TOWARDS A NEW STRUCTURE

In a New Year's statement, during an interview with the Danish press, Inge Genefke dealt with the tasks of the coming years: "We have been too reticent in putting pressure on governments and organizations in the rich part of the world, apart from Denmark, in order to make them support the creation and running of treatment centres for torture victims in developing countries. In this field Denmark has so far been the main sponsor. There is a crying need for more centres."

This statement is based on the experiences of RCT/IRCT and the realization of rather more than one hundred rehabilitation centres for torture victims around the world. The background for the statement, however, was the need for economic expansion caused by this increasing number of centres, and the need for renegotiation at the end of 1996 of an economic guarantee from the Danish State to last for several years. The capacity of RCT and IRCT was analysed during 1996 with the aim of clarifying the possibilities of obtaining of framework agreement over several years with the Danish Ministry of Foreign Affairs. The analysis concluded that RCT/IRCT was carrying out important and necessary work internationally by its efforts in calling more attention to the fight against torture, and by taking international initiatives for the treatment of torture victims. But the analysis was critical of the unclear definition of the mandates of RCT/IRCT. Furthermore, it characterized the organization as a typical "first generation organization", with the usual attendant weaknesses. The analysis also focused on the strength of the organization, especially in playing a well-developed and effective "advocacy" role at the UN, in the EU, and with the general public, and for having an efficient documentation function.

In taking note of the criticism, RCT has prepared itself for a new structure, including new rules; similar work is in progress for IRCT. According to the new structure, RCT will still be involved in the treatment of torture victims as part of clinical methodology and development of methods. Other functions will include training, project management, finance, and other common functions. IRCT will also be restructured. It will be responsible for documentation, information, and publication as well as for a newly established department for development and coordination of new projects with respect to bilateral support. An important task for the IRCT will be to increase the multilateral resources, mainly from the EU and the UN. IRCT’s council will be strengthened, especially in the regional functions. The restructuring will involve changes in the management. Thus, Inge Genefke, RCT’s Medical Director, will leave her post to become Secretary General of IRCT. An essential function of the restructured IRCT will be advocacy for provision of resources for torture victims and for the prevention of torture. Other advocacy tasks include:

- To advocate for the establishment and maintenance of rehabilitation services
- To advocate for the education and training of health professionals and other relevant professions in medical, social, legal and ethical aspects of torture
- To advocate for research in all aspects of torture
- To advocate for the continued development of documentation activities

and in more general terms

- To advocate for the prevention of torture.

This latter objective may lead to a reduction in the practise of torture, and to political and financial support for communication and information activities by development organizations in donor countries. It may also increase the attention and acknowledgement from the mass media at a political level, among the general public, and among professional groups.

Advocacy can be seen as acts of communication with the purpose of persuading target groups to take certain actions. This persuasion implies that the target group acknowledges the message in the sense of taking appropriate actions to support it. In broad terms, the tools for advocacy can be summarized as documentation, communication, and information.

H.M.
Torture survivors in the long term after liberation

Donald Skinner, Senior Researcher*


Introduction
It is still a relatively short time since South Africa had its first democratic elections on 27 April 1994, but it is important already to begin thinking about the long term effects of apartheid and political repression, especially in a changed situation. For many it is in any event a long period since the torture actually occurred and they were released from prison or detention.

The issues of stress and trauma leading to mental health problems with a particular focus on the post traumatic stress disorder (PTSD) are well known. What this paper attempts to unravel is the long term effects of this torture and detention and how the manifestations of the problems change over time.

This paper is too short to provide a full systematic analysis so it will rather try to draw out some key issues. Presentations of symptoms will also not be reported because this is not useful for the present. Rather, some key trends will be addressed. Much of what will be presented is in the form of ideas and hypotheses. These need to be tested by further research and comparison with clinical data. It is hoped that this will form part of ongoing work on the long term effects of human rights abuses, including cross generation effects.

Sources of information/methods
The information is drawn from a much larger research project of a needs assessment carried out for the Trauma Centre. The particular data that will be used are 35 depth interviews conducted with ex-detainees and ex-political prisoners. Material from a survey questionnaire done with 23 ex-political prisoners will also be called on when appropriate.

Results
Torture occurs at the same time as detention and imprisonment, so this is a combined trauma. It is also not possible totally to separate out the effects of this from other trauma, such as being on the run, harassment, the witnessing and taking part in violence and socioeconomic conditions. Data from the survey indicate the type of other trauma that the respondents will have faced. Table 1 shows how many of the 23 survey respondents claimed to have experienced the named traumas at least once.

Due to the influence of apartheid on the nature of South African society, the level of the severity of the trauma and level of poverty have been found to follow the racial categorisation.

Current context of person
The context in which the detainee finds him or herself has a significant effect on the long term problems. This differs in terms of three major areas. Those who have done better materially since liberation have a significantly better mental health. They are more in control and there is a sense of concrete results coming from the political victory.

Employment plays a similar role, as well as the fact that the work itself provides meaning.

There are far greater resources in the urban areas that in the long term will allow those people some chances and space for healing. The general difficulty of life in the rural areas makes dealing with these effects more difficult and the problems more complex.

Time as a healing process
Time facilitates healing. The mind, like the body, has certain self-healing capacities. The effectiveness of these depend on a range of issues. Some of the key points are listed below.

The severity of the original trauma will obviously have an effect. The more severe the original trauma the more difficult it will be for the person to achieve healing.

As indicated above, all the detainees have had other traumatic experiences. These will reactivate the original trauma, particularly if that earlier trauma was not adequately dealt with. These will also interact with the earlier problems to make the resultant picture more complex.

Many people may have had healing experiences that will reduce the negative effects of trauma. The victory in attaining some level of democracy will be one such experience. Others may include a well functioning family life or a positive encounter with the previous perpetrators.

Material wellbeing, as stated before, is very important for the person's sense of coping. If the persons are poor then they will not have the energy to deal with the problems resulting from the trauma.

A high level of support has regularly been found to play a healing role for people who have suffered trauma. It is important that this support is unconditional and does not leave the person feeling entrapped again.
Having a better education often allowed the person to attach meaning to the events that happened, which in itself is a protection factor. Having a leadership position will provide protection for a similar reason.

Silences
There are significant areas over which the respondents were silent or gave very little information. These silences make detailed assessments difficult, but are in themselves important to consider because they make it more difficult for the person to reach out for help. A number of potential reasons for the silences need to be considered.

No problems
This may be genuine. In many cases there may be no problems, or they are insignificant.

Denial of problems
This involves the person using the defence of the denial to keep out of consciousness any acknowledgement of the problems that they are experiencing, and especially denying any link between the trauma and the problem. This is a potentially dangerous situation for those persons and others close to them. The nature of the problems is such that they are likely to keep appearing in different forms to disrupt the person's life.

Do not see problems
In this case the problems are acknowledged at a conscious level, but perception of their severity has reduced over time so that they are seen as having got better in relation to their acute manifestation. It could also be that the persons think that the problem is not something that interferes in their own or other people's lives.

Unwilling to talk about problems to the researchers
This partly deals with the issue of private knowledge and who the person is prepared to share information with. There are likely to be different pieces of information that the person is prepared to share with different people. There will also be some information that the survivor is not prepared to share with anybody.

This inhibition may be due to a number of factors:

THIS SILENCE CAN BE DUE TO SELF PROTECTION
The person does no wish to revisit the trauma and the anxiety associated with it. The humiliation is also terrifying to revisit.

A SENSE THAT ONLY THE WEAK SEEK HELP
This desire always to be portrayed as strong can be ascribed partly to a macho type culture. However there is also the "strong women in Africa" slogan which limits some women from seeking help.

A SENSE OF ISOLATION IN THE TRAUMATIC EFFECTS
This is also a secondary effect of the silence. There is a need to get the effects of detention and torture normalised as same responses to an insane practice. Many victims are still sitting alone with their problems.

A SENSE OF THE VICTORY BEING REDUCED IF ANY DAMAGE IS ACKNOWLEDGED
Victory does still feel a little precarious, especially with so many of the previous regime around. So there is a sense that the victor should stand strong and tall and not allow any weakness to show, of which advantage may be taken.

FEAR OF DOING DAMAGE TO OTHERS
The level of trauma was so severe, and the barbarity of the treatment that was meted out in the torture chambers was so severe that the person feels that by telling others those people will also be damaged.

Problems may not be due to torture and discrimination
There is a considerable interaction between the effects of the original trauma and other trauma that may have occurred in the intervening periods. It is difficult for both the survivors and those around them to differentiate in terms of effects.

This silence may be broken by the Truth and Reconciliation Commission. A great deal of importance is attached to this commission to start a process of opening up and healing. The Truth and Reconciliation Commission is an independent, but state nominated commission charged with the authority of investigating the history of human rights abuses in South Africa. The aims are to document this history for the nation as a whole, to suggest legislation that may prevent these abuses from ever occurring again, to provide some rehabilitation and reparation to victims and to facilitate the granting of amnesty for the perpetrators within some clear parameters. The Truth and Reconciliation Commission as a whole is seen as facilitating healing broadly within the country.

Loss of time/youth/career development
Loss due to the struggle was experienced by many due to time spent in detention and jail as well as commitment to resistance activities which cost time and energy.

Loss of schooling and professional advancement was expressed as a problem by many.

Of course, everyone achieved a lot of things in this country, but there are no tangible results. You know, I didn't finish my MA because of all this, and I didn't ever get to go overseas on a year's study, and I missed out on travel - you know, all those sort of things. I'm going to work very hard to achieve now in my thirties, what I didn't really achieve in my twenties. And that's a problem. I mean, overwork - it's a very big problem I find at the moment.

Those who were imprisoned faced a worse situation in that they were now several years behind where they had been and had also missed out on developments in the world during that time. This involved changes in society, technology, art, culture and relationships. Plus for many people they were seen as being dead.

There was also the loss of youth.

It doesn't necessarily mean that I am not angry. I have been deprived most of my youthful life in prison. What is vital in any other person not to pass or transgress stages of his growth or development in the way I did, ah! I am in totality angry.

Many of those who complained about the loss of time have established excessive work schedules for themselves to catch up.

There is also the loss in terms of things that families should
have shared such as watching their kids grow up, that have been lost.

**Loss of identity**

This was not specifically raised by many of the respondents, but it appears implicitly in many of the interviews. It is a disorientation in relation both to the self and to key aspects of the outside world. The latter disorientation can be to time, names or appropriate behavioural interactions. This normally reduces over time and the person interacts with the world and reality checks appear, although the memory problems often remain. Disorientation in relation to the self may not reduce over time, although positive affirming experiences may play some role in reducing the problem. It may appear to reduce as the person becomes adapted to changed persona.

Some spoke about a loss of identity and humanness, and then the difficulty of once again taking on your role in the family.

Ja, the most important thing is that in prison though I was fighting very hard, we were made to believe that we were no longer people, but are property of the prison. Even thinking for yourself, somebody had to think for you. You were completely under control now. When you go back you resume the responsibility and control over the family. To be able to adjust and be able/capable to do that, I just ... you have to be the provider, when you have been provided for, for a long time.

(male, 36, black, prisoner, unemployed, ANC)

**Relationship issues**

Many of the detainees experienced relationship problems, found it difficult to trust and had problems with intimacy after their release from detention.

But I think it was just the combination of those factors which I found, when I got out, became mistrustful, became very - not reclusive, it's the wrong word, because I was a student leader, ... so I couldn't very well stay away from people – but began to become more turned inwards, more difficult to make friends or to sort of contact people.

(male, black, detained, tortured, banned, senior activist, ANC)

This mistrust is not only directed towards family and close friends, but would incorporate all people, such as work colleagues, etc.

Within the relationships during the periods of internship there were often high levels of support and need for each other. However on release this position often changed. There were increased tensions that had to be dealt with resulting from the pressure of the detention. The person released from detention or prison would often withdraw. This was often due to the effect of the imprisonment and a need to protect themselves. In many cases the activists would spend a considerable time running away from their feelings. As a result there were a considerable number of divorces. Many relationships did not survive because many activists ran away from these feelings.

Many of the ex-detainees found that they wanted to be alone for long periods. They wanted to isolate themselves. Others became more withdrawn.

I do create boundaries very seriously. You can't reach me at times when I want people cannot reach me within the family.

(male, 51, black, prison, terrorism, AZAPO)

Strains developed in relationships when one person wanted the other to reduce political involvement so that the risk of re-detention or harassment would be reduced. This generally happened in relationships in which only one party was politically involved, but even when both parties in the relationship were involved in politics there were often strains.

There was a strong tendency among activists not to take care of themselves and to devote everything to the struggle. This undermined both themselves and their relationships with time. It is a matter of the detainees making time for themselves and for the people they love.

A particular additional problem was that at the time many of the needs and trauma of the victim's partner had not been dealt with. This person was likely to have found it very difficult to claim the space to demand this attention because they did not experience the detention or the major trauma themselves. They felt guilty about claiming space. The detainees themselves would also not be able to provide that support because they were trying to heal themselves.

**The relationship between the trauma and the current problems**

It is difficult to establish the contribution that the detention and torture experience has made to the development of medical and mental health problems. As was shown above a considerable number of people have also experienced other forms of harassment.

Many respondents see a direct relationship.

