the Project’s assistance team keeps in touch) for diagnosis and specific medical orientation
- patients who have suffered physical trauma that requires physical rehabilitation are referred – after the necessary medical assistance and tests – to the support team’s body therapist or physiotherapist.

The doctors and psychotherapists who are part of the Project’s assistance team have grouped the clientele into two basic groups:

1. those who have suffered physical violence or torture during the most cruel and violent times of the military dictatorship, about 20 years ago. Sequelae are observed in this group that require medical/therapeutic action
2. more recent victims of institutionalized violence who are still in an acute state, thus needing medical/therapeutic intervention.

As to this second group, we like to add that institutionalized violence in our country has increased against organized workers fighting for their rights, including militants of left-wing political parties, union members involved in social movements, community leaders and participants in the sem-terra movement, black people, street kids, the shantytown inhabitants, and other minorities.

Table 1. Treatment activities.

<table>
<thead>
<tr>
<th>Description of the clientele</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals arrested for political reasons during the military dictatorship</td>
<td>7</td>
</tr>
<tr>
<td>Family of persons arrested during the military dictatorship</td>
<td>14</td>
</tr>
<tr>
<td>Family of missing and murdered persons</td>
<td>10</td>
</tr>
<tr>
<td>Current victims of institutionalized violence (former militants or their family at the time of the military dictatorship)</td>
<td>15</td>
</tr>
</tbody>
</table>

Support team

This team is composed of professionals with proven professional experience, referred to by the project's coordination who work for Human Rights organizations or are linked to social movements. They develop physical and social rehabilitation activities with any patient who might need them. Whenever necessary, those professionals attend the fortnightly meetings and are in permanent contact with the psychotherapist of the patient involved, with one of the Project’s assistance team, and with the other experts responsible for the patient's medical care, through the supporting team supervision meetings.

Physical rehabilitation

We consider that physical rehabilitation is part of the social rehabilitation, because the therapeutic actions with patients who present traumatic-orthopaedic lesions prevent or reduce...
the occurrence of several disabling sequelae (when applied early), cancel or reduce the degree of disability of the patients with physical deficits or trauma, and help to provide a quicker return to daily occupations, productive activities, and social life.

The professionals involved in this work have a global vision of the patient, not only of the affected segment(s). The physical rehabilitation process is thus a global process, an activity of functional integration by movement (kinesitherapy). Whenever necessary, conventional techniques are used as devices to attain the desired objectives.

Social rehabilitation
Social rehabilitation is necessary when the patient's contact with his/her environment is severely hindered due to serious psychological difficulties, e.g. serious phobia, psychotic crises, and depressive states resulting from physical or psychological violence.

In those cases, apart from the usual psychotherapeutic practices (individual, group, family therapy), social rehabilitation activities are included in the treatment as a means of following up the patient – both at home and in the streets – in his/her attempts to restore broken connections; acting as catalysts in the building processes of new devices and strategies that can bring other desirable investments into the scene: facilitating the patient's access to other people, places, or activities that can produce new resources for living; mapping, together with the patient, the activities capable of providing better possibilities of expression or fulfilment, or those that offer the greatest risks; providing interventions at moments in which action is interrupted when it would have to go on or goes on, and when the most prudent thing to do is to interrupt.

Thus, the social rehabilitation professional acts as a kind of actée interprète, directly operational and concrete in the patient's daily reality when a trip to a restaurant, a museum or a park can provide other possibilities of connection with the world.

The activities are developed at the patient's home, with him/her and his/her family, in walks through the city or nearby places, preferably outside the already known and crystallized places. That is how the professional tries to recompose the patient's world, taking him away from the repetition of crystallized places, whatever they might be; the house, known pathways, people, and other places outside the home.

The social rehabilitation work can make use of other resources (art workshops, for instance), since they are used as bridges, as devices that will help to provide more creative forms of life and action.

The rehabilitation work is systematically discussed among the agents involved in the process; the social rehabilitation professionals, the psychotherapists who assist the patient, and the psychiatrist who follows up the case, during meetings we call support team supervising meetings and during the fortnightly meetings.

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Please also see the centre presentation of the Grupo Tortura Nunca Mais/RJ on page 59.

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Grupo Tortura Nunca Mais/RJ in Brazil


The Grupo Tortura Nunca Mais/RJ (GTNM/RJ) was created in 1985 when the Brazilian political movements showed signs of weakness in exposing matters related to state terrorism, which spread throughout Brazil during the 1970s. The Law of Amnesty from 1979 was not broad or general enough, or without restrictions, as the social movements demanded. The Comités Brasileiros pela Anistia (Brazilian Committee for Amnesty) almost ceased to work even though the repressive apparatus was still present. Several torturers continued to hold, and are still holding, public posts; different forms of torture continued to be practised; paramilitary groups and death squads kept on acting with impunity. During the 1980s, however, people began to talk openly; their tongues were slowly loosened in a touching way after the difficult years. It is in this context that the GTNM/RJ was founded, initially in Rio de Janeiro and later in other states: Pernambuco, São Paulo, Minas Gerais, and Goiás.

