CONTENTS

EDITORIAL
UN Torture-Resolution, 1997 ........................................ 35

DOCUMENTATION AND BACKGROUND
Medicine’s search for the truth
Steve Kahanowitz .................................................. 36
Effective implementation of the Principles of Medical Ethics
Erik Holst .................................................................. 39
Need for international funding of rehabilitation services for torture victims worldwide
IRCT .......................................................................... 41

INVESTIGATIONS AND RESULTS
Torture survivors, dental and psychological aspects – illustrated by two case stories
Birna Jerlang, John Orloff & Peter Jerlang ........................................ 43
The self-concept and the alienation of Palestinian adults: a comparative study between Gazans and returnees
Ramadan T. Kodaih ................................................................ 46
Psychological effects of torture: a comparison of political detainees and non-political prisoners in Malawi
Karl Pelzer ....................................................................... 48
Torture inside and outside police stations in Egypt 1993-1996
El Nadim Center ................................................................ 54

CENTRE PRESENTATIONS
El Nadim Center, Egypt .................................................... 55

DE JURE, DECLARATIONS ETC.
The need for a Special UN Rapporteur on Health Professionals and Human Rights .................................................. 56

CONFERENCE REPORTS
Quality Course for Advanced Therapists in Copenhagen ................................................................. 58

LETTERS TO THE EDITOR
Pentagon admits torture education ........................................ 60

OBITUARY
Erik Karup Pedersen, consultant surgeon ........................................ 61

BOOK REVIEWS
Fotler: an der Seite der Überlebenden, Unterstützung und Therapien ........................................ 61
Michael Lapsley – priest and partisan: a South African journey ...................................................... 62
Report on knowledge, attitude and practice of physicians in India concerning medical aspects on torture ...................................................... 63

NEWS IN BRIEF
Selection of a new High Commissioner for Human Rights ............................................................. 63

ANNOUNCEMENT
Bent Sorensen’s Travel Grants .................................................. 58
Selected list of publications .................................................................. 42, 47, 53, 63

Forthcoming conferences and seminars ......................................................................................... 64

34
UN TORTURE-RESOLUTION, 1997

It is significant for the 53rd Session of the Commission on Human Rights that, in connection with the 10 year anniversary of the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, it was decided to suggest to the UN General Assembly that June 26 should be a UN International Day in support of the victims of torture and the total eradication of torture and the effective functioning of the Convention against Torture of 1987 — something IRCT has been advocating for years.

IRCT was present at and contributed to the 53rd Session of the UN Commission on Human Rights in Geneva, March and April 1997.

As a member of the Danish delegation, Erik Holst made a speech under agenda item 8 “Torture and other cruel, inhuman or degrading treatment or punishment” — a speech that is published on page 39 of this issue of Torture.

The Human Rights Commission’s resolution on torture this year contained a series of points that, in varied terms to the member countries, “takes note”, “urges”, “encourages”, “calls upon”, “stresses”, “reminds”, “emphasizes”, “welcomes”, “requests”, “considers”, “invites”, and “appeals”. With these requests in moderate diplomatic, but nevertheless clear language, the member countries are reminded of the obligations and reporting which the ratification of the torture convention entails and which to a very large extent are neglected, despised, or even counteracted. In this way the research done by IRCT has revealed that torture, which is used in more than one third of the countries of the world today, is done because governments want to stay in power. Therefore we refer to torture as the most destructive instrument of power used against democracy.

The Commission recalls that freedom from torture is a non-derogable right and that the prohibition of torture is explicitly affirmed in article 5 of the Universal Declaration of Human Rights, and further that no one should be subjected to torture or other cruel, inhuman or degrading treatment or punishment, and that such actions constitute a criminal attempt to destroy a fellow human being physically and mentally, which can never be justified under any circumstances, by any ideology, or by any overriding interest. The Commission is convinced that a society that tolerates torture can never claim to respect human rights.

The appeal to the UN urges all state parties to comply strictly with their obligations in accordance with article 19, including their reporting obligations. Also, the Commission on Human Rights “calls once more upon the international community to give due attention to the right to restitution, compensation and rehabilitation for victims of grave violations of human rights”.

The resolution encourages all governments to give serious consideration to inviting the Special Rapporteur to visit their countries, so as to enable him to fulfil his mandate even more effectively.