I thought, well, this (his detention) is the first time really in my life that I'm totally on my own. But totally. There is absolutely no-one, other than myself, that I can depend on. There's no family, there's no parents, there's no partner, there's nothing, absolutely nothing. And that probably set in, you know, set quite strongly for the next decades how I tended to deal with things, often very on my own. I'll deal with that. Which leads to a whole lot of problems, because you don't delegate, you don't trust other people, you get overloaded, overworked, and all the problems occur after that. I think I would trace it party back to that time.

(male, white, 35, detained twice, banned, senior activist, ANC)

Some problems have an obvious origin, e.g. one person developed a fear of blankets at the end of the detention. She had spent a night in detention sleeping under lice infested blankets and only found out in the morning.

The second time I came out of detention I was a cat, because I was confined in quasi solitary for a period of three months, only out in the morning to exercise, only out in evening – afternoon to exercise. The rest of the time I was in the cell. A bed, a cupboard, a toilet. (There was virtually no floor space in the cell) I was on the bed, on the cupboard, on the toilet, on the cupboard, on the - like a cat. When I came out, in my house, I was sitting on the furniture. It took me a long time with the assistance of my husband – "No, you don't sit like that. You're not an animal. People don't sit like that. You don't walk on the furniture." I never used to get into my bed. I used to walk on the bed and then get into my bed.

(female, coloured, 49, multiple detentions, divorce, ANC, senior activist)

In a careful examination of the data it would appear that some of the lifestyles that people lived after detention arose out of the detention experience. For example the level of over-involvement in politics in turn leading to continued repression and its heightening. Those who went into hiding took on the role of being their own jailers. In some cases symptoms such as hypervigilance fed into a general paranoia about being caught and security within the organization. The
lack of trust made it difficult to share problems with others, and thereby increased both the material and emotional load that the activist was carrying.

And I think that almost immediately I got involved with the United Democratic Front (UDF) national executive, which was quite a lot of work, and I think looking back, I wasn’t ready for a different type of pressure, which is the pressure of national politics, and within, like any political organisations, the intrigue, the factionalism, the rivalries, and a lot of the very unpleasant stuff that went on in the 1980s, so I think I kept that tension within me, there was no space to let it go. (...) So I began to feel quite messed up after about five years, about 1986, just feeling unconfident or feeling anti-social, not being able to take any responsibility or not being able to take decisions, indecisive. And, I mean, I think I clearly felt that was because of my detention, or detentions and subsequent bannings.

(male, white, 35, detained twice, banned, senior activist, ANC)

The other crucial factor to consider is the presence of pre-morbid mental health problems. The variety of problems noted and the particular longevity of some may be due largely to the presence of problems even prior to the detention.

Creation of a subculture around torture

The experience of torture created a subculture that only those who participated in it can share. When they get together it is the only time when the depths of the experience can truly be shared; nobody else is capable of understanding. It is a very different experience from talking to someone who has not had those experiences. With a person who has had the experience the survivor can talk with ease, and there would be a natural catharsis plus a feeling of normalizing the experience.

It’s often with them (the other detainees) that I have the most meaningful interaction when we speak about detention. There was really – I think, like I say, I think they understood at the time what it was like. And things that only you can relate to or only they can relate to. (...) I think the nuances things – I mean, I can’t give you an example offhand now – one might come to mind – but I think that these nuances are very personal emotional experiences that one had at the time.

(male, coloured, 25, detained at age 15, Unity movement)

Contact between torturer and tortured

The process by which the handover of power took place in South Africa presents particular challenges for torture survivors. It has resulted in torture victims sharing work spaces and communities with their torturers, raising a conflict between revenge and forgiveness.

Contact between victims and perpetrators is not an easy process to set in motion. The early contacts, during detention, were based on a huge power difference between the victim and the torturer/interrogator. The detainee became part of the interrogator’s world for a period of time and visa versa. During that time the victim was not only exposed to the violence that the interrogator meted out on the victim, but also the interrogators would often boast of what they had done to others, e.g. a group came in to interrogate one of the respondents boasting of how they had arrested and beaten 50 children, and shot others.

Some of the victims are working on a day to day basis with members of the previous government’s security forces. Mixed responses were given to having contact, some finding it possible, depending on the person. Others find it far more difficult and feel sick at the thought. A few acknowledged that the perpetrators were in many respects victims as well.

One respondent reported that while on Robben Island prisoners began counselling each other about being able to forgive the torturers and about reducing the levels of resentment. This made it easier to confront the torturers later.

Confrontation of torturers could also become a way of taking back control destroyed in the interrogation. Two detainees reported this.

I met Mr van Logenberg who handled my case; it was at the border post; I was commanding the marshals and he was supervising the transports (buses). I had my ANC colours on; I went up to him, shook hands and said, “Hello Mr. van Logenberg. I am still an ANC member.” He laughed. (...) I was sick when I saw him, but proud because I am still serving for the same organisation which he tried to prohibit me from.

(female, 39, black, multiple detentions, tortured, ANC)

I meet with quite of few of them, because I’ve been on the community SAP Forum here in Mitchell’s Plain. Some of the majors are now detectives here, and in Strandfontein, and we meet at that level. Initially they avoided me. They didn’t want me to remember them. Until I gradually cornered each and every one of them, in front of the South African Police, in my time. Saying, “Why don’t you want to know me any more? You used to be my interrogator. Don’t you remember?” And they’re all very apologetic. Every one of them are very apologetic. And trying to say, “I was never the one that was rude to you.” “But you were in charge, and you delegated other people to be rude to me.” Okay? So I have a feeling of shame, sorry, for the guys – poor guys. They have to now deal with this.

(female, coloured, 49, multiple detentions, divorce, ANC, senior activist)

Effects on the family as a whole

The effects of detention went beyond the individual to the family and community, as this quote acknowledges. This is a set of effects and a group of people that still have to be dealt with.

When one is detained – detention itself, maybe one person is detained, but the impact is experienced by the entire social network around that person. So much so that I think that the state doesn’t have to detain one – what you were saying is, you’re really imprisoned in your own family. Your social network then – because they’ve so traumatised through the experience themselves, and don’t want to re-experience that, they do the job of the state indirectly by restricting your activities. And I think – without trying to sound conspiratorial about the security forces, and the state’s intervention and so on, I think really at some level people who detain others are quite aware of those kinds of effects. That at a social level they’ve caused a restriction of people much broader.

(female, 39, black, multiple detentions, tortured, ANC)

Conclusion

Trauma does have an effect. This is partly immediate, but often continues in the long term. These long term effects are mediated by a number of factors. The importance of these mediating factors increases as the time elapses from the point of the trauma. This paper highlights some of the issues that will need to be considered in the future.

The role of the Truth and Reconciliation Commission is going to be very important as a power for healing in South Africa. It could have the positive effects of making public the nature of the abuses that have occurred and highlighting the problems for individuals and communities that have resulted from this. This is positive because it will break the silence that is a limiting force on healing taking place. It will also allow those who are suffering negative effects to acknowledge these effects and begin to deal with them. It is however not an end, but a beginning.
Research from here needs to look at the process for this group; to look at the potential for healing and for breakdown, the prospect of generations of people suffering similar long-term effects and the influence of current problems on future generations.

Acknowledgements

This draws on work that I do as part of the Trauma Centre for Victims of Violence and Torture. This is a non-governmental organisation (NGO) based in Cape Town that provides broad health services to victims of political and organized violence. It drew its base from the rehabilitation of torture survivors, but has extended and now provides services to those who have been detained, tortured or imprisoned; are returned exiles; refugees; victims of other general political violence such as harassment, beatings, shootings, destruction of property, vigilante attacks; and will in the future be extending to begin looking at gang violence and farm worker violence.

I would like to acknowledge all the staff of the Trauma Centre, especially my research assistants, Tim Hart, Trudy de Ridder, Madoda Mangxola, Xoliswa Ngubane and Mandy Drummond.

Selected list of publications

received in the IRCT International Documentation Centre


In solidarity with the people of Sudan / Sudan Human Rights Organization - Cairo Branch. - Cairo : Sudan Human Rights Organization - Cairo Branch, 19940000. - 14 + 14 p.


Iraqi aggression on Kuwait : a crime unpardonable = L'agression irakienne sur le Kuwait : un crime impardonnable / Almansouria : Center for Research and Studies on Kuwait, 19960000. - 77 p.; ill.


Instruments of torture : from the Middle Ages to the age of enlightenment / Inter-Expo. - Amsterdam : Inter-Expo, 19910000. - 16 p.; ill.

Dilemmas of professional ethics as a result of the involvement of doctors and psychologists in interrogation and torture : a symposium, Jerusalem, April 19th, 1993 / The Public Committee Against Torture in Israel; IMUT - Mental Health Workers for the Advancement of Peace. - Jerusalem : The Public Committee Against Torture in Israel (PCATTI), 19941200. - 68 p.


The "acceptable enemy": torture in non-political cases

James Welsh, PhD* & Mary Rayner, PhD*

This article is a revised version of a paper presented at VII International Symposium Caring for Survivors of Torture: Challenges for the Medical and Health Professions, Cape Town, 15-17 November 1995.

Introduction
In 1984, Amnesty International published a global survey of the practice of torture1. It presented evidence of torture and ill-treatment in more than half the countries of the world, with torture as an especially serious problem in some 40 countries.

The report made no attempt to quantify torture or establish a hierarchy of offenders. Nor did it attempt to establish a difference between torture as a tool against political activists or as a means to investigate ordinary crime. While torture is widely perceived in the popular imagination as a tool of political repression, there is ample evidence that torture is inflicted on a wide range of victim types for a wide variety of purposes. This makes the idea of citing "typical" incidents or patterns of torture unreliable except with reference to particular locations, periods and contexts. The implications of the widespread perception that torture is above all a phenomenon of political control has important consequences for how we address torture in its wider dimension, particularly with respect to the prevention of torture. When government members who have experienced torture during their period of political struggle come to address problems of controlling crime and illegal immigration (as well as other social problems) there is a risk that they may not recognise as torture the kinds of gross ill-treatment in non-political cases that are regularly documented by national and international human rights organizations, including Amnesty International.

What is torture?
The definition given in the United Nations Convention against Torture is the following:

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

To this definition could be added the phenomenon of suffering of the kind referred to above inflicted by individuals not associated with the government – political groups and criminal gangs for example – though these would not be encompassed in the terms of the Convention against Torture, which applies only to governments.

The UN Declaration on the Protection of all Persons from Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (Declaration against Torture) of 1975 also notes that:

Torture constitutes an aggravated and deliberate form of cruel, inhuman or degrading treatment or punishment.

These definitions make no distinction between "pain or suffering" inflicted for political or for non-political reasons.

While torture is perhaps easily perceived in its extremes, the lower threshold below which ill-treatment cannot be regarded as torture is difficult to define. However, given that cruel and inhuman treatment is itself also contrary to international law, attempting to set clear borders between the two is probably a futile and potentially misleading task. In this paper we will be considering examples of cruel, inhuman or degrading treatment, some of which are torture. In some states ill-treatment of detainees is not carried out to control political opponents and, indeed, may represent standard practice for arrested criminal suspects or marginalised individuals who, through no fault of their own, become the object of police attention. It is important that these abuses are not disregarded because the victim of ill-treatment does not conform to stereotypes of torture or the tortured.

Reasons for torture
Two separate issues need to be addressed here: what is it that encourages the use of torture or its continuation and what are the purposes of torture. The reasons for the development of the practice of torture are too many to consider here, but the process arises out of ineffective control of the law enforcement agencies and impunity for those who carry out torture; it is clearly linked to the objectives of torture which include the maintenance of control, the defence of ruling values and the suppression and prosecution of political and criminal "enemies"; in short, political and social control. In some police and security forces, for example, the pressure to be "effective" in the fight against crime leads officers to use short cuts to extract confession evidence to gain convictions. Without the will on the part of political authorities and senior police or military officers to maintain a minimum level of supervision and staff discipline, increasingly unacceptable practices can develop that may lead to the routine use of torture in criminal investigations. In other words, a culture of torture develops. This can lead to law enforcement officials using torture for their own ends. One such product of this culture is the extortion of money from detainees by the infliction of torture.

Amnesty International
1 Easton Street
London WC1X 8DJ
UK

TORTURE Volume 7, Number 1 1997
While some authors have attributed a single purpose to torture—commonly destruction of the personality or of the individual—this does not adequately address the complexity of the phenomenon of torture and is particularly ineffective in accounting for the practice of torture as a tool for harassment, extortion, and criminal investigation. The two reasons for torture probably most widely held in the public imagination—to gain information and to force confessions—are undoubtedly a major focus of the contemporary use of torture both in criminal cases and in political cases. However, torture is also used to immobilise political or social activists by intimidation or the infliction of serious psychological damage, or more widely, to induce in a population a sense of terror. If there is a difference between "political" torture and "non-political" torture it is less related to the suffering endured by the victims than to the context and objectives applying in each case. These differences may be important to accommodate in order to campaign effectively (1).

Who gets tortured?

Persons who are arrested or otherwise held by agents of the state lose a measure of control over their own destiny; some are at risk of ill-treatment. In some states, the police and security apparatus are constrained by existing good practices and adequate openness to scrutiny, which make blatant torture a rare occurrence. However, in many others, police or security agencies function either in the absence of adequate scrutiny or in a climate where the government actively or passively encourages torture. Some countries have police forces with a tradition for "physical" investigative methods (2). Those who are arrested are ill-treated as a matter of routine.