In general terms, the GTNM/RJ has based its activities on the following points:

- investigation of the deaths and political disappearances that took place during the military dictatorship as a vital and efficient way of rescuing part of our history
- removal of torturers from public posts and punishment of those who in some way gave technical support to the system of repression: doctors and lawyers, for example
- continuation of the fight against impunity by reporting openly to society what the horrors of torture and any other form of violence meant and still mean.

The fact that those who, directly or indirectly, participated in the serial killings committed in the 1970s have not all been properly punished has, we believe, contributed crucially to present violations of Human Rights. Furthermore, the media’s massive lack of objectivity applauds and supports the exterminations and the lynchings, inducing different forms of violence and/or producing what we call “politics of indifference”.

Since 1990, the GTNM/RJ has been developing, among other activities, a pioneer project of Psychological, Medical, and Rehabilitation Support to the Victims of Torture. The project aims to contribute to the training of professionals who are interested in dealing with subjects such as torture, violence, and lack of respect for Human Rights.

As far as we know, no similar work is carried out in Brazil. This work is necessary and has priority for the GTNM/RJ because the violence of everyday life in Brazil is frightening and increasing and takes different shapes, causing violations of Human Rights. Daily reports contain new and convincing revelations about torture during the military dictatorship.

The headoffice of Grupo Tortura Nunca Mais/RJ is situated in Rio de Janeiro in Brazil.

The people for whom this work is meant are persons who have experienced violence, directly or indirectly, such as ex-political prisoners and their relatives, relatives of dead or missing politicians, people who have returned from exile, prisoners who were tortured for minor offences, relatives of those who were murdered by political or military violence, witnesses of murders who have been threatened, social minorities, victims of indiscriminate violence (social, racial, sexual), carriers of the HIV virus and relatives who are victims of discrimination within the health care system, etc. It is obvious that these people have suffered severe emotional damage as the result of compulsory marginalization.

These people have no means to pay for treatment, which can be obtained only in the private health care system. The increasing deterioration in public health care, the fact that it is placed too far away from the working population, the lack of priorities in the health care and educational systems, and the lack or deviation of funds, give a complete picture of the institutionalized violence. On the other hand, the context in which people are assisted makes us refer to the training of the professionals who are dissociated from socio-political reality and therefore incompetent as regards the theoretical and...
CENTRE PRESENTATIONS

ethical/political questioning of practices carried out from an individual/intimate/private perspective.

The GTNM/RJ, which carries out the project, is composed exclusively of volunteers and is partially sponsored by the United Nations. Unfortunately, these funds are inadequate to meet the needs, and it is therefore necessary to find other sources of support and financing to be able to continue and expand.

The GTNM/RJ identifies people who seek help through personal stories or from their relatives, and also based on evidence from other groups. These persons are helped by professionals who form part of the project: doctors, psychotherapists, psychiatric escorts, physical rehabilitation professionals, and others who participate in social movements in the field of Human Rights. They also attend the meetings of the GTNM/RJ and work together, continuously discussing their activities.

 Attendance is either individual or in groups. Since the beginning, the project has stressed the importance of group therapy with a clear understanding that it provides a privileged forum for analysing the production of subjectivity and interactions in the social field. Such an approach makes the task easier, intensifying the solidarity and the process of transformation.

CONFERENCE REPORTS

Report from the World Confederation for Physical Therapy’s Congress

The World Confederation for Physical Therapy (WCPT) arranges a World Congress every fourth year. This year the event, attended by 10,000 physiotherapists from 65 countries, took place from 25-30 June in Washington DC.

As a follow up from the WCPT Executive Committee’s visit to RCT in July 1994, and in cooperation with the Association of Danish Physiotherapists, a new motion to the existing guidelines for physiotherapists concerning torture and other cruel, inhuman and degrading treatment or punishment was proposed by the Association of Danish Physiotherapists at the delegate meeting and unanimously accepted by all member nations.

The new article 6 and the amended article 7 read as follows:

§ 6
The practising physiotherapist should have adequate knowledge of the general and specific neurological, musculoskeletal and psychological dysfunction which can be expected to appear as the effects of physical and psychological torture, as well as of appropriate functional assessment and treatment procedures for survivors of torture.

§ 7
Education regarding the prevention and prohibition of torture as well as the assessment and treatment of torture victims should be included in the curriculum for undergraduate and continuing physiotherapy education programmes.

Three contributions by physiotherapists at IRCT were presented:

1. Platform presentation: Falanga Torture – Sequelae, Examination and Treatment.
2. Poster Presentation: Examination and Treatment of Torture Survivors.