Furthermore, the Commission emphasized the importance of the UN Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment, articles 10 and 14, and of the UN Voluntary Fund for Victims of Torture, which was mentioned several times.

Inge Genefke, Secretary-General of IRCT, also talked about these topics and expressed herself very clearly in her plenary address:

“In article 10 it is mentioned that education and information regarding the prohibition against torture should be fully included in the training of law enforcement personnel, civil or military, medical personnel, and public officials. Very few of the ratifying countries have systematized this education.

In article 14 it is mentioned that the State Parties of the convention shall ensure in their legal systems that the victim of an act of torture obtains redress and rehabilitation. The three famous Ms: Moral, medical and money rehabilitation.

It is not difficult to implement these two articles of the convention. Because today we have sufficient knowledge and educational programmes, educational material, etc., sufficient knowledge about rehabilitation programmes. I repeat: It is not difficult to implement this. But very few countries have done so.”

She also spoke about the UN Voluntary Fund for Victims of Torture:

“Many of these courageous health professionals, who help victims of government sanctioned torture, are in great danger of becoming victims themselves – in fact many of them are already victims of torture.

They need finance urgently. They need protection desperately.

What can you do? You can in fact do a lot:

Firstly, you have the United Nations Voluntary Fund for Victims of Torture (UNVFVT). This year it has received 2.7 million USD, shamefully little compared with the need. This year only 24 countries have so far contributed to the Fund. The help is not just help with money. It also shows the donor’s disgust for the dictatorships in which government sanctioned torture is practised. The money would be a moral support and thereby protection for the many courageous people who work against torture. It would support the process of democratization. Finance shows your interest, will, and commitment – or the opposite. Here, sorry to say: The opposite.

Today the Fund appears as a shameful symbol of the bad will of many rich governments and others, to fight and work against torture."

It would be gratifying if this strong appeal to the will of the donor countries to increase their financial contributions resulted in increased funds available for the important and much appreciated work of the UNVFVT.

Concerning the global need for international funding of rehabilitation services for torture victims worldwide, IRCT also tabled a paper, which is published on page 41 of this issue of Torture.

H.M.
It was a noble manifestation of the aims of the present South African government when they appointed the Truth and Reconciliation Commission. This Commission has a very sensitive mission, which is to investigate the thousands of politically motivated murders and other crimes that occurred during the apartheid era, and to issue official pardons to White and Black perpetrators who fully admit their crimes. This Commission held a consultative workshop in November 1996 to reach consensus on the process through which the health care sector, particularly nurses, doctors and psychologists, can examine the role which it played and/or failed to play in the human rights abuses of the past. The keynote speech at this workshop was given by the human rights lawyer Steve Kahanowitz. We are grateful to be able to print a large part of the speech he made on that occasion.

Speech given by Steve Kahanowitz at the Truth and Reconciliation Committee-organized workshop for the Health Sector, Cape Town, 23 November 1996

Medicine’s search for the truth

I am moved by the writing in the South African Medical Journal of Christian Pross, Medical Director of the Centre for the Treatment of Torture Victims in Berlin, Germany. He reminds us of the post war period, of attempts by the few doctors to raise the very important issue of medical complicity in violations of human rights, of their being ostracized for doing so – and he says: “It would be a great achievement if you could break the silence among your own medical profession so early after the end of apartheid.” He suggests elsewhere that this would be a unique “historical opportunity”.

He makes the comment, knowledgeable of the German history and of complicity by the medical profession in the holocaust – a history of medical involvement documented by many others, including Robert Jay Lifton in his book “The Nazi Doctors: Medical Killing and the Psychology of Genocide”.

In it he writes of an Israeli in Haifa looking around his new world (his new South Africa) and saying: “This world is not this world.” He continues: “Psychologically speaking, nothing is darker or more menacing, or harder to accept, than the participation of physicians in mass murder. However technicized or commercial the modern physician may have become, he or she is still supposed to be a healer – and one responsible to a tradition of healing, which all cultures revere and depend upon. Knowledge that the doctors have joined the killers adds a grotesque dimension to the perception that this world is not this world.”

Perhaps as we continue on our democratic and constitutional path we need a very hard push so that we ensure that this (new) world does reflect this new world, and for that we need to understand the past.