In some countries police use torture as an instrument to enrich themselves. One prisoner awaiting trial in Pakistan told Amnesty International:

In our ward in Karachi Central Jail there are 15 punishment cells. They are all full. All new prisoners are put there first, to break their resistance; if they are new in prison, what are they punished for? In a punishment cell one is kept all alone, in bar fetters and they add cross fetters, from ankle to ankle so you cannot close your legs. I was held in cross fetters for almost two weeks and was also blindfolded. My ankles were swollen but because I could not pay the money they demanded, they did not take the fetters off. I had not done anything for which they could claim to punish me, they were only after the money. I know some prisoners who have paid 5,000 rupees and their fetters were removed.6

In other countries the torture of political activists has been particularly brutal, notably more so than that inflicted on criminal suspects, though this may reflect the different purposes of political and non-political torture (3). In other countries, it has been reported that use of torture against political activists has been stopped because of political change or the activists' high public profile, but torture of others, particularly those accused of criminal behaviour, has not been subject to the same constraining pressures (4).

Patterns of torture

Torture of alleged criminals to gain confessions

In many countries the police appear to rely upon the extraction of confessions under duress as a major, if not sole, "method" of investigating crime. The extent of the problem can be obscured in situations where public awareness of, and mobilisation against torture, is focused upon torture as a tool of political repression.

In South Africa, where politically-motivated torture was in the past an endemic problem (and is now primarily confined to the province of KwaZulu-Natal), human rights monitors have nonetheless continued to document a disturbing pattern of torture by electric shock and near-suffocation practised by members of the specialised units of the South African Police Service (SAPS) such as the Murder and Robbery Units6. The victims include suspects in criminal investiga-
tions as well as marginalised groups such as street children and illegal immigrants.

The pattern predates the political transition period. Mduduzi Maphanga, a senior clerk with the Natal Provincial Administration office in Imbali township, was arrested on 19 August 1993 by members of the South African Police in the course of a criminal investigation. During the ensuing four or five hours he was subjected to a brutal assault by the police who interrogated him about the whereabouts of a missing firearm. During the interrogation, he was assaulted with punches and kicks, stripped of his clothes, tied to a chair with a rope, and subjected to partial suffocation with rubber tubing which his interrogators pulled over his face. The police eventually released him, uncharged, dumping him in a state of shock and pain in the streets of Pietermaritzburg.

In a recent case under investigation, Mxonsi "Advice" Dlamini was arrested by police from a "suspect tracing unit" at his home in Katlehong on the morning of 2 October 1995. He was taken by four police officers to a building next to the Katlehong police station where he was allegedly kicked, punched and assaulted with a knife. With a policeman sitting on his back, the prisoner was then subjected to having a piece of rubber tubing pulled repeatedly and tightly across his mouth and nose.

Later his interrogators took him to Vosloorus police station, which refused to accept the prisoner because of his extensive injuries. When he was seen by a human rights worker several days later, he had multiple abrasions on his face, marks on his wrists and ankles where the cuffs dug into his skin, and bruises on his back.

In Turkey, torture is widespread and systematic. On 7 November 1994, a 13-year-old apprentice, Abdullah Salman, was taken into custody by the police in Istanbul. During the following two days he was brutally tortured while being interrogated about the disappearance of money and cheques from a store where he worked. He was beaten, punched and choked. Later, as he described it:

"(...) they blindfolded me and trod on my hands. They took the sock off my left foot and tied something to it. Then they began to give me electric shocks. My soul really burned [meaning: it really hurt]. First I thought he had cut off my toe, then it was as if my body did not work from the waist down. Every now and then they hit my head. When they were giving me electric shocks, it was as if it would never end. This went on for three days. When I shouted out, those in the room shut my mouth and laughed."

On the third day a lawyer managed to get access to the boy and to arrange for a medical examination. The resulting medical certificate confirmed extensive bruising of different parts of his body. Abdullah Salman was released from custody on 9 November 1994 by order of the prosecutor. He was never charged and the missing items were recovered from another person. Abdullah remained traumatised by his experiences, waking up in the night screaming and fleeing at the sight of police officers in the streets. He was placed under psychiatric care at Capa Medical Faculty.

Torture occurring in the context of poor discipline

There have been many reports in post-communist Albania of the severe ill-treatment and torture of detainees, among them women workers, members of ethnic minority communities, homosexuals and suspects in criminal investigations. The police had been one of the instruments of the extreme repression in the communist era and had been regarded with distrust and fear. Following the end of one-party communist rule and the election in 1992 of the Democratic Party, a purge of the police forces took place. In 1995, 80% of the 23,000 employees of the Ministry of Interior — of whom 10,000 are police officers — had been recruited since 1992. Many of the new police recruits came from the ranks of former political prisoners, who had often been deprived of normal education and careers, as a consequence of prolonged detention and exclusion from higher education.

Among other victims of police brutality are members of the Shoqata Gay Albania (SGA: Gay Albania Society). Prior to June 1995, homosexual acts between men were illegal under the Criminal Code and punishable by up to 10 years' imprisonment. In October 1994 three SGA members were arrested and beaten by police in Tirana District 1 police station. One of the detainees was so severely beaten that he was admitted unconscious to hospital with multiple fractures of a leg.

In one of the four known instances of deaths in custody as a consequence of police ill-treatment in 1994, Irfan Nanaj had been arrested on 15 January 1994 after a drunken quarrel broke out in a cafe. Police officers beat him so severely at the police headquarters in Saranda that he was unconscious when taken to the local hospital. He remained in a coma for two weeks and died on 26 January 1994. The doctor in charge of his treatment was later quoted by journalists as stating:

"The patient Irfan Nanaj came to hospital in a very severe state of health. Medical experts who examined him concluded that he had been beaten in the most terrible way in Saranda police station. He had been beaten with a rubber truncheon, causing internal haemorrhaging."

Torture of women

In Kenya, torture is used by the police to obtain confessions in criminal investigation cases, as well as in political cases. Common methods of torture include beating, whippings, various forms of suspension, submersion in water, sexual abuse, and rape. Women and girls have fallen victim to these abuses. For instance, in August 1992 a 16-year-old girl was tortured by two police officers from Buru-Buru police station in Nairobi. She was accused of stealing money from her employer, who was one of the police officers involved in the assault and interrogation. She was reportedly burnt, tied up with a rope and a stick was forced into her vagina. She required hospital treatment for her injuries. By 1995, the two police officers who had been charged with causing her grievous bodily harm had still not been brought to trial. They were reportedly also still on active duty. Josephine Nyawira Ng'egi, an AI-adopted prisoner of conscience and member of the Release Political Prisoners campaigning group, was arrested in May 1994 and held illegally and incommunicado for 22 days. She has stated that she was beaten and had blunt
objects pushed into her vagina until she bled. AI is not aware of any investigation into her case 13.

Women in Turkey are also victims of police ill-treatment. On 23 January 1995, Sultan Aygün and her husband Garip Aygün were detained in Istanbul in connection with a traffic accident. While her husband was blindfolded and subjected to *falanga* (beatings on the soles of the feet) in an attempt to get him to confess to other traffic offences, she was handcuffed to a radiator, beaten and subjected to threats that her daughter would be taken into custody and raped. The couple reportedly received medical reports from the Forensic Medicine Institute confirming injuries 14.

To Amnesty International's knowledge, in none of the cases above has compensation or specialised medical after-care been offered by the state that was responsible for the ill-treatment.

**Torture of the marginalised**

Brazil is a country with one of the most marked disparities of wealth in the Americas. Millions of poor are forced to survive in conditions of deprivation and poverty. Those living in the streets and shanty towns can be the target of unofficial "clean up" operations by police and armed squads of vigilantes which lead to torture and killings. In Rio de Janeiro, in the early hours of the morning of 14 October 1992, a group of eight armed men, some of them wearing civil police jackets, RAIDED the home of Romilson dos Santos Reis, in the shanty town of Nossa Senhora da Guia, Lins de Vasconcelos. Some of the men were reportedly masked. They had no warrants. The men woke Romilson dos Santos Reis, who was asleep in the living room, and tied him up. For around two hours, they allegedly beat him with a stick, and kicked him and burnt him with a hot iron on the abdomen, legs, genitals and other parts of the body. His father was in his bedroom and could hear his son's screams, but could do nothing to help him. Romilson dos Santos Reis lodged a formal complaint with the police and identified some of his assailants. He then allegedly received death threats 6 15.

The torture of children and juveniles during interrogation for criminal offences has been frequently reported in Tijuana, Mexico. The victims are usually from the disadvantaged sectors of society: homeless teenagers, the children of poor urban families and young rural migrants from the Mexican interior. They have neither the money nor the status to protect themselves from abuse. The methods of torture include beatings and whippings with belts, near-asphyxiation in water and with plastic bags over the head, mineral water forced into the nostrils and sexual abuse. And they include electrical torture, as this 17-year-old young man's testimony indicates:

They attached the wires, one to each foot - to each big toe - and when they connected them I convulsed from the shocks. But before they did this they put a cloth in my mouth, and a judicial [police officer] grabbed me from behind and told me not to stick out my tongue because the electricity might make me bite it 16.

**Torture on grounds of ethnicity, "foreignness"; asylum seekers**

As Amnesty International noted in its 1992 report on Greece, "although the fall of the military government in 1974 brought an end to the systematic torture of political prisoners, the torture or ill-treatment of people in detention by law enforcement officials has not been eradicated" 17. Outsiders and foreigners have fallen victim to the abusive tactics of, for instance, the Athens Anti-Narcotics Police. In one case, Sehmus Ukus, a Kurd and citizen of Turkey, was arrested by this unit in July 1990 when he was returning to his hotel in central Athens. In an area of high ground the police allegedly stripped him of his clothes, hung him from a tree and, after taking him down, forced him to lie on the ground, tying his legs together and handcuffing his hands behind his back. They then allegedly burned the soles of his feet and his genitals with a cigarette lighter and beat him with sticks. Later he was taken to the Headquarters of the Anti-Narcotics branch where the torture continued on the following day. At one point a senior police officer allegedly came into the interrogation room and asked them why they were beating Sehmus Ukus; the officers replied, "he is a Turk". When he was brought before the examining magistrate, who was prompted to report the allegations of torture to the public prosecutor, Sehmus Ukus was never called for examination by a forensic doctor, in spite of his battered condition. In November 1991 he was given a 30-month prison sentence for using drugs 18.

In France, a high proportion of the victims of unlawful shootings, killings and ill-treatment of detainees by law enforcement officers in 1993 and 1994 involved victims of non-European ethnic origin, mostly from the Maghreb countries, the Middle East and Central and West Africa. In one case, Rachid Harfouche, a 20-year-old French national of Algerian descent, was returning to his home on the evening of 10 December 1993 when he saw a police car stop outside the apartment building where he lived with his family. When three police officers got out and ran towards him, he took fright and fled up the stairs to his parents' apartment. Neighbours and family then saw him being stopped by the police, ostensibly for an identity check, handcuffed and then beaten by the police with truncheons. The police continued to beat him as they led him downstairs. He started to vomit following a severe blow to his throat. When people tried to intervene the police used teargas to clear the area. He was dragged outside, and beaten and kicked while lying face down on the ground, before being taken to the local police station. He was never apparently charged with any offence. He required hospital treatment for a fracture to his nose and multiple injuries to his throat, chest, back and wrists. Later that month he made a complaint against the police to the court 19.

The vulnerability of outsiders to ill-treatment and torture at the hands of law enforcement officials appears to increase in situations of general public intolerance towards those perceived as foreigners. In Germany, for instance, severe ill-treatment of detained members of ethnic minorities sometimes seems indistinguishable from racially-motivated attacks carried out by youths or members of right-wing organisations. Yusuf Barzan, an asylum-seeker and survivor of torture at the hands of the Iraqi authorities, became a victim again when, on 12 May 1994, he was attacked in the centre of Magdeburg by a group of youths wielding baseball bats and chanting: "Germany for the Germans, foreigners out". As they pursued him through the streets, two police cars arrived on the scene. Instead of offering him assistance, one of the officers allegedly threw him on the ground, stuck him on his shoulder with a baton and kicked him in the testicles. His protests were silenced with "Shut your mouth, you bastard!", and he was thrown into a police vehicle where he was beaten again. He was detained in police station cells overnight, before being released uncharged. He did not seek immediate medical help, feeling that he was "only" bruised.
and did not lay a complaint about his ill-treatment and detention because he was afraid he would not be able to pay his legal expenses. Following publicity about his experiences in a news magazine, police officers did interview him and, in September 1994, an officer was charged with causing bodily harm to Yusef Barzan.20

Vietnamese detainees appear to be vulnerable to serious ill-treatment, particularly at the hands of the Berlin police authorities. In one incident in May 1994, two Vietnamese asylum-seekers attempted to flee from plainclothes police trailing them in east Berlin. One of the men, when he was caught, was repeatedly punched in the face while being interrogated about possession of cigarettes he was allegedly involved in illicitly selling. When he did not answer he was made to run up and down in a nearby canal, knee high in water for approximately 20 minutes. The officers eventually left him and he returned home. Although his face hurt so much he could not eat, he did not think of complaining or of going to a doctor because he was “only” an asylum-seeker, did not have permission to be in Berlin and had been involved in the illicit sale of cigarettes.21

During the 1990s, members of the minority Roma community in Romania have been targets of imprisonment, beatings and other ill-treatment at the hands of law enforcement officers, who have also failed to protect them from racist violence from other members of the community. One Roma family became victims of police harassment apparently because they had provided shelter to survivors of large-scale anti-Roma violence in Mureș County in 1993. In an incident on 24 December 1993, four police officers assaulted members of this family in their home, including the mother, her twelve-year-old son and her daughter-in-law. One police officer handcuffed 19-year-old Mircea Lacă and reportedly beat him all over his body. According to his mother’s testimony, the police pushed him between two wooden benches and continued to beat him by hitting the top bench. He was also hit with truncheons on the soles of his feet. The police allegedly shouted: “We will kill you as well as all the other gypsies”. Mircea Lacă was then taken to the local police station and held for several hours before being released without charge. The harassment of the family continued in 1994, including beatings and threats against Mircea’s father when he attempted to lodge a complaint against the police.22

Torture as an instrument of war
Torture and ill-treatment have frequently preceded arbitrary killings throughout the war in Liberia. Amnesty International has received first-hand testimonies and reports of raids by armed groups in which victims were robbed, tortured and ill-treated, some of whom were killed.