Each topic was followed by a round-table discussion.

Many physiotherapists attended the presentations. Most of them were astonished by the extent to which torture is practised in the world today, and by the magnitude of its physical and psychological sequelae.

There were many opportunities during the five days to spread awareness of this topic among physiotherapists who will meet torture survivors in their daily work.

The book “Physiotherapy for Torture Survivors – a Basic Introduction” was published for this event with support from WCPT and the Association of Danish Physiotherapists. It was distributed throughout the five-day congress.

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First course on health and human rights

Seventeen South African medical students visited detention centres, interviewed police detectives, spoke to torture survivors, and listened to doctors who fought against police torture as part of the first-ever course on health and human rights held at the University of Cape Town last April.

The week long seminar course was part of a fourth year elective for students wishing to learn more about the ethical challenges of the medical profession under apartheid and under the new democratic dispensation in South Africa. The course was organized by the Trauma Centre for Victims of Violence and Torture in Cape Town and sponsored by Warner-Lambert South Africa (Pty) Ltd.

Emphasis on experiential learning

This was no ordinary lecture theatre style course, however. In designing the course, the team consciously tried to steer away from didactic teaching methods and more towards experiential learning techniques – taking students to prisons to see conditions for themselves, letting them ask torture survivors about their experiences in custody, grappling with ethical dilemmas through case studies, and visiting other “total institutions” where the abuse of power takes place. Supporting these “experiential learning” activities were a course reader of selected literature, case studies, and human rights educational exercises.

The objectives of the course were:

1. To educate students about the wide range of roles that health professionals played as victims, as bystanders, and as perpetrators of human rights violations during the apartheid era.
2. To impart a working knowledge of international human rights protocols for medical professionals who may find themselves in conflict with the state in places such as prisons, jails, in the military, or in the police.
3. To expose students to potential conflicts between the state and health professionals in institutions such as hospitals, psychiatric facilities, prisons, and police stations.
4. To share alternative methods of managing survivors of human rights violations in community and non-governmental health care agencies such as the Trauma Centre for Victims of Violence and Torture.
5. To inform students about the international campaign by medical professionals against torture and other human rights violations.
6. To encourage South African medical schools and other training institutions to develop curricula around human rights issues.

The course opened on the first day with a panel discussion involving medical doctors who themselves had been imprisoned or tortured by the apartheid regime. The students were surprised to learn that health professionals had been tortured in the past. They were even more surprised to learn that they are now in positions of power in the new government – in the military, in the police force, in health agencies, and in Parliament itself! The interaction between torture survivors and the students was videotaped for future courses.

Doctors challenging torture

On the second day, the students met medical doctors who challenged their fellow professionals and state authorities about human rights violations in South Africa. Dr. Wendy Orr, for instance, told the students a riveting story about how she documented hundreds of cases of torture as a district surgeon in Port Elizabeth before she obtained a court interdict against the police, preventing them from assaulting detainees in 1985. Dr. Orr is one of the few doctors around the world who has successfully challenged the state on torture – and won.

Another champion of human rights in South Africa, Dr. Frances Ames, recounted how she applied pressure on the South African Medical and Dental Council in the early 1980s to suspend the three doctors involved in the torture and death of the political leader, Steve Biko. Dr. Ames also led the medico-legal investigation into the thallium poisoning of another prominent young activist from the Eastern Cape who later “disappeared”. Once again, the medical students did not know that there were role models like Dr. Orr and Dr. Ames who had successfully challenged the old regime on human rights violations.

Police stations and prison visits

On the third day, the students visited a police station and a prison where human rights violations continue to take place. By this stage of the course, the students had learned enough about detention facilities to begin asking critical questions: who monitors an interrogation session? why are the cells so poorly lit and ventilated? why are juveniles kept in a maximum security prison? who will hear the screams of the prisoner if abuse takes place? how accessible is health care to prisoners and detainees?

After touring the prison facilities, the students met some of South Africa’s top penal reformers – including Dr. T. S. Farisani, a torture survivor who is now a member of Parliament. Dr. Farisani sits on the select committee on correctional services as well as on the standing committee on health.

On the final day of the course, Professor Erik Holst, IRCT, shared his perspectives on the role of doctors in treating survivors of human rights violations at centres in more than 50 countries around the world.

The success of the course was evident in the enthusiasm of the students. But the significant index of success, according to Dr. Leslie London, one of the organisers, “will be the degree to which the medical profession is transformed, as students challenge their colleagues and their teachers to take ethical practice and human rights seriously. It is the start of a long road to creating a human rights culture in the institutions training our health professionals in South Africa.”