But first – our law reports do not come to us silent on the question of medical collusion with human rights violations - there are the brave doctors who faced the oppressive legal regime of the state. I remind you who bravely stood up to challenge legal and medical professionals both in a court where a magistrate had tried to close down the Biko issue and in the South African Medical and Dental Council (SAMDC in the following), and to persuade them to listen, to listen, to listen again and then to judge and take action.

I will return often to the issue of the practice of the medical profession and the way in which the court (and the public) will in future need to see more vigorous and expeditious dealing with errant doctors. (If the role of medical practice is to be properly achieved.)

The Biko battle took many years. The legal question facing medical professionals today, which needs to be answered, may be whether the exchange of ideas, journal debate and stimulating workshops such as these are sufficient in light of evidence already brought before the Truth and Reconciliation Commission when one of your statutory obligations is to be the practice of medicine.

There are many other cases scattered through the law reports and in files that are worth noting.

In all these, professional ethics came into play, as Jay Levin, in the midst of the 1986 emergency, reminded us in the South African Journal of Human Rights:

“Professional ethics is concerned with describing a particular relationship between the professional and his patients. A central principle of professional ethics is that the client’s interests are given priority above the interests of all others. At least four internationally accepted codes of clinical practice have been established for professionals, the Hippocratic Oath, the Declaration of Geneva adopted by the General Assembly of the World Medical Association in 1948, the International Code of Medical Ethics adopted by the General Assembly of the World Medical Association in 1949 and the Declaration of Tokyo adopted at the 29th World Medical Assembly in Tokyo in 1975.”

My reaction to the very many cases is to ask whether all of them need to be reviewed, in light of a 1996 democratic perception of medical practice. The following other incidents could also be subject to the same review system.

Going through our law reports, we can see already a vibrant arena where certain actors, often actively searching for truth relating to the medical profession, interact with the security system. I submit that part of the battle reflects a desire by doctors to ensure that the ethical and legal duty to be practised is carried out by all doctors.

Secondly, the organized profession within its own ranks did not always come across as uniformly silent. Examples of this to me as an outsider include:

1. The SAMDC hearings show both a vigorous and a challenging environment where those who eventually preferred silence may have won – but for a short term and it is hoped not forever.
2. Recent reports are that you will make records available to the TRC.
3. Today is a continuation of the decision to research that past, and I want to turn to that debate briefly, again as an outsider.

Insofar as there are protagonists in this debate, all have said
let us explore, let us find out what happened. One approach says that the TRC process could suffice and let us grant them access to our records and apologize for past indiscretions, i.e. let outsiders judge us.

The other grouping says it is an empty apology, hollow, and shows the failure to get to grips with the real challenges.

The apology is documented and has been extensively discussed – the SAMJ editorial bluntly states that this is about “the Steve Biko saga and other incidents of unethical behaviour by doctors entrusted with the care of political prisoners ...”.

One notes that there is no hesitation here, no “alleged” or "apparent", as would appear in guarded comments.

The editorial concludes that, in light of the Medical Association of South Africa’s activities of the 1990s, it is now in a position of “having publicly come to terms with its past, the MASA is now content to devote itself to a better future for the medical fraternity and for the people of this country”. I will not judge whether the medical profession has indeed come to terms with its past. Those doctors who ask for more to happen than just the TRC activity do not accept that the profession should be content to devote itself only to the future – it must rectify certain wrongs if it is proudly to be allowed to practice.

I have looked at the initial 1995 MASA statement. It is much more than any Law Society has done. I do not believe that it is glib. It is frank and a not easily obtained admission. It does however hesitate at times: “MASA was perceived here and abroad as essentially a white organization” – why not simply concede that it actually was a white organization?

Furthermore the association “was perceived as and probably was insensitive and indifferent to the lot of its black members” – only “probably was”?

The statement did suggest scope for more enquiry, and when we look at the TRC ambit we will need to ask whether what is available through the TRC will be sufficient to enable a challenge that has to be met of the medical profession’s “coming to terms with its past”.

I started by looking at the German doctors who resorted to silence for so long after the war. MASA contrasts strongly, but possibly they go too far because at the end they state: “We hope ... that statement will stand as a beacon of our transition.” Thus they suggest, without recourse to the citizenry, the patients and the public, that they should be able to make that extremely important judgment themselves. I want to remind you that the SAMDC once did make that judgment themselves – and the courts had to chase them back and force them to reconsider. I would like to suggest that MASA’s admission is really in many ways but a start to, and acknowledgement of, the need for the transition.