One of the most common forms of ill-treatment is known as the tabey, in which the victim’s elbows are forced together behind the back and tied in that position, causing extreme pain to the muscles of the shoulders and chest as well as rope-burns to the crooks of the arms. Tabey victims often lose feeling in their lower arms for days or weeks following their torture. In some cases, nerve damage is so acute that irreversible paralysis of the arms results. There are also reports, in exceptional cases, of death caused by breathing difficulties experienced by a person subjected to tabey.

All of the Liberian warring factions have subjected captives to tabey. In some cases, victims tied in this manner are subjected to further ill-treatment and torture including beatings and rape. One of the main purposes of torture is undoubtedly to intimidate and inspire terror in the general population. Intimidation and torture are also intended to establish control over the civilian population. All the Liberian factions have terrorized the local population in disputed territory in order to discourage support for rival factions.23

Difficulties for victims in obtaining redress
Personal rehabilitation
Some traumatic stress specialists have suggested that political activists who are persecuted for their political beliefs and who are aware of the risks they face have a greater chance of interpreting and understanding their suffering and therefore of “processing” the trauma than individuals who have no idea why they are being persecuted. To this extent, criminals who have either experienced police ill-treatment or have bad friends who have been ill-treated may have, in an analogous way, a marginally better chance of resolving their trauma than those who are arrested with no knowledge or prior experience of arrest or ill-treatment. In certain countries people arrested by police expect to be beaten or to be ill-treated in other ways and therefore approach their impending torture as a “normal” event. Those who are arrested in error, or for no apparent reason, may have less ability to understand their fate and therefore find it much harder to come to terms with the experience.24

Irrespective of the capacity of individuals to survive torture or other ill-treatment through their own resources, there are serious questions about the extent to which affected individuals have access to other sources of help. Many victims who are arrested in the course of criminal investigations are from the margins of society; others who are abused are victimized because they belong to ethnic minorities or are refugees or asylum-seekers. Frequently they are not part of the “cared for” community. Their suffering is seen by many as self-inflicted, deserved or inevitable – in any event, not of great importance. Because they frequently lack connections with the conventional structures of society, they are excluded from specialist, and sometimes even basic, social and psychological services.

While there are many “centres for torture victims” which do excellent work, they are unable to cope with the numbers of people who might need some kind of support following the traumatic disruption of their lives caused by imprisonment, ill-treatment, separation and loss, and for many, exile. However, at least they exist and are addressing the needs of refugees and political activists and, as in the case of the Cape Town Trauma Centre, are trying to intervene in the cases of criminal suspects and street children. However, in general there is not the same imperative to address the needs of the marginalised, the criminal and the powerless as there is to respond to the needs of “innocent victims” or people who have suffered while struggling for ideals.

Police accountability and compensation
As long as the tortured are seen as representatives of a political movement, party, organization or as someone campaigning for a better society, then their torture can be expected to provoke opposition and concern among certain sectors of society. This introduces a measure of pressure for police to be accountable for their acts and for the victim to receive recompense. However, when the victim is widely seen as deserving his or her fate, the police may feel less public opposition to their activities and, indeed, may feel support for their behaviour in certain circumstances. This is particularly the case
when the police are engaged in a “war against crime”. In any event, there is less likely to be pressure for accountability or for compensation for the victim of torture.

Reforms
The use of torture as a political tool of government is widely seen as unacceptable. It prompts national and international campaigns for abolition and for restoration of the rule of law. However, the application of torture to the solution of crime or social problems often reflects deeply entrenched social values and, in many countries, is less likely to provoke public outrage than political torture. Therefore, it can be correspondingly more difficult to implement reforms effectively.

Conclusion
Torture and ill-treatment of criminal suspects and other non-political detainees is under-documented yet appears common throughout the world, including democratic states. In some countries it is routine to apply “third degree” methods of interrogation in criminal investigations, and public concern is muted because of a preoccupation about crime and its control. On the other hand, various kinds of marginalised individuals can be victimised with relative impunity because they have no voice in society.

Such victims of ill-treatment do not appear to have the same access to legal, medical or psychosocial resources as political refugees or activists who are seen as more deserving and who are more likely to be able to seek help effectively or be referred for help. Torture of criminal suspects and other non-political detainees maintains or promotes a culture of human rights violations. There is a risk that the concept of the “acceptable enemy” could weaken international efforts to combat torture, and the campaign against torture in non-political cases needs to be strengthened and widened.

Notes
(1) In some countries, political detainees are treated worse than criminal detainees because they are seen as a greater threat to ruling interests than criminals. In others, the reverse situation applies, possibly as a result of the high profile of some political activists and the perceived political cost of such ill-treatment.
(2) An Amnesty International delegation to India in 1994 was told by one senior civil servant that “a policeman who does not beat is not a policeman”.
(3) For example, where police “solve” a crime as soon as a confession is made, then torture stops. Where there is a deep level of ideological hatred or fear, torture exists independent of such a functional role and torture can continue irrespective of confession or information given.
(4) Amnesty International has recorded numerous examples where the prominence of a political activist or their international connections appears to have protected them from torture while others who are lesser known are routinely tortured. This “protection” is frequently partial and does not extend to all prominent activists. After the military coup in Turkey in 1980, for example, the only political detainees who were not tortured were members of the Turkish Peace Association who were all prominent members of Turkish society. Examples of the protection of some political activists could be cited from Brazil, Indonesia, Lebanon, Kenya and numerous other states. In countries in transition to reform, the number of political detainees decreases and the ill-treatment to which they are exposed can also decrease.
(5) Reported by the Independent Board of Inquiry, Johannesburg, and under investigation by the Police Reporting Officer, Witwatersrand.
(6) In January 1993, the Vice Governor of Rio de Janeiro wrote to Amnesty International that a civil police detective and a military police officer were in detention and another military police soldier and a civilian were being sought for the torture of Romilson dos Santos Reis. He attributed the positive outcome of the investigation to the work of the newly created Delegacia Especial de Tortura e Abuso de Autoridade, a special police unit to investigate reports of torture.

(7) The term “cared for” in this context refers to a wider social provision of services. In many societies, care is provided within the family and the social circle of the individual, and provision by the state or official agencies is neither expected nor delivered.

References
3. Ibid.
5. Amnesty International. Pakistan: “Keep your fetters bright and polished” the continued use of bar fetters and cross fetters. AI Index: ASA 33/12/95, May 1995.
10. Ibid., p. 16-7.
11. Ibid., p. 22.
18. Ibid., p. 6.
21. Ibid, pp. 12-15. Asylum seekers are assigned to a particular district in a particular Land in Germany and need written permission from the authorities before they can leave it.
Turkey undeterred in her human rights violations

The European Court of Human Rights in Strasbourg has convicted Turkey for torturing a Kurdish man - the European Commission for the Prevention of Torture condemns Turkey for systematic torture for the second time

Henrik Docker

Turkey is now committing so many documented violations of human rights, not least the use of torture, that it is difficult for this journal to keep pace with the development. On 18 December 1996 the European Court of Human Rights in Strasbourg, in a historic decision, found Turkey guilty of having tortured a man, Zeki Aksoy, who had been detained by Turkish police for some weeks in November 1992.

Torture victim murdered after application to Strasbourg

The Court found evidence that Aksoy, suspected of supporting the Kurdish insurgent party PKK, has been subjected to electric torture on his genitals, beatings, hosing with cold water, and "Palestinian hanging" (suspension by the arms that have been tied behind the back). As a result the man lost the use of his hands and arms. This is a clear-cut violation of article 3 of the European Convention on Human Rights of 1950, which stipulates: "No one shall be committed to torture ...". Aksoy personally, however, took no advantage of the Court decision; he was murdered during a stay in London in 1994. His father, claiming that this act was a direct result of the application to Strasbourg, represented him in 1996. The European Court of Human Rights found Turkey guilty of three violations: 1) torture, 2) too lengthy detention (two weeks), and 3) no authorities in charge of complaints of torture.

Already on 6 December 1996 the European Committee for the Prevention of Torture (CPT), also a Council of Europe organ based in Strasbourg, made a public statement, confirming, depressingly, that there is "clear evidence of the practise of torture and other forms of severe ill-treatment by Turkish police". In particular, beatings of the soles of the feet, blows to the palms of the hands, and suspension by the arms. This was only the second public statement of the Committee, which prefers to act "behind the scenes". The first, also on Turkey, was made in December 1992 (see TORTURE vol 3:43-5).

Denmark backs individual application to Strasbourg

On 4 January 1997, Denmark decided to take Turkey to the European Court of Human Rights on behalf of the Turkish-born citizen Kemal Koç, who was detained for six weeks in Ankara July-August 1996, as he was visiting his country of origin in order to participate in his late brothers funeral. Koç was examined at RCT in Copenhagen shortly after his return to Denmark.

During interrogation by the Turkish police he was beaten, subjected to extreme heat, and sprayed with ice-cold water as he was charged with financially supporting the PKK, which is a legal organization in Denmark. RCT found it substantiated that Koç had been tortured.

This was the first time a Council of Europe government decided to charge another government based solely on suspected violation of the Convention with respect to just one person. In about 20 other cases, states such as Ireland, Cyprus, Denmark, Norway, Sweden, The Netherlands, and France have accused other countries of widespread violations concerning many different articles in the Convention and referring to a great many victims. Turkey, however, faces many other charges from individuals in Turkey, many undoubtedly concerning torture - 80 such applications with the Strasbourg-based European Commission of Human Rights have been admitted and will presumably be dealt with later by the Court of Human Rights. The Court made 127 judgments in 1996.

Serious charges by the European Committee for the Prevention of Torture

The public statement by the European Committee for the Prevention confirmed various reports from Amnesty International and others, not least the Turkish Human Rights Foundation (HRTF), that the Turkish police continue to torture and ill-treat detainees. Police stations in Adana, Bursa, and Istanbul were visited and some persons were examined in a prison after mistreatment by the Anti-Terror Department at Istanbul Police headquarters. Motor function and/or sensation in the upper limbs of all seven persons were impaired, severely in most of them, and several of them had ecchymoses or tumefactions in the axillary region - indicative of recent suspension by the arms. Two of the examined men had lost the use of both arms. The CPT stressed once more that the public prosecutors must react expeditiously and effectively when confronted with complaints of torture and ill-treatment. They frequently omit totally to react to a very seriously mistreated person. For instance, when Zeki Aksoy

Henrik Docker is a journalist and member of the Editorial Board of TORTURE.
was released by the police in 1992, he had received no medical or legal assistance during his detention.

Since 1990 the CPT has been calling upon the Turkish authorities to reduce the maximum periods during which persons suspected of offences falling under the jurisdiction of State Security Courts can be held in police custody. They can still be held incommunicado for up to 15 days (in regions where a state of emergency is declared, up to 30 days), as in the case of Aksoy.

80 Turkish complaints pending in Strasbourg

The Turkish government's case against the Turkish centres for rehabilitation of torture victims in Adana, Izmir, Istanbul, and Ankara — which was initiated at the beginning of 1996 — continued with the fifth court session on 17 January 1997, upholding the accusation that Tufan Köse, medical doctor, and Mustafa Cinkilik, lawyer, should be penalized for not communicating the names of the torture victims to the public prosecutor — with a view to finding the torturers and having them put in prison. Unfortunately the case was adjourned for the fifth time because of formal objections from the judge. The date for the next hearing was set to 21 February 1997.

The unwilling accomplices of torture practices in Turkey

What is to be done against Turkey after more than ten years of intensive campaigning to get the practice of torture ended? No one knows for certain. But it is evident that the answer is closely linked with creating a basis for talks between the Ankara government and the leaders of the PKK. The book Torture in Turkey & its unwilling accomplices gives several recommendations: Turkish law should among other things:

- prohibit incommunicado detention in all cases
- permit detainees immediate access to lawyers, family members and medical care
- secure a judicial hearing to assess the validity of all arrests within 24 hours (habeas corpus).

In addition, physicians should receive adequate training in methods of documenting torture.