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LETTER TO THE EDITOR

Qual non fecerunt barbari - fecerunt Barbarini*

Valentina Pjeshkazini, Psychiatrist*

After 50 years of dictatorship, with total isolation from the civilized and democratic world, the Albanians are now free to talk.

During these 50 years organized violence was carried out in many ways to suppress the population. Everybody was scared of being spied on and of plots being made against them. If you expressed an opinion not fitting the rulers either in words or through art, you were arrested, subjected to harsh interrogation and torture, put into prison and/or moved away, perhaps together with your family, to an internment camp. Extermination was very often the end.

In Albania what foreign barbarians could not do, was done by some of our own citizens.

After the fall of the former regime thousands of survivors from the prisons and camps were released. However, these people and their families are suffering from social, economic, and health problems. They quickly formed the National Association for Ex-Political Prisoners, which actually and in a moral way supported the establishment of the Albanian Rehabilitation Center for Torture Victims (ARCT) in Tirana in the beginning of 1994, as a non governmental organization founded through IRCT.

The applicants for rehabilitation tell their traumatic experiences to the staff of the Center. The clients have been subjected to physical as well as psychological torture. Here are some examples: unsystematic beating, wounds scratched with a piece of wood, muscles pierced with a hot wire, fingers squeezed with pincers, flesh burnt with a cigar, heavy chains worn around the neck, electrical torture, deprivation of food and water for days, poor hygiene in every aspect, cold water poured over them in the winter, placed for hours in full sun in the summer, threats, witnessing torture of other prisoners or even the rape of daughters, humiliation techniques such as faeces put into the mouth, and finally mock-executions.

It was recognized at ARCT that survivors of torture and persecution are in need of a place where they can talk in a context of confidence about their traumas and express their feelings about them, and where they can receive special treatment.

Those who were tortured remember their traumas but are still waiting for the torturers to confess their crimes.

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PERSONAL COMMUNICATION

The psychiatrist as a political leader in war:

Does the medical profession have a monitoring role?

Derrick M. Silove, MBChB, Professor*

I knew that a psychiatrist could make an insane person rational ... now I understand that a psychiatrist can make sane people irrational – comment about the war leadership by a Bosnian patient recently released from a concentration camp.

The present conflict in Bosnia is not simply another war. Atrocities occur in most wars, but in Bosnia there are indications that a deliberate policy of "ethnic cleansing" has resulted in widespread human rights violations and atrocities. As a psychiatrist specializing in the treatment of torture and trauma survivors settling in Australia, I have yet to be confronted with a more traumatized and psychiatrically disturbed group than those refugees escaping from Bosnia. Whether the atrocities committed against these people have been motivated mainly by the resurfacing of old ethnic rivalries, by expansionist ideologies, or by religious differences, remains contentious. At an international level however, it is essential that questions be asked about the culpability of the...
leadership who appear to be propagating or condoning a policy of “ethnic cleansing” in order to propel the hostilities forward. The composition of that leadership poses a new, and as yet unexamined quandary for world psychiatry: what should the profession’s response be when a psychiatrist assumes a leadership role in a conflict which appears to foster not only torture and other human rights abuses, but even genocidal policies?

In recent decades, the medical profession has at last grasped the nettle by confronting the widespread problem of medical involvement in torture and other political abuses. In the main, the opprobrium of the medical profession has been directed at physicians who have transgressed in their activities qua doctors, that is, for committing sins of omission or commission when operating explicitly from within their professional roles. In censoring such practitioners, professional colleagues have been able to draw, at least broadly, on the heritage of ethical principles underpinning acceptable medical practice. Within this context, psychiatrists have come under criticism for using their specialist knowledge to support or condone the persecution of healthy citizens for political or ideological reasons – for example, in Nazi Germany and in the former Soviet Union. Explanations offered by transgressors have been various – they had no choice, the victims would have suffered more had the doctors not been present, or the psychiatrists were simply performing their duties according to the tenets and dictates of their profession, at least within the social, political and professional context in which they worked.

A more complex question – and one which has not attracted much debate – is whether the psychiatrist who elects to participate directly in the political process remains subject to the ethical constraints of his or her avowed profession as a physician. This question is particularly relevant at present in view of the contemporary conflict unfolding in the former Yugoslavia where one of the war leaders previously was a practising psychiatrist.

The participation in politics by psychiatrists is not a new phenomenon. Notable psychiatrists have led dual psychiatric and political careers in the past – Benjamin Rush pursued an illustrious political and psychiatric career, making outstanding contributions in both arenas. Franz Fanon’s polemics against colonialism drew freely on his knowledge and experience as a psychiatrist as well as on revolutionary political theory. Fanon clearly believed that his encouragement of the oppressed to achieve psychological liberation through the armed struggle was a legitimate endeavour consistent with his mission as a psychiatrist.

The question, however, is whether the psychiatrist who takes up a leadership role in war should remain subject to the censure of his/her erstwhile professional peers – particularly if the behaviour of the neophyte politician conflicts with the stated mission of psychiatry as a medical and humanitarian profession. Alternatively, should such a psychiatrist be expected to renounce publicly any affiliation with his former profession, actively eschew the title of “doctor”, and state explicitly that henceforth he is operating according to the rules of war rather than being constrained by the ethical principles underpinning psychiatric practice?

The above considerations may be of little import where psychiatrists enter into the political arena in peaceful, democratic societies. The situation becomes much more grave when a psychiatrist assumes a position of supreme authority in times of social chaos and war, particularly when, as presently the case in Bosnia, allegations of gross atrocities are being made against the combatants on both sides. The extent to which such atrocities can be directly attributed to the leadership in conditions of war remains a vexed issue. For example, will it ever be possible to confirm allegations that the widespread rape of women in the current Bosnian conflict reflects a deliberate policy – propagated by the leadership – to demoralize the opposition by transgressing one of the most sanctified taboos of the opposing ethnic group? The Nuremburg trials, and their aftermath of controversy, indicate how difficult it is to establish individual culpability for such mass crimes against humanity. The difficulty becomes greater where ambiguities exist about the frame of reference which should be used in prosecuting possible transgressors. If a doctor and indeed a psychiatrist is in a position of supreme political leadership, should he/she be judged according to the code of ethics of the medical and psychiatric professions or according to the international conventions of war – or both?

If such a leader is to be judged according to the contemporary principle and knowledge base of psychiatry, then it is clear that no psychiatrist in the present epoch can claim to be ignorant of the egregious psychiatric consequences of genocidal policies, torture, concentration camp experiences, and the mass sexual abuse of women – human rights violations which have marked the recent conflict in Bosnia. Prohibitions against psychiatrists participating in, or condoning torture are explicitly adumbrated in international instruments such as the Declaration of Hawaii (1977) and the Tokyo Convention of the World Psychiatric Association. The immediate and long-term psychological damage caused by the exposure of mass populations to “organized violence” is now very widely documented. Apart from the psychological disabilities caused by combat, there is every reason to fear that the widespread violation of human rights in the former Yugoslavia will result in a psychiatric disaster of major proportions – one which will create such widespread morbidity and disability that the impact can be expected to reverberate for generations through the affected communities.

The Nazi psychiatrists stood accused of sheltering under the respected mantle of medicine in fostering the genocidal policies pursued by their political masters. Are we now facing the converse: doctors who use the mantle of ideology and war to shelter from the ethical prohibitions of their profession? Can psychiatrists legitimately abrogate their professional responsibilities once they plunge into the arena of politics and war? What should be the response of the psychiatric profession when confronted with a colleague undertaking a leadership role in a war in which human rights violations are rampant? The aim of this commentary is to stimulate debate rather than to provide answers to a question which, to date, appears to have elicited only silence from the psychiatric and wider medical communities.

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PERSONAL COMMUNICATION

TORTURE Volume 5, Number 3 1995
PERSONAL COMMUNICATION


BOOK REVIEWS

The echo of the 2 o’clock knock on the door


The military dictatorships in Latin America conducted brutal total-war policies against their own populations. The aim of this state terrorism was not only to combat opposition but even more to prevent it; to subjugate the population. Disappearances, systematic torture, and control of the mass media were the means: to scare, terrorize, and paralyze the population, the intention. People were shattered and fell back in a defensive regression. Political repression became a part of the psychic structure, and as such it influenced mental well-being, behaviour, communication, and social relations. The aftereffects can still be seen and felt. The book convincingly shows how this process operates, using psychoanalysis as its explanatory base.

Terror manipulates society. The fear that is spread is an effective coercive force. It penetrates into almost all aspects of daily life. The masses are afraid and silenced, and out of powerlessness they adapt themselves. This causes guilt, fear, and shame: "... the most intolerable shame is the fact of having adapted to the inhuman situation." (p.27) "It’s the horror of the idea of having implicitly accepted the terror that hurts most. It’s like being an accessory.”

Especially deep-rooted are the social and psychological consequences of disappearances. Losing a loved one is terrible, but in this case of uncertainty, the process of grief is jeopardized as well. Not knowing for certain that the person is dead, starting to accept his/her loss is like declaring him/her dead. Endless waiting and trying to keep up hope, however, are devastating too. "It’s almost like having to decide yourself about the fate of your son,” one mother once said. As a consequence, people suffer not just the loss and pain, but a feeling of guilt and shame as well. Psychosis-producing mechanisms are deliberately generated with devastating results.

The same is true for sexual torture. Cultural sensitivities are deliberately violated: methods are specially designed to make the victim feel ashamed and guilty and not, as would be fairer and more appropriate, angry and hurt. An inappropriate but deliberately implanted and devastating self-condemnation is the result. The horror and terror last long after the actual crime is committed. Basic trust in the world, people, and oneself are destroyed fundamentally. The torturer is within.