The examination (of persons suspected of having been tortured) should under no circumstances be conducted at a police station. The World Medical Association (WMA) is urged to stand by its pledge (in the Tokyo Declaration of 1975) to “support and encourage the international community, the national medical associations and fellow doctors, to support the doctor and his or her family in the face of threats or reprisals resulting from refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment”.

The book, published by Physicians for Human Rights in 1996, gives several personal stories of torture survivors. It tells us that medical neutrality has been violated in the emergency legislation of 1987. Five years later a delegation of the Turkish Medical Association (TMA) to South-east Turkey (Kurdish areas) documented detention and extrajudicial executions of health professionals.

The delegation concluded that it was impossible for health personnel in the region to provide medical treatment without regard to language, religion, race, neutrality, and political orientation. Among the many documented accounts in the book, that of Dr. Hüseyin Usta, a 34-year-old general practitioner of Izmit, is characteristic:

In 1992 the police accused him of providing medical care to revolutionaries (i.e. the PKK). Two months later he was arrested, asked to give information about the revolutionaries, and beaten with truncheons because he did not answer. He was kicked and punched, and given electric shocks to his fingers, toes, and genitals. Later his wife was arrested and terrorized psychologically. As the police threatened to continue to torture her, he was talked into signing a confession. He was sentenced to three years and nine months in prison by the Istanbul Security Court on charges of providing medical care to an illegal organization (the PKK) and of collecting money for and being a member of this organization.

The book reminds us that the most egregious form in which medical care is being obstructed in South-east Turkey is through the forced destruction and evacuation of rural villages. According to the Turkish Interior Minister, as of March 1995, 2,297 villages had been evacuated and burnt down. Between 275,000 and two million people have been displaced. The European Court of Human Rights in Strasbourg found Turkey guilty of violating the European Convention on Human Rights in burning down the village of Kelekci in the Akdivar case of September 1996. The compensation for the village inhabitants is to be negotiated within six months.
At the hearing in September 1996. At the front in the middle is Tufan Köse and, to the right, Mustafa Cinkılıç. Behind them are the Turkish and international observers.

The CPT felt inclined to stress that it abhors terrorism, but added that the response to it must never degenerate into torture and other forms of ill-treatment by law enforcement officers. The Committee reminded the Turkish government that article 17, paragraph 3 of the Turkish constitution proclaims that “No one shall be subjected to torture or ill-treatment; no one shall be subjected to a penalty or to treatment incompatible with human dignity”.

It must be added that Turkey has twice given compensation to Turkish citizens who had made complaints according to article 3 of the European Convention on Human Rights (torture) as part of friendly settlements according to the Convention, and that 68 members of the military forces have been charged with killing six Kurdish prisoners in a prison in Diyarbakır in September 1996.

As of January 1997, 1100 Turkish citizens had made complaints to the European Commission of Human Rights in Strasbourg. 80 of these cases had been admitted and may come before the Court of Human Rights. This is a remarkably high number of cases to be brought against one country.

Post-traumatic stress disorder
in a refugee camp in Serbia

Nikos Bilanakis, MD, Director, Psychiatrist,* Evagheles Pappas, MD, Psychiatrist*, Vasilije Baldić, Coordinator** & Milorad Jokic, Clinical Psychologist, Psychotherapist**

Summary
In October 1995, representatives from the RCTV of Ioannina visited the Center for Psychosocial Support of Victims of Traumas and Torture caused by War in Požarevac (New Yugoslavia); in cooperation with the personnel at the latter centre, they tried to detect and record the mental health of the refugees in one camp, using questionnaires.

44.8% of the sample were found to suffer from PTSD, which was not much related to demographic parameters, but only to the parameter trauma events.

The consequences on human beings of war are much more serious than those of any physical or other catastrophe. Humans in a war are exposed to numerous and intense stressful events for a long time. The loss of familiar and loved persons, the feeling that their lives and the lives of their families are in danger, the injuries, the torture, the experience of witnessing massacres and acts of vandalism, the loss of property, poverty, hunger, being a refugee, all these facts together endanger the health of the population involved in war, and especially their mental health.

The war in the former Yugoslavian Republics, apart from all the other destructive consequences, also had serious consequences on the mental health of the population of this region. Some specific characteristics of this war helped to make its dramatic implications even more serious. Such characteristics were the sudden and unexpected outbreak of war, the national character of the conflicts in the regions with mixed population, the "national cleansing operations" that followed with great intensity and barbarity, and the large numbers of refugees that were created. It is estimated that ca. 2.5 million refugees are living today in the territories of the former Republic of Yugoslavia, while the number of refugees internationally is about 18 million.

The importance of the explosive situation that arises from this huge number of refugees in our European neighbourhood can be better understood when we consider the fact that the refugees in the whole of Europe, until 1986, were only 200,000 individuals, a number that is considered to be three times that of 1983.

Several studies refer to the consequences of war and the status of being a refugee on the mental health of the population that is involved in the above activities. The veterans of war, women, children, teenagers, the old, and the people who were already suffering from psychiatric illnesses...
are considered to be the groups that are most at risk of developing mental disorders, or of having them aggravated. Depressive, anxiety, and somatoform disorders, adjustment disorders and reactions of bereavement, and intense and temporary psychotic disorders comprise the overwhelming majority of the psychiatric problems that researchers detect most often in the civilians and the refugees. This population is inclined to overuse alcohol and psychoactive substances.

It would be a mistake to consider immediately that all victims suffer from psychiatric disorders. Not everybody responds in the same way to war trauma, and many people remain able to cope with the new conditions in their lives without expressing any loss of their mental function. Furthermore, most research on the psychosocial rehabilitation of refugees has shown that the most pathogenic factors for their failed rehabilitation and for the creation of chronic problems on their mental health are unemployment and separation from relatives, i.e. factors that affect them after the end of the war.

But to return to the war in former Yugoslavia, there is no doubt that a large number of people from this area are suffering from the intense psychological trauma of war. Agger wrote that, according to estimates by specialists, 700,000 people in Bosnia-Herzegovina and Croatia alone have undergone intense psychological trauma from the war, and that they need help from specialists in mental health. If these people do not receive treatment, it is certain that chronic psychiatric disorders will develop, not only in them, the first generation, but also in their children. Apart from the psychiatric disorders, increases are expected in the use of alcohol and psychoactive substances, in the number of suicides, and in all kinds of violence (criminal and family). The purpose of our research was to examine the mental health of refugees from Bosnia-Herzegovina who were living in refugee camps in Serbia, and to research the relationship that exists between the level of mental health of these people and other social-demographic factors.

Material and method

The survey took place between October and December 1995. Our sample comprised refugees from the region of Banja Luka in Bosnia-Herzegovina who were living at the time of the survey in a camp for the reception of refugees in Petrovac, a town in Serbia. They were forced to leave their homes 3-4 months before we interviewed them, and had been living in the camp for 3 months. The camp was previously used by the army; it now housed 320 refugees.

To obtain a representative sample, we randomly selected an area of the camp. An interviewer went from building to building, and all persons aged 18-64 who were present at the time were selected for interview. They were asked to complete a questionnaire, by themselves or in the presence of the interviewer.

All the interviewers were Serbs, members of the Center for Psychosocial Support of Victims of Traumas and Torture caused by War in Pozarevac, a Center that had the responsibility for the psychosocial rehabilitation of these refugees; they were therefore familiar with them. The questionnaire that we used included: a) questions of social-demographic interest and b) the Harvard Trauma Questionnaire.

The Harvard Trauma Questionnaire (HTQ) is a cross-cultural instrument designed for the assessment of trauma and torture related to mass violence, and their sequelae. The HTQ measures symptoms that are associated with the diagnostic criteria for post-traumatic stress disorder (PTSD) as defined by the current American Psychiatric Diagnostic and Statistical Manual (DSM-III-R).

Results

The interviewees comprised 58 persons, 22 men (37.9%) and 36 women (62.1%). 58.6% of the participants were married, 13.8% widowed, and the rest single (17.2%) or divorced (8.6%). The mean age of the sample was 40.1 years (SD: 15.75). 17.2% of them had been educated for 6 years, 48.3% for 7-12 years, while 34.5% had received higher education.

The mean number of trauma events derived from section I of the HTQ was 26.276 (SD: 17.367). The number who stated having personally experienced traumatic events (70.7%) was much larger than the number who had just heard or witnessed such events (29.3%). Suffering from lack of food, water, shelter and health care and forced separation from family members was over 37.2%. Suffering from brainwashing, enforced isolation, being close to death and being in a combat situation was over 25.5%. Imprisonment, serious injury, torture, murder and unnatural death of family, friend or strangers, and being lost or kidnapped was 36.5%. Only one woman reported having been raped or sexually abused.

Section II of the HTQ included an open-ended question about the "most hurtful or terrifying events" they had experienced. Most refugees gave more than one answer; the commonest answers were killings of family members (22%), starvation (21%), and the sense that the enemy forces were close (16%).

Section III of the HTQ, which includes a few brief questions about traumatic experiences that may involve head injury (drowning, suffocation, beating on the head), was answered positively by 7 persons (12.1%).

The continuous measure of experienced symptom severity, formed by averaging the responses on each symptom scale of the HTQ over subjects, resulted in a mean of 36.193 (SD: 15.37). The categorical measure of symptomatology (i.e. the presence or absence of symptoms) that can identify the individuals who meet the DSM-III-R criteria for PTSD, resulted in 26 refugees (44.8%).

To assess the effect of the several factors separately (sex, age, marital status, education, traumatic events, number of traumatic events, personal experience of traumatic events, number of traumatic events personally experienced) with respect to the presence of PTSD, we used univariate logistic regression (Table 1).

Multiple logistic regression was then used to find out which of the above factors affected simultaneously the presence of PTSD. Selection of the important factors was made by Forward Stepwise Selection and Backward Stepwise Elimination (Table 2).

Discussion

The high percentage of the sample who had personal experience of traumatic events (70.7%) can be compared with figures from other researches that show high percentages of exposure of refugees to organized violence. This may indicate a generally high prevalence of exposure to organized violence among refugees from conflict areas, who have no other possibility of refuge than a temporary camp.

Some interviewers suggested that women had been exposed to sexual violation. Our examination procedures did
not allow for exploration of these suggestions, one reason being that this subject is very much taboo. We therefore assume that the information we received about sexual violations of women (only one woman of the total sample reported it) represents minimum figures on the matter.

44.8% of our sample suffered from PTSD. This high percentage is not surprising since similar percentages have been reported by other researchers\(^{10,11,14}\) on refugees from Bosnia-Herzegovina. But it underlines the great need to take measures, or to implement existing measures, to give medical treatment and rehabilitation to these people.

As was obvious from our analysis, the health of these people was related, statistically, only with the factor "traumatic events" and more specifically, with the personal experience of traumatic events and the number of these events. The significance of other social-demographic factors (such as sex, age, marital status or education) was not statistically important. Kotaric-Kovacic\(^{31}\) reported that a single traumatic experience of our sample that were involved in the generation of PTSD was related statistically, only with the factor "traumatic events". Kotaric-Kovacic\(^{31}\) reported that a single traumatic event of our sample that were involved in the generation of PTSD was related statistically, only with the factor "traumatic events". Kotaric-Kovacic\(^{31}\) reported that a single traumatic event of our sample that were involved in the generation of PTSD was related statistically, only with the factor "traumatic events".

### Table 1. Univariate Logistic Regression of PTSD.

<table>
<thead>
<tr>
<th>Variables</th>
<th>B</th>
<th>SE</th>
<th>Sig</th>
<th>Exp (B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td>1.0560</td>
<td>0.0629</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td>1.8426</td>
<td>0.3478</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;34</td>
<td></td>
<td></td>
<td>0.0514</td>
<td></td>
</tr>
<tr>
<td>35-49</td>
<td></td>
<td></td>
<td>0.0148</td>
<td></td>
</tr>
<tr>
<td>&gt;50</td>
<td></td>
<td></td>
<td>1.0562</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>married</td>
<td></td>
<td></td>
<td>0.3941</td>
<td></td>
</tr>
<tr>
<td>unmarried</td>
<td></td>
<td></td>
<td>0.4286</td>
<td></td>
</tr>
<tr>
<td>divorced</td>
<td></td>
<td></td>
<td>0.6109</td>
<td></td>
</tr>
<tr>
<td>widowed</td>
<td></td>
<td></td>
<td>1.6227</td>
<td></td>
</tr>
<tr>
<td>Education Level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-6 years</td>
<td></td>
<td></td>
<td>0.2364</td>
<td></td>
</tr>
<tr>
<td>7-12 years</td>
<td></td>
<td></td>
<td>0.7639</td>
<td></td>
</tr>
<tr>
<td>Higher Education</td>
<td></td>
<td></td>
<td>1.1764</td>
<td></td>
</tr>
<tr>
<td>Profession</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>labourers</td>
<td></td>
<td></td>
<td>0.9687</td>
<td></td>
</tr>
<tr>
<td>scientists/dealers</td>
<td></td>
<td></td>
<td>-1.4053</td>
<td>0.0033</td>
</tr>
<tr>
<td>retired/unemployed</td>
<td></td>
<td></td>
<td>-1.6725</td>
<td>0.0053</td>
</tr>
<tr>
<td>students</td>
<td></td>
<td></td>
<td>-0.8886</td>
<td>0.0002</td>
</tr>
<tr>
<td>Duration of being refugees</td>
<td></td>
<td></td>
<td>0.0008</td>
<td></td>
</tr>
<tr>
<td>Duration of stay in the camp</td>
<td></td>
<td></td>
<td>0.0405</td>
<td></td>
</tr>
<tr>
<td>Trauma events</td>
<td></td>
<td></td>
<td>0.0592</td>
<td></td>
</tr>
<tr>
<td>Personal experience trauma events (heard or seen)</td>
<td></td>
<td></td>
<td>0.0143</td>
<td></td>
</tr>
<tr>
<td>Number of personal experienced trauma events</td>
<td></td>
<td></td>
<td>-1.8426</td>
<td>0.0001</td>
</tr>
<tr>
<td>Head injury</td>
<td></td>
<td></td>
<td>0.3388</td>
<td></td>
</tr>
<tr>
<td>Loss of senses after a head injury</td>
<td></td>
<td></td>
<td>1.2383</td>
<td></td>
</tr>
</tbody>
</table>

### Table 2. Multiple Logistic Regression of PTSD.

<table>
<thead>
<tr>
<th>Variables</th>
<th>B</th>
<th>SE</th>
<th>Sig</th>
<th>Exp (B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td>0.0428</td>
<td></td>
</tr>
<tr>
<td>Trauma Events</td>
<td></td>
<td></td>
<td>0.5470</td>
<td></td>
</tr>
</tbody>
</table>

References

The Swiss Red Cross Therapy Centre for Torture Victims in Bern, Switzerland

Conrad Frey, MD, Medical Director* & Ladislav Valach, PhD, Research and Documentation*

In the early 1990s, following a Swiss Red Cross study on tortured refugees in Switzerland1, a feasibility study was contracted and performed on establishing a specialized therapy centre for torture victims2. The establishing and running of the Red Cross Centre was defined as a project taking 12 years to complete.

The Centre was established in new premises in the area of the Bern University hospital, Inselspital, and opened in September 1995.

Organization

Tasks

The out-patient centre is a medically supervised and managed institution offering interdisciplinary consultation and out-patient treatment to torture victims and war traumatized people and their relatives. In addition, it covers research and documentation, further education and training of all those dealing with refugees, as well as co-ordination between various careers, and, finally, it performs referral services and sets up arrangements for those who cannot be catered for at the Centre.

The supervising organization

The supervising organization is the Department for Refugee Aid of the Swiss Red Cross.

Supporting organization

There is a supporting organization whose founding members are professionals and politicians. The group of supporters has grown substantially and consists of people from a broad occupational and social spectrum.

Internal structure

There is a psychiatrist who is competent in adult and child treatment and who acts as a full-time medical director, an economist who works as a full-time administrator, and ten part-time co-workers: two medical doctors for somatic check-ups and consultations, two psychologists-psychotherapists, two social workers, a physiotherapist, a nurse, a secretary and a psychologist-researcher. A team of carefully selected freelance interpreters are contracted and thus subjected to the same liability as all other members of the Centre. As much as the limited resources allow, the rule of gender parity is observed, enabling us to cater for female and male patients alike.

Premises

The Centre, although not a part of the University, is located in Bern's University hospital area (Inselspital).

Financing

On establishing the Centre financial support was provided by the Swiss Red Cross. The Federal government and some canton governments contributed seed money to start the Centre. Should the proposed revision of the asylum law be accepted by the Swiss parliament we can hope for an annual contribution by the Federal government. However, at the moment, the main financial source will be donations. An innovative money raising campaign was initiated in which artists and art collectors donated works of art for an auction of which the centre will be the beneficiary. The health insurance of the patients cover only a small part of the medical and therapy costs.

Opening of the Centre

The official opening of the Centre was in September 1995.

The patients and clients

The decision to treat is solely oriented at symptoms and depends on subjective, somatic, psychological and social com-
plaints of the patients. There are no restrictions with regard to age, gender, country of origin, language, religion, political affiliation or the method, place or time of the torture. However, only those refugees whose request for asylum has been processed can be included in the whole therapy programme. Other migrants will be helped further by the co-ordination and information office operated by the Therapy Centre.

**Therapy**

*The general therapeutic approach*

The main goal of the therapy can be characterized as empowering, as helping torture victims to renounce the role of victim, and leading them towards an active life as torture survivors. The therapeutic relationship can be qualified as an attempt to understand and accept the tortured persons with all their experiences, and to show solidarity. We provide physical and emotional security for the patient, respect the patient’s self determination, express a clear political stance based on human rights and emphatic respect of religion and culture, and deal comprehensively with the whole person in his/her socio-environmental embedding.

**Therapy methods**

This approach implies a multimodal and interdisciplinary therapy in which the patient’s family is included. The following methods of psychotherapy are used: cognitive behavioural therapy, psychodynamic therapy, systemic family therapy, gestalt therapy and body oriented therapy. These are complemented by medical therapy, counselling and social support.

**Tasks of the team**

The team is engaged in tasks at three levels of responsibility. It represents a functioning community for patients and strives for the therapy goals. It serves the community by increasing co-ordination between the therapeutic and counselling resources, by providing knowledge, by disseminating knowledge and in sensitizing society to the problems of torture victims. Finally, it serves individual members of the team in supporting them (psychohygiene).

**Co-operation with other helpers**

An attempt is made to develop close co-operation with various University Hospital in and out-patient clinics. The location at the University Hospital facilitates the development of such a network. Specialists monitor injuries and damage from physical torture. In order to optimize the use of all therapeutic resources, a case oriented co-operation with regional counsellors and carers (aid agencies, social services, physicians, psychotherapists) is sought.

**Organization of the treatment**

The following diagnostic-therapeutic phases are observed, based on experience in other Centres (RCT, Copenhagen). First, a clarifying phase performed by two team members. A comprehensive history is taken and the patient is examined with respect to physical, psychological and social problems. Second, a treatment plan is worked out. Family members are included. The treatment is monitored and a time plan is reconsidered. Third, in the therapy itself, cognitive, emotional and reintegration phases can be distinguished. Fourth, aftercare and follow-up are also an integral part of the treatment.

**Supervision**

Therapy is performed by various specialists such as psychiatrists, psychologists, social workers, nurses, medical doctors and physiotherapists, and also by a team. Regular team supervision completes the monitoring and supportive working environment.

**Interpreters**

They play an important part. The role of an interpreter must be clearly defined in advance; interpretations should be from and into the mother tongue of the patient; interpreters should not be known to the patient prior to therapy, and family members are not used as interpreters; there should be no private contact between patient and interpreter following the therapy; interpreters are not responsible for the therapy, but each therapist offers discussion and seeks an exchange with the interpreter; interpreters should not work for a governmental office during their contract with the Centre; the patients should know their right to request another interpreter; professional discretion is imperative.

**Further education**

Considerable energy is given to outlining proposals for further education and training projects, planning and participating in lectures, discussions and training, and in supervising students’ theses on medical subjects, psychology and social work. One of the goals is to enable other professionals in health care services to take over the treatment and therapy of the torture victims so that the Centre can be transferred to regional offices in about ten years.

Some of the information on the Centre and on the question of torture victims will be presented at a current series of education courses on migration organized by the University of Bern¹. Following the establishment of the Centre a series of introductory lectures and courses are planned and already partly executed; they address various groups, e.g. nurses, general practitioners, social workers, psychologists, remedial educators, and administrators. Particular attention will be given to informing the public in order to promote better understanding of the situation of the torture victims and of our work.

**Some research themes**

It was indicated in the feasibility study that research activities will be an important agenda and that an interdisciplinary research approach is required. The utility of the therapeutic concepts, further education concepts, co-ordination concepts and, finally, the financial benefits for the health services are some of the pertinent themes.

**Information and Co-ordination Office**

The Swiss Red Cross Therapy Centre for Torture Victims is running an Information and Co-ordination office for refugees seeking asylum. It aims at better use of the resources for counselling and treatment of torture victims available in Switzerland. Its task is to counsel and support refugees seeking asylum, and to help them in their search for appropriate treatment and for experts’ reports.

**References**

1. Wicker HR. Die Sprache extremer Gewalt: Studie zur Situation von gefolterten Flüchtlingen in der Schweiz und zur Therapie von
The Stress Clinic, Institute for Mental Health, Belgrade, FR Yugoslavia

Dušica Lečić-Toševski, MD, DMSc, Neuropsychiatrist, Associate Professor of Psychiatry*,
Bogdan Drakulić, MD, MA, Psychiatrist**, Zoran Illić, MD, Psychiatrist**,
Saveta Draganić, MD, MA, Psychiatrist**,
Vladimir Jović, MD, MA, Resident in Psychiatry**,
Dejan Florihić, MD, Resident in Psychiatry**, &
Srdan Bokonjić, MD, Neuropsychiatrist**

The Stress Clinic at the Institute for Mental Health (IMH), Belgrade, started to function in 1994, after the necessary preparations at the end of 1993. Due to the unfortunate events in the former Yugoslavia, the predominant activity of the Clinic was in the field of primary, secondary, and tertiary prevention of the acute and chronic psychosocial consequences of major war- and exile-related traumas. The severe sanctions of the international community against FR Yugoslavia (Serbia and Montenegro) considerably worsened the general and, in particular, the humanitarian situation in the country, both for the local population and for 700,000 refugees. The Stress Clinic, nevertheless, managed to keep the focus on the prevention and treatment of stress reactions of different genesis: natural and man-made disasters, illnesses, loss of close relatives, severe somatic illnesses, surgical interventions, marital and family problems, existential problems, etc. Considering the intensity and duration of the stressors which the majority of the population in FR Yugoslavia is exposed to, it is expected that a high prevalence of stress disorders will continue in the years to come.

The staff of the Clinic comprise psychiatrists, psychologists, and social workers, in cooperation with expert consultants in neurology, endocrinology, oncology, law, and other relevant fields. The finalists at the School of Medicine are also involved in the activities.

The levels of the Clinic’s functioning, determined by its objectives, are: organizational, diagnostic-therapeutic, research, educational, and prevention of the psychosocial consequences of crisis.

Organizational level
The out-patient unit is open morning and afternoon five days a week, thus being easily accessible to the target population. The Stress Clinic is directly connected with three day-hospitals of the IMH and in-patient wards, so that severely traumatized people can be hospitalized. It also cooperates with the Department for Child and Adolescent Psychiatry, the Centre for Marital and Family Therapy, and the Department
for Research and Training of the IMH. Outside the Institute
the Clinic cooperates continuously with primary health care
centres, and with other psychiatric institutions and humani­
tarian organizations, above all with the UN High Commis­
sioner for Refugees (UNHCR) and the Red Cross. The
Clinic has established its own computer database, and each
patient has specially prepared files (diagnostic, follow-up,
and evaluation). The Stress Clinic is a member of the Balkan
Network for Rehabilitation of Torture Victims.

Diagnostics and therapy
In addition to clinical interviews, a number of contemporary
diagnostic measures are taken (for clinical syndromes, stress,
personality, child abuse, defence mechanisms, etc.). Follow­
up and team assessment of the individual cases are also car­
rried out. Individual therapy (analytically oriented, cognitive,
stress-inoculation training, relaxation) is carried out at the
Clinic, and group therapy is planned. A specific target-phar­
macotherapy, based on contemporary knowledge about the
biopsychosocial nature of stress reactions, is being applied.

Research
Several research projects are being carried out at the Clinic.
The findings form the basis for doctoral and master theses,
presentations at congresses and seminars, and articles for
publication in national and international journals. The most
important topics of these projects are: epidemiological char­
acteristics of stress disorders, co-morbidity of the PTSD and
other disorders, the PTSD and personality/personality disor­
der, the PTSD among raped women and war invalids, psy­
chiatric disorders in refugees accommodated in collective
centres, the stress and malignant diseases, etc.

Education
Members of the Stress Clinic actively participate in the train­
ing of people who are faced with the problem of stress disor­
ders at various levels (psychiatrists and general practitioners).
The training of professionals is carried out through seminars,
professional meetings, and supervision. Through the series of
seminars organized by the Swiss Disaster Relief, whose expert
team involves members of the Clinic, several hundred
para-professionals and laymen who work in collective centres
were provided with basic knowledge of stress disorders.

In future, the Clinic will work on the introduction of disas­
ter psychiatry into graduate and postgraduate studies at the
School of Medicine.

Prevention
Since July 1991, the Stress Clinic has been much involved in
the Programme of Psychosocial Support to Refugees. Since
October 1993, the Programme has been implemented with
the support of UNHCR. For this purpose, a network of 100
teams in FR Yugoslavia has been established, based on the
regional principle. The teams consist of psychiatrists, psy­
chologists, and social workers, whose work is initiated, sup­
ported, coordinated, and supervised by the Clinic. The team
members are directly involved in resolving the psychological
and all other existential problems of refugees, particularly in
collective centres. Within the Programme, close cooperation
has been established and maintained with the Red Cross and
other humanitarian agencies, centres for social work, primary
health care centres, governmental institutions, the mass
media, etc.

Future plans
In future, in addition to the continuation of ongoing activ­
ities, the Clinic will work on introducing disaster psychiatry
in medical schools and carry out continuous training of
physicians, psychologists, social workers, and laymen. Spe­
cial emphasis will be given to the training of primary health
care workers and to the development of community psy­
chiatry. The Clinic will communicate with centres for disas­
ter psychiatry in other countries, and will initiate cross-cul­
tural research. The biological research of trauma is planned in
cooperation with immunologists, according to the principles
of psychoneuro-immunology. The Clinic will produce papers
and publications, and will organize seminars and conferences
with multi-profile participation and multi-disciplinary co­
operation.
A true friend of mankind, the father of victimology, the Norwegian Professor of Psychiatry Leo Eitinger, died on 15 October 1996 in Oslo at the age of 83.