These are just a few examples of many that are to be seen as symbolic of what happens to the victim and the victimized society alike. It paints the picture of what happened to Latin America under the iron grip of the infamous generals. Too little attention, however, is given to the recovery phase. For instance, the difficulties endangering and possible jeopardizing the democratization process, such as the psychosocial consequences of the impunity of the perpetrators. What does it mean to the population, the relatives of the tortured, dead, and disappeared, to know that their tormentors are ‘still at large’? How convincing does an outcry such as “nunca mas” sound under these conditions?

On the whole the book leaves more questions open than it answers. It does not keep the promise it seemed to make. This applies especially to the promising title of part two, which is supposed to deal with the “oppositional culture”. There are a few good and interesting articles, but only one or two really touch upon this subject. Most merely discuss the consequences of state terrorism. The book does, however, arouse interest, and if that is its true aim, as stated on the back cover, it succeeds. It gives hints of unmasking the successful methods of subjugating minds and as such has effectively shown how in South America “the struggle for human rights is fundamentally a struggle for psychological health” (p. 11). The book makes this perfectly clear and is therefore undoubtedly worth reading.

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Evidence of torture in Nepal


Ten years ago the only thing I knew about Nepal was that it was the country the “flower children” were dreaming of, the country of high mountains where, as on our Mount Olympus, only gods can live.

My meeting and acquaintance with Bhogendra Sharma was the beginning of a slit in the curtain, the start of replacement of imagination by the tough reality that took its place. Then this book, which describes the current situation in Nepal, made me feel that the distance between our two countries, Greece and Nepal, was only geographical.

It may seem strange, but the two peoples have shared an experience in common—in prisons, in places of exile, edible vegetables spotted with “meat” (worms), falanga, torture because of refusal to sign a statement, impunity for the torturers, common problems of the transition period from dictatorship to democracy.

I would like to dwell a little more on this period because of the common characteristics I have met in both Chile and Argentina after the dictatorships, characteristics that were also prevalent in my country twenty years ago.

After a dictatorship that was abolished not only because of a massive opposition movement, but also because of its own failure, transformations are carried out only gradually. Moreover, the structures of army and police are not interfered with because their cooperation is necessary for the unobstructed election process (Mallik Commission Report, N 3, p. 47). The same happened in Chile, where Pinochet still commands the army). The situation is similar in my country where, for reasons of internal security, dictatorship was deemed a “momentary crime”. Apart from the main military actors and a few torturers who were brought to trial, the issue for the rest was regarded as completed as far as legal action was concerned.

An aftermath of this hasty conclusion regarding the punishment of those guilty of loss of life during the transition to democracy, as in the case of Nepal, is that “catharsis” is not fulfilled and the tragedy goes on.

Thus, torture still continues in the police stations. It concerns penal detainees as well as people accused of anti-government activities. The justification is that “torture was a necessary step to find out the truth” (p. 9).

Certainly nowadays “they are very careful to avoid making obvious wounds or scratches” (P. 27) because the International Convention on the Abolition of Torture has been ratified by Nepal. Nevertheless, the margins for abuse are amplified as far as police stations are concerned, because they function as autonomous units over which it is not possible to exercise control (p. 6), partly due to lack of transport and telephone communication.

The work of the Centre for the Victims of Torture is thus valuable as far as the evidence of torture is concerned. In addition, public opinion provides information that torture is indeed still taking place.

Considering that the Ilam case took place in 1992, i.e. during a period of democracy, the matter of signing the supplementary protocol of the International Convention concerning “visits on the spot” is made more urgent. In addition to the above, the purchase of materials such as chains, handcuffs and other tools of torture, moreover by an official order placed by a minister, a fact that was also published in the press, displays the extent to which public opinion is ignored.

In the case of the Manikala Rai rape in December 1992, it is reported that “she was physically and mentally abused by policemen and policewomen...” (p. 23). If the policewomen did participate in torture and abusive processes, I have to point out that this constitutes one of the rare cases in which women are involved in such proceedings. Such participation by women was reported in Nazi Germany and in certain African countries. Victims of rape are widely dispersed, but women torturers are not so well known.

Chapter 4, which describes the campaign against torture, and chapter 5, which gives recommendations, are rich in similar reports of practices.

In conclusion, I found this book about torture in Nepal of great value, both for the well-documented facts that it presents and for the historical, social, political, and cultural elements that enable the reader to make references and come to conclusions that make Nepal “our next-door”.

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Please turn to page 66 for cases from Indelible scars: a study of torture in Nepal.