Leo Eitinger was internationally renowned for his great unselfish work in helping his fellow concentration camp prisoners. His research work on the kz-syndrome became the foundation for all future work in this field.

Leo Eitinger was born on 12 December 1912 in the town of Lomnice in the part of the old Austro-Hungarian Empire that is today the Czech Republic. He graduated as a medical doctor in 1937, but, because of his Jewish background, he was deprived of his right to practice as a doctor. With the approach of the Nazis he fled to Norway in 1939, with support from the “Nansen Aid Programme”.

In his new home country, Leo Eitinger took up his medical practice, but after the Nazi occupation of Norway in 1940 he was once again deprived of his right to practice, again because he was a Jew. In March 1942 he was arrested by the Nazis and was kept in different Norwegian prisons and concentration camps until he was deported to Auschwitz in 1943. 600 Norwegian Jews were sent to Auschwitz; only 12 of them survived.

Auschwitz taught him what “the evil in man combined with the madness of racism can accomplish”, as described in his book “Experiences of Life”. In the concentration camp Leo Eitinger practised as a doctor, which made it possible for him to help his fellow prisoners, not only through his medical skills and his great compassion, but also by succeeding in saving people from the gas chambers by falsifying their papers. He was forced out on the infamous “march of death”.

By contrast with so many others who assisted the concentration camp prisoners after the war, Leo Eitinger had inside knowledge of their situation and of the after-effects of such tragic experiences. It was based on his experience from the Nazi camps that his future work as a psychiatrist was focused on questions such as: Is it possible ever to become a whole and normally functioning person again after having experienced such horrors? Is it possible to grasp the consequences of such inhuman treatment? What possibilities are there for helping these people? He would quote the philosopher Theodor Adorno: “After Auschwitz, how is it possible to think of humanity and the human race? After Treblinka, will it be possible to write poetry again?”

After the war he took up his practice again as a medical doctor in Norway, and became a specialist in psychiatry. He carried out large-scale studies on the psychological effects of traumatic stress in different groups of the population, and his contributions were crucial to the development of this particular field of research. His doctoral thesis from 1958 was a psychiatric examination of refugees in Norway. It was, however, his publications on the kz-syndrome that earned him wide international renown. He became the father of victimology (the study of how aggression affects the victims). He was the first researcher to focus on the victim and not the aggressor. His main field of research became the victim's ability to cope with anxiety and other sequelae of, for example, rape, hostage-taking (together with Lars Weiseth, Professor of Psychiatry, he documented the “Stockholm syndrome”), and attacks.

Leo Eitinger always gave his full support to the rehabilitation work with torture victims. He was among the first counsellors of the Rehabilitation and Research Centre for Torture Victims (RCT), always being ready to offer his help and advice whenever needed – at meetings, lectures, inaugurations of new centres abroad, or in publications, etc. It has always been his ethical standard that we have tried to live up to.

Leo Eitinger was a professor and senior psychiatrist at the Psychiatric Clinic of Oslo University from 1966 to his retirement in 1983. Many honorary offices were bestowed on him, and he received a number of honorary awards, the latest being the prestigious WISMIC-Prize, which he received from the World Federation of Veterans on 12 November 1995.

All his life, also after his retirement, Leo Eitinger was actively fighting racism and anti-semitism. In the chapter on “Values that must be defended” in his book Menesker blant mennesker (Humans among Humans), he prescribes how to fight racism: The first condition is a society with true democracy where human rights are not just officially recognized, but where they are safely lodged in the mind of each citizen. The next condition is vigilance: each time anti-semitic, racist, or other discriminatory remarks or tendencies arise in the public debate, they have to be denounced, strongly and clearly.

The most important thing, however, is to realize that neither democracy and tolerance nor mutual understanding...
and respect for fellow human beings and their rights can be taken for granted. They are noble values, costly privileges, treasures that you have to fight for, conquer, defend and reconquer every single day, so to speak.

The beautiful book about Leo Eitinger, Læge for livet (Physician for Life), quotes at the end one of the numerous concentration camp prisoners who owe so much to Leo Eitinger. It is the Nobel Peace Prize Winner Eli Wiesel, who says, “Even down there, in the inhuman hell, even there it was possible to be human. And good. – What have we learnt from Sjoa? That the human being must prove that he is human even in a world where he is destined to endure humiliations and horrors. Between the torturers’ sneers and the victims’ tears there must be room for a comforting smile. – It is not surprising that he became a psychiatrist. Without him it would have been impossible to survive the madness of the world. Between the torturers’ sneers and the victims’ tears – between the pain of sickness and the patient’s tears – there was an upright fellow human being."

While Sjoa lived we tried to show him how much we loved and respected him. But a person like him can never be thanked in the way he deserves.

Inge Genefke, MD, DMSc hc
Secretary General, IRCT
Copenhagen
Denmark

Literature

Amnesty International conference launches Plan of Action Against Torture

An International Conference on Torture, numbering 120 participants from 50 countries, in Stockholm, Sweden, on 6 October 1996 launched a plan for worldwide action.

The Plan of Action Against Torture highlights the need for legal reforms, national and international inspection visits to places of detention, and an end to impunity for the perpetrators of torture.

“For too long, governments have failed to live up to their commitment to abolish torture,” said Dick Oosting, the conference chairman and a lawyer from the Netherlands. “It is time for human rights workers everywhere to join forces to step up the fight against torture and hold governments accountable.”

The plan states that non-governmental organizations should draw up programmes for legal and institutional reforms for the abolition of torture in every country. They should also establish a system of vigilance so that any occurrence of torture will be detected and swiftly acted on. Special support should be given to vulnerable social groups, raising their awareness of what constitutes torture and of their rights and how to defend them.

An important part of the plan states that respect for human rights is inherent in policing. Human rights education should be built into training programmes on police ethics and professional conduct. Action to prevent torture is needed because police officers are among the first to run the risk of violating human rights.

The Plan of Action Against Torture, believed to be the first of its kind, also states that governments should be pressed to adopt the strongest possible Optional Protocol to the UN Convention against Torture, providing for a global system of inspection visits to places of detention as a safeguard against torture. The system can and should be set up by the year 2000.

The International Conference on Torture also adopted the following as parts of the new plan of action:

- Non-governmental organizations (NGOs) should work for the increased use of on-site international monitoring and investigation. Where such field presence can operate under proper conditions, it can be a direct and potent way of protecting people from torture.
- NGOs should work together to document and oppose transfers of equipment, know-how and training for military, security or police use that facilitate torture by governments or armed opposition groups.
- NGOs should oppose all forms of sexual abuse by state agents, reaffirming in particular that rape by state agents clearly constitutes torture.
- NGOs should explore ways of collecting information on those responsible for torture with a view to ensuring that they are brought to justice.
- NGOs should press governments to pass effective laws and take action so that alleged torturers from anywhere in the world who enter their country are investigated, arrested and prosecuted or extradited, as required by the UN Convention against Torture.
- NGOs should continue campaigning together for the establishment of a just, fair and effective Permanent International Court by 1998.

Sunday 6 October 1996
How to make the world better


The report Prescription for change by Amnesty International (AI) focuses on the role of the health professional as witness and exposers of torture and other human rights violations. Health professionals are well placed to observe such violations: victims may seek medical treatment for their injuries, and cases of mishaps and death in custody require medical certification. In some countries, e.g. Iraq and Pakistan, doctors can be forced to carry out amputations or supervise flogging. Moreover, some doctors assist governments actively or passively in the practice of violating human rights.

The difficulties many health professionals face in keeping up with acceptable ethical standards are well described by many examples. At least one Iraqi doctor has reportedly been executed and many have been imprisoned for their refusal to exercise medicine punitively. There are many other examples from, for example, Turkey, Kenya, and Peru.

Thus, the health professional often finds him/herself in a dilemma: the moral obligation towards the patient vs the demands of the authorities.

Ideally, in such conflicts, the doctor should be able to rely on the support of their professional associations, nationally and internationally. AI mentions the insufficient wording of the WMA Declaration of Tokyo and the UN Standard Minimum Rules for the Treatment of prisoners; it is stated what the doctors should NOT do, but guidelines are not given for what should be done when cases of human rights violations come to the knowledge of the doctor. By contrast, the code for nurses states that nurses who have knowledge of ill-treatment of detainees must take appropriate action, including reporting the matter.

AI stresses the importance of proper training for health professionals in the field of documentation of human rights abuses. Lack of training is seen as an important factor in the failure to recognize and report human rights violations.

The report gives guidelines for collecting and processing medical evidence of human rights violations in order for it to be effective. A medical examination may by itself be a protective measure; during the period of a detention repeated medical examinations may influence the course of the case, provided that the medical examiner is independent and feels safe to report any remarkable medical finding without fear of retribution.

The protection of the reporting doctor is a matter for both the national authorities and the international community. Professional associations must set out clearly what their members are expected to do when they encounter evidence of human rights violations. Governments must offer doctors clinical independence, including absence of reprisals, and adequate professional training, including human rights issues.

The recommendations of the report are addressed to the UN, the WHO, national governments, and to national and international professional associations. These recommendations once again stress that the observance of human rights is an issue for the international community. Doctors must be independent of the authorities that are responsible for detention, and the latter in turn should be independent of the interrogating authorities. Personnel who violate human rights must be brought to justice. Support for individual health professionals who report human rights violations should be offered by both national and international bodies, e.g. the professional associations.

The report is an important document. One hopes that it will reach the relevant bodies and governments, and that the recommendations will be included in future international declarations, which should define more extensively the role of the health professional. It is hoped that the recommendations will be included in national laws and practices in the future. Meanwhile, the international community should continue to put pressure on countries in which human rights are systematically violated. Cases of retaliation by a state against health professionals who have fulfilled their moral duty to report on, for example, torture must be made public; this is now probably the best way to offer protection for health professionals.

Hans Draminsky Petersen
Granstuevej 13
DK-2840 Holte
Denmark

Torture / medical ethics – and the case of Israel


The book comprises the Proceedings from the Conference on the International Struggle Against Torture and the Case of Israel, Tel Aviv, 13-14 June 1993. More than 450 persons participated.

The book is about torture performed by Israel against Palestinians up till June 1993. To the best of my knowledge, it is unfortunately not out-dated: the torture goes on – and, even worse, Palestinians are now also torturing Palestinians.

The book consists of four main parts, and “each part consists of chapters providing a theoretical analysis of the issue, concluded by action-oriented recommendations taken from the conference’s working groups. This combination and balance of an academic approach with practical prescriptions for
BOOK REVIEWS

action make the book unique” – an evaluation with which the reviewer agrees totally.

The first part, “The public realm”. In this, Haim Gordon describes why torture is torture who performs it, and why it goes on. He ends by saying: “In summary, I want to stress one crucial point. The unwillingness of liberals, doctors and even human rights agencies to straightforwardly challenge and to firmly denounce state-sanctioned sadism often allows it to continue unabated. I hope that such a firm denunciation will emerge from this important conference.”

Stanley Cohen, in “The social response to torture in Israel”, gives, prophetically, the Israeli authorities’ answer to accusations:

“What is happening.”

“What is happening is really something else.”

“What is happening is completely justified” – which, by the way, are exactly the answers given by the Israeli delegation to the Committee against Torture, when presenting Israel’s report at the meeting in April 1994.

Jonathan Fine ends the first part of the book by reporting from the workshops. He presents very practical proposals for action.

Part II, “Participation of health professionals in the practice of torture: the struggle against it”. Ruchama Marton describes the conditions in Israel in a very moving way and also mentions, among other things, the famous (ill-famed) “Medical fitness form” (printed in the book). In all fairness it should be said (and it is written in the book) that the President of the Israeli Medical Association repudiated the form as soon as she knew about it, and the form is no longer used.

Hernán Reyes writes: “The conflict between medical ethics and security measures”, and James Welsh: “The role of codes of medical ethics in the prevention of torture”. Both articles are musts for everybody involved in the work against torture – for which reason they are not described in detail here.

Mamdouh Al-Aker, a doctor, describes four severe cases (including his own) of ill-treatment and torture, and asks what the IMA does in such cases. James Welsh ends by reporting from a workshop, presenting practical proposals for action.

Part III, “The legal struggle against torture” is about legal matters, but should be read by doctors as well. It makes awe-inspiring reading. It describes how the GSS (General Security Services) arose, based on some circulars and not subject to any law.

Furthermore, the ill-famed Landau-Report is described, with the secret chapter that gives the definitions of “Moderate physical pressure”. Thus, Israel takes a special position among all other countries of the world:

The State of Israel permits torture officially.

Part IV: “Rehabilitation of torture victims” deals with a more familiar subject for the readers of the journal TORMURE. Inge Genefke accounts for the evidence of the use of torture – torture seen in a global perspective

Eyad El-Sarraj describes torture among the Palestinians – very convincing reading indeed. Neve Gordon talks about compensation as a link in the rehabilitation, and finally Helen Bamber gives a description of the treatment in the Medical Foundation.