German language edition of Medicine betrayed


TORTURE wants to bring your attention to the German language edition of the BMA’s Medicine betrayed, first published 1992 (Zed Books). The Behandlungszentrum für Folteropfer Berlin stands behind this very notable initiative, with support also from the Berliner Ärztekammer and Amnesty International. The important issue of medical ethics in the face of torture and other human rights violations will now reach an even wider audience – another real step forward.

(See also the review of Medicine betrayed by V. Lök in TORTURE 1993 (3), which suggests that translations should be facilitated by all medical associations).
Documented cases of police torture


**Baglung District (January 1992)**

On the night of January 15, 1992, police inspector Gyaneshwor Vaidya was murdered in the town of Jaiminighat, Baglung District (West Nepal). Vaidya was off duty and eating in a restaurant when a fight broke out nearby. In the altercation that followed, he was stabbed in the back. Police officers arrived too late to identify his assailant. A curfew was imposed in the area and more than 500 persons arrested. Most of them were released after an initial inquiry; however they were all beaten severely. Of the ten who remained in custody, one was released on bail after a few days.

A month later, a fact finding team interviewed and photographed the nine detainees at the district jail.

All of them reported being kicked and beaten all over the body during detention in the police barracks. Ram Poudel, Dal Bahadur and Bhim Bahadur were hung upside down with their legs tied together on bamboo poles. The police made a torch with pieces of cloth on a pole dipped in kerosene, and set fire to their legs. Their nails were also pierced with pins. When Ram Poudel asked for water, two policemen urinated into his mouth instead. At the time of the fact finding team’s visit, they were unable to walk.

The nine detainees were kept in police custody for periods ranging from 10-36 days without charge. ( ... )

Ravi Chandra Basnet, the District Superintendent of Police, did not deny that these detainees were tortured in police custody. Police Inspector Prem Chand even went as far as to say that “torture was a necessary step to find out the truth.”

All those who were tortured were affiliated with opposition parties. After interviews with eyewitnesses and other locals, the investigation team concluded that the detainees were tortured for their political beliefs, and that both their arrest and torture were obvious acts of political intimidation.

**Gorkha District (October 1992)**

Police arrested Purna Bahadur Biswakarma and Bhim Bahadur Gurung in connection with a theft at Tej Bahadur Gurung’s house in the village of Thalajung on October 30, 1992. During the next few days, four others—Surya Bahadur Rana, Dewan Singh Gurung, Pratap Sunwar and Sanumaya Biswakarma (wife of Purna Bahadur) were also arrested. They were kept in custody for periods ranging from 7 to 24 days. None were issued arrest warrants.

A fact finding mission conducted interviews with the arrested persons, witnesses and local authorities and concluded that all six were severely tortured in police custody.

**Surya Bahadur Rana, 23, male**

Rana was arrested on November 3 from his shop in Gorkha Bazaar. At the police station, the policemen beat his ankles with a rough stick. He was forced to squat in the *kukhura* position and hit on the soles of his feet. Policemen ordered him to jump up and down continuously. This was repeated several times during his 22 days detention.

Rana was also forced to lie prone on the floor while two policemen walked on top of him. On another occasion his hands were spread flat on the ground and a stick placed over them. The police then tread on the stick. He was also repeatedly punched, beaten and kicked on the abdomen, arms, thighs, ankles and back.

**Children**

The presence of “street children” is a relatively new phenomenon in Nepal. Children in Nepal end up on the street for various reasons: some because they suffer mental or physical cruelty at home or abuse by step-parents. Others simply want to escape the toil and hardships of village life.

Usually the children come from villages to bigger cities or towns like Kathmandu, seeking work. As urban areas are often usually unsafe, the children face many problems. They face violence of fighting other gangs of street children on the one hand, and intimidation by police on the other. These children are usually the first suspects in theft or burglary cases. As a result they are often arrested and tortured by the police on the pretext of conducting an investigation.

The following cases are typical examples.

Arun Ghimire and Raju Tamang are two children who live on the streets of Kathmandu and are known as “rag-pickers” as they earn a meagre existence picking through garbage heaps. Arun left his home two years ago when he was just 11 years old after suffering repeated physical abuse from his aunt who had taken care of him since his mother’s death.

On 29 July 1993, Arun and Raju were collecting plastic and other waste materials from the garbage heap at Kalankishan when a group of local people who suspected them of theft caught them, tore off all their clothes and proceeded to beat them up. They then took them to the Kalimati Police Station where they were accused of theft.
TORTURE WORLDWIDE

The policemen beat them with whips, sticks and boots. Their heads were rammed together until they bled. At midnight they were taken out of the detention area and threatened at gunpoint by the police. They were beaten until the next morning. Arun fell ill and nearly collapsed on the third day due to exhaustion. Both children were denied food for these three days. As these two children had run away from their families, no inquiries were made as to their whereabouts. The police did not issue an arrest warrant, nor were they taken to the court for due process of law. Arun was finally released from custody when he became seriously ill.

It is estimated that there are about fifteen hundred street children in Kathmandu alone.

NEWS IN BRIEF

Executive Director of HURIDOCS

The Continuation Committee of HURIDOCS has appointed Mr. Manuel Guzman of the Philippines as executive director.

Manuel Guzman formerly of the Task Force Detainees of the Philippines comes to the job with the requisite educational qualifications and a solid background in NGO work, particularly in Asia. Until his appointment, he was a member of the Continuation Committee of HURIDOCS. He is also a Consultant to FORUM-ASIA and the Philippines Human Rights Information Centre. He co-authored (with D.J. Ravindran and Babes Ignacio) the very useful Handbook on Factfinding and Documentation of Human Rights Violations.

Manuel Guzman started with his functions as Executive Director of HURIDOCS as of 17 August 1995.

New General Secretary for APT

The Association for the Prevention of Torture (APT), created in 1977 by the late Jean Jacques Gaultier under the name of Swiss Committee against Torture, has informed that its Secretary General, Mr. Francis de Vargas, will leave his post as of 31 August 1995, after a commitment of over 18 years in its service.

Mr. Francis de Vargas will be replaced by Ms. Claudine Haenni, who will take office as Secretary General and will officially represent the APT from 1 September 1995.

Borderline towns project for training and public awareness

In view of the fact that Greece has borders with countries that either "produce" refugees or provide transit routes for them, the MRCT considers it very essential to increase awareness in the local communities near our external borders, for the protection of the refugees and even more for the recognition of torture victims and provision of help to them.

The criteria to set up the project and select the towns where it should be carried out were:

1. Proximity to the border area where refugees come in (north and east).
2. Existence of large hospital units and a large number of medical professionals.
4. The possibility of collaboration with the local administration and the professional organization (Medical Association and BAR Association).

The programme started in November 1994 with a two-day seminar in Ioannina, the capital of NW Greece, where large numbers of Albanian citizens seek medical assistance and treatment from the two large hospitals (State and University Hospitals).

The seminar, which was organized with the collaboration of the municipal authorities, the BAR and the medical associations, and the local Amnesty International group, was very successful and resulted in the establishment of a rehabilitation centre that is already in operation. The medical director is Dr. Nikos Bilanakis, psychiatrist, and its address is: 14 Korai Street, 454 44 Ioannina, tel.: 0651-78810, fax: 0651-72378.

We were honoured by and had the pleasure of the presence of Professor Ole Espersen, who inaugurated the seminar and gave his prestige to it. The event attracted considerable media attention and was attended by the local authorities, deputies, etc.

The second seminar took place in Alexandroupolis, near the border with Turkey, on 2-3 June 1995. Again we had the collaboration of the local authorities and large coverage by the media. The seminar was attended by a large group of physicians and psychiatrists who were working in the area.

The third seminar is scheduled to take place in Thessaloniki from 1-3 December 1995 in collaboration with the University of Thessaloniki, sector of psychology, under the presidency of Pr. Mika Haritos-Fatourou, well known for her work on Torture and the Torturers. The organizing committee is now finalizing the programme, which will be sent to the magazine TORTURE in due course.

All the above activities of our centre are connected with the activity of the Balkan Network, and this will be the specific character given to the Thessaloniki seminar. Representatives of centres and of groups in the other Balkan countries will be invited to participate and speak about their work and experiences.

Medical Rehabilitation Center for Torture Victims, MRCT Athens

Greece
FORTHCOMING CONFERENCES AND SEMINARS

Jerusalem, Israel
9-14 June, 1996

Second World Conference of the International Society for Traumatic Stress Studies

Further information:
Second World Conference of ISTSS
Peitours-Te'um Congress Organisers
POB 83880
Jerusalem 91082
Israel
Tel: +972 2 617402
Fax: +972 2 637572

Sheffield, United Kingdom
17-20 March 1996

European Conference on Traumatic Stress in Emergency Services, Peacekeeping Operations and Humanitarian Aid Organisations

Further information:
Emergency Planning Department
Trent Regional Health Authority
Fulwood House
Old Fulwood Road
Sheffield S10 3TH
United Kingdom
Tel: +44 0114 263 0300
Fax: +44 0114 230 9439

Utrecht, the Netherlands
12-14 October 1995

European consultation on medical ethical standards in mental health care for refugees and displaced persons

Aim of the meeting: to draw conclusions and formulate recommendations directed at policy makers, researchers and (mental) health care workers concerning medical ethical standards in research and (mental) health care for victims of organized violence, refugees and displaced persons, based on documentation, studies and experiences.

Further information:
PHAROS
Hoofdvestiging
Herenstraat 35
Postbus 13318
3507 LH Utrecht
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Fax: +30 364 560

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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.