At the end, the book has some useful appendices: Conventions, Codes of Ethics, Declarations, etc.

The book weighs 244 g and measures 13.5 by 21 cm. You can easily have it in your pocket or at the bedside. It should be essential reading for everyone involved in the work against torture.

Bent Sørensen, Professor, MD, DMSc, Vice-Chairman of the UN Committee against Torture (CAT) and Member of the Council of Europe’s Committee for the Prevention of Torture (CPT) RCT/IRCT, Copenhagen, Denmark

Break of medical neutrality


This report describes and analyses the medical implications of the massive human rights violations in the former Yugoslavia. It starts with a short sketch of the historical background of the war and reviews the content of the main principles in International Humanitarian law and Human Rights Conventions.

The title Medicine under siege in the former Yugoslavia points to a tragic and disastrous reality of this civil war – the intentional attacks on hospitals, ambulances and other medical facilities. The book presents a detailed and systematic analysis of the infringements of medical neutrality. This analysis, based on concrete references, is the most valuable part of the report.

The authors distinguish between “Abuse of rights guaranteed by medical neutrality” and “Abuse of responsibilities required by medical neutrality”. The former is documented by examples of infringements against the sick, wounded, civilians, and medical personnel, such as killings and disappearances, torture or cruel, degrading treatment, harassment of medical functions, and punishment for upholding medical confidentiality. The massacre of patients at the hospital in Vukovar in December 1991 is described in detail. In this connection the important role of independent non-governmental organizations such as Physicians for Human Rights in unravelling the facts is demonstrated.

With regard to the second type of abuse, the authors distinguish between abuse of medical facilities, such as use of hospitals for military purposes, and abuse of medical skills, such as participation in torture and discriminatory treatment.

There are few facts about the latter type of abuse, and the
BOOK REVIEWS

report states: “So far, there appears to be no evidence that any of the warring factions in the former Yugoslavia have systematically used physicians and other health professionals to carry out war crimes against humanity”. The practice of “Discriminatory Medicine” is explicitly discussed with reference to The First Protocol to the Fourth Geneva Conventions, which states: “All the wounded (...) shall be respected and protected (...) with no distinction among them founded on any grounds other than medical ones”.

Although the ethnic conflicts seem to have been a central point in the war, there are only very few episodes in which discriminatory medicine has been documented. All the details of this issue have probably not yet been clarified. However, the facts so far indicate that most of the physicians and health personnel, working under extremely difficult conditions, maintained their professional integrity. The last chapter discusses the role of the international medical community. Although assistance from outside is necessary, the building of new cooperative structures with the existent institutions and colleagues in the new Republics in a transition phase is of utmost importance. (This is exemplified by the four meetings during the period 1993-1996 between the Medical Associations in all the six Republics, the Norwegian and other Scandinavian Medical Associations, and WHO.)

*Medicine under siege in the former Yugoslavia* is a stimulating and valuable report that challenges the reader to go further into the important and growing interface between medical work and human rights.

Nils Johan Lavik
Professor, MD, DMSc, Director
Psychosocial Centre for Refugees
University of Oslo
Norway

---

From victim to survivor with the help of the group


Since the end of the 1980s, the number of victims suffering from the consequences of traumatic experiences has greatly increased among the population of displaced persons. These victims, having to face simultaneously the physical and psychological sequelae of violence, and the difficulties of displacement, exile, and immigration, often request medical and social assistance. Faced with this flow of refugees, the health care systems concerned are unable to provide individual help. Dr Perren-Klingler’s book is therefore a most welcome contribution to this problem, by highlighting some basic principles and guidelines for a collective approach to the treatment of these survivors.

Victims of violence who are treated in and by their own communities seem to have a better prognosis and a lower incidence of PTSD. The suggested approach to the treatment of large populations is therefore based on providing help in the reorganization of communities, enabling them to mobilize traditional resources and coping skills to assist individuals. This concept is supported by some basic findings: many cultures are unceptive to individual psychotherapy, the PTSD model is for many authors a culture-bound perception, there is a therapeutic benefit in clearly pointing out the failure of the state as the main cause of the suffering (which therefore should not be privatized in individual treatment), and, finally, migrants are often submitted to multiple traumatization (violence followed by the trauma of immigration and exile, difficulties of reception in the host country, waiting for political asylum). Retraumatization is then a major cause of chronic PTSD.

In this context a culturally dependent concept of treatment can be a major hindrance in dealing with traumatic experiences. Dr Perren-Klingler suggests a form of approach in which the patient is actively involved in the elaboration of his treatment. The assumption is that similar reactions may have a culture-specific interpretation, and that in most cultures silence is more pathogenic than useful. “Two-tiered thinking” consists therefore in establishing a relationship in which the helper uses his knowledge to guide the victim in the discovery of his personal coping mechanism and in the building up of his own answer to the problem.

After a traumatic experience, the culturally non-specific reactions described are a feeling of helplessness, breakdown of trust (the shattered assumptions), and extreme negative stress. The normal reactions to stress are physical overexcitation, dissociation, and focalization. The persistence of these normal reactions may lead to the Acute Stress Reaction, in which physical overexcitation, recurrent memories, and avoidance are maintained. Help should consist in providing support, security, and protection. Critical incidence stress debriefing (CISD) is the suggested tool to prevent the freezing of these coping mechanisms (avoidance or confrontation in the form of denial and intrusion) and the development of chronic PTSD. By confronting the experience on a cognitive level, and by learning to overcome and avoid the emotional reaction linked to the memory of the trauma, the victim is helped to work through his trauma. In this work the community support is essential and has a potentiating effect. Replacing the trauma in the social context favours distancing. Developing cultural coping skills favours the reconstruction of “basic trust” and social rehabilitation.

Ten adaptations of this model by helpers working in different countries, with different populations and in different political, social, and cultural contexts, are then presented. These cases underline the necessity for health workers to create a new approach for each individual or collective situation.

We agree with the author that supportive group treatment in and by the community is more effective and brings a better stabilization for survivors suffering from PTSD. It enables health care systems to provide assistance to large populations. However, there are situations in which community
BOOK REVIEWS

treatment is not possible. Some victims have great difficulty in rebuilding links with their community because the suffering was inflicted by the group itself, or because of feelings of shame and guilt, or because the story could be too disruptive for the community. On the other hand, as mentioned by the author, complete healing is seldom possible. A sensibility to hypertext will persist, as will the occasional recurrence of overpowering memories, and diminished faith and confidence. The suffering seems to be contained through the treatment and the help of the community, but the energy spent on this containment is often exhausting, finally bringing the victim to breaking point, at which help on an individual level is sought.

Dr Laurent Subilia
Travel and Migration Medicine Unit
Department of Community Medicine
University Hospital
Geneva
Switzerland

Nightmare or reality


Angela Delli Sante has written a historical book about Guatemala.


To the best of my knowledge, no one in any other country has produced so well-documented a description of a country in uproar/civil war. On top of that, Guatemala’s internal history and conditions, for everybody who has gone into the subject, have been very complicated – for most people incomprehensible. Delli Sante is able to give a clear description of the reasons for the civil war (it was a civil war!) and the functions of the involved parties in the conflict, including the role of foreign states such as the United States, Israel, Taiwan, and many European states.

The book contains horrifying sections on torture and ill-treatment; so cruel that one can only believe in them because the notes are so complete and convincing. The severity of the conflict is made concrete by these descriptions, but they also create an understanding of why the parties involved acted as they did, however painful this realization is to the reader.

When the work on the book was finished in April 1995, an end to the civil war seemed in sight – however far off, in Delli Sante’s opinion. She convincingly describes all the conditions that need to be changed in order to create a lasting peace.

On 29 December 1996, however, the parties in Guatemala signed the agreements, and there seem to be good reasons for hope in the future, especially if the momentum is used.

If the country is to be rebuilt, the inhabitants must be rehabilitated, so that they can participate as good democratic citizens in governing the country’s and their own future. In this connection there is a need for very large efforts indeed, also internationally, both by states and by NGOs – probably one of the biggest challenges put on the international community in recent times.

For all persons who are going to work for a lasting peace in the years to come, Delli Sante’s book is a must, and if the persons who are going to assist in this in Guatemala have read the book and acquired knowledge of its contents, many, many errors might be avoided in the future work. Thus, the timing for the publication of the book could not have been more perfect. It can contribute considerably to the creation of conditions on a rational basis which can ensure a lasting peace.

The list of acronyms has been very helpful to the reviewer, who is also very impressed by Delli Sante’s extensive knowledge and her language; despite the terrible contents of the book, it is easily read. The book should be read not only by everyone who is going to work for or in Guatemala; those who are interested in the problems concerning torture, and in Human Rights in general, can also profit from reading it.

Bent Sørensen, Professor, MD DMSc
Vice-Chairman of the UN Committee against Torture (CAT) and Member of the Council of Europe’s Committee for the Prevention of Torture (CPT)
RCT/IRCT, Copenhagen, Denmark

Children in armed conflicts


Research was conducted on the use or involvement of children in armed conflicts in some 20 countries where there was
evidence that children were involved in armed conflicts; and in-depth analysis in up to 10 further countries.

The report is divided into 9 chapters: (1) executive summary and recommendations, (2) the project, (3) introduction, (4) recruitment, (5) who are child soldiers? (6) treatment in armed forces and armed opposition groups, (7) demobilization, rehabilitation, and social reintegration, (8) military attitudes to child soldiers, (9) strategies to prevent recruitment. In addition there are two annexes.

Recruitment is divided into forced and voluntary recruitment. For the latter, cultural, ideological, economic, and social reasons, and protection are given. For example, ideological reasons involve children who volunteer for armed opposition because they believe in what they are fighting for. This may be synonymous with the stated aims of the group, the holy war, the fight for freedom, freedom to practice their religion, the right to occupy their ancestral lands, ethnic liberation, political liberty. Reasons for the deliberate choice to recruit children are that they are more easily moulded, manipulated, trained, and disciplined than adults. Furthermore, the young fighters normally have no family responsibilities, and they are healthy.

In order to cut off the possibility of return, a number of child soldiers are forced to commit atrocities against their own family or community, or to participate in operations against the rural community, in which many were born and raised. Many child soldiers are severely abused physically for failing at military training, failing asleep on sentry duty, or disobedience. Children are beaten to death or shot for attempted escape and disobedience.

In most cases, children receive the same training and health care as other soldiers. Many captured child soldiers are treated in the same way as captured adult soldiers. This means that they may be treated as criminals or terrorists, or they may be held in military prisons.

In direct violation of the Convention on the Rights of the Child, children participate actively in most of today's armed conflicts. An estimated 250,000 children under 18 are presently serving in government armed forces or armed opposition groups, children took part actively in 33 conflicts during 1995/1996, child soldiers often carry out extremely dangerous tasks such as spying and mine-detecting, and no peace accords have so far recognized the role and needs of child soldiers.

Concerning changes over time, it was found that on each side of the conflict in Afghanistan, some 10% of the combatants were under 16 years old during the first 14 years, and 16-18 years old, making a total of about 27% child soldiers. In the latest stage, however, characterized by hostilities between factions of the winning coalitions, the estimated proportions are 19% and 26%, respectively, making no less than 45% of the combatants child soldiers.

The chapter on psychological impacts is rather short. With respect to "trauma and recovery", the danger is mentioned of placing focus on the "traumatic" experiences and psychological consequences of these children which may lead to the implementation of a Western therapeutic or treatment model. A suggested alternative strategy is to focus on re-establishing support from within the child's immediate environment of home, family, and community. Perhaps the most significant issues that compromise the child soldiers' return to civil society are family reunification and re-integration.

However, for many of them, the army or armed group will have become their protector and provider, and they in turn will have identified with it. This loss, as much as the direct influence of militarization, should be recognized as influencing their behaviour, so that social re-integration is based on a process of re-attachment to their families and communities.

The Convention on the Rights of the Child is believed to address the core of the issues that must be considered in implementing procedures to secure the well-being of child combatants.

Physician complicity in misrepresentation and omission of evidence of torture in postdetention medical examinations in Turkey

Vincent Iacopino, MD, PhD; Michele Heisler, MPA; Shervin Pisehvar; Robert H. Kirschner, MD

Between June 1994 and October 1995, representatives of Physicians for Human Rights studied the problem of physician complicity in torture (i.e. misrepresentation and omission of medical evidence in postdetention examinations of detainees) in Turkey. The research consisted of a survey of medical reports of detainees, and interviews with survivors of torture. Results from the survey, interviews, and medical report analyses provide evidence that torture of political and criminal detainees continues to occur in Turkey and that Turkish physicians are coerced to ignore, misrepresent, and omit evidence of torture in their examinations of detainees to certify that there are no physical signs of torture.

JAMA. 1996;276:396-402

Professor Karl Peltzer
Dept. of Psychology
University of the North
Private Bag X1106
Sovenga 0727
South Africa
FORTHCOMING CONFERENCES AND SEMINARS

Ioannina, Greece 5-7 September 1997

Stress – related to violations of human rights – and its consequences

Organised by The Rehabilitation Center for Torture Victims of Ioannina and The University of Ioannina
First Announcement

Further information:
Rehabilitation Center for Torture Victims
RCTV
Organizing Secretariat
14, Korai Street
45444 Ioannina
Greece
Phone: +30 651-78810
Fax: +30 651-72378

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.