There is another voice raising a challenge. An editorial letter of the September 1996 edition of the Medical Journal says that: “... For health officials ... reconciliation requires a more positive demonstration and willingness to confront the past.” The reconciliation spoken of here is intraprofession – I ask: “Shouldn’t the challenge be to go further and to find reconciliation between the abused patient, the patient refused care, the disappointed patient, and the professional carer?” If that reconciliation is achieved, the profession could then maybe say that, together with others, they are finally transformed.

Against this whole background, I would like to suggest that we now have to look at what the TRC process can offer health professionals who wish to go further than simply declaring at this stage that they are transformed, and then whether that process alone is sufficient to enable health professionals to regain a position where they can comfortably practice.

The question that I raise as we look through these provisions is that the Committee is primarily there to deal with victims of gross human rights violation, and the tendency within the Commission to date has been to reserve its activities to the investigation of those.

The definition of a “gross violation of human rights” is as follows:

(a) the killing, abduction, torture or severe ill-treatment of any person; or
(b) any attempt, conspiracy, incitement, instigation, command or procurement to commit an offence referred to in paragraph (a), which emanated from conflicts of the past or which was committed during the period 1 March 1960 to the cut-off date within or outside the Republic, and the commission of which was advised, planned, directed, commanded or ordered, by any person acting with a political motive.

A question facing this gathering is whether the record that you wish to establish situations where there was complicity between doctors, health professionals, and the security police fits easily into those definitions (and the time that the Commission have), or whether you wish to engage in establishing a far more extensive record of complicity in the violation of human rights in South Africa. The doctor who advised a police officer on how to torture (if such existed), or on how to kill, would undoubtedly be easily fitted into the definition of a gross violation of human rights. The complicity that has been discussed in the various articles up to now does not fit as easily into that definition, and it will be a challenge for today’s discussions to establish what exactly health professionals wish to have covered in this enquiry – and then only to establish whether the Truth and Reconciliation Commission can offer that opportunity; in brief, will a review of the past under TRC rules be sufficient or do medical professionals want to review it on the basis of the 1996 democratic agreed caring principles?

The second committee of the Truth Commission deals with amnesty. It is to provide amnesty not only to those who have committed gross human rights violations but simply to anybody who has committed a crime. This will enable any health professional who has committed a crime to go and seek amnesty. It is this provision of the Act that has once again seen the Biko name appear in our court records because Steve Biko’s family, the Maenge family and the Ribero family, were angered that the killers of their family could now possibly seek amnesty. In the course of that court case at paragraph 17 (page 16):

“Every decent human being must feel grave discomfort in living with a consequence which might allow the perpetrators of evil acts to walk the streets of this land with impunity, protected in their freedom by an amnesty immune from constitutional attack, but the circumstances in support of this course require carefully to be appreciated. Most of the acts of brutality and torture which have taken place have occurred during an era in which neither the laws which permitted the incarceration of persons or the investigation of crimes nor the
methods and the culture which informed such investigations, were easily open to public investigation, verification and correction. Much of what transpired in this shameful period is shrouded in secrecy and not easily capable of objective demonstration and proof. Loved ones have disappeared, sometimes mysteriously, and most of them no longer live to tell their tales. Others have had their freedom invaded, their dignity assaulted or their reputation tarnished by grossly unfair imputations hurled in the fire and the cross-fire of a deep and wounding conflict. The wicked and the innocent have often both been victims. Secrecy and authoritarianism have concealed the truth in little crevices of obscurity in our history. Records are not easily accessible, are often unknown, dead, unavailable or unwilling. All that often effectively remains is the truth of wounded memories of loved ones sharing instinctive suspicions, deep and traumatizing to the survivors, but otherwise incapable of translating themselves into objective and corroborative evidence which could survive the rigours of the law.}\textsuperscript{14}

Doctors who have been implicated in any human rights violation and who seek amnesty have already had an opportunity to do so, and they have a further three weeks from today to apply for amnesty. The purpose of offering amnesty was in part to obtain evidence from them for the purposes of the Truth Commission’s role of establishing the truth for the record – few will argue that this carrot has operated well.

In the light of this I raise the following questions to those who believe that a medical search for the truth requires of necessity any type of amnesty:

1. In view of the fact that doctors and any others who ought to have applied for amnesty, could already have done so, and have not done so – do you wish to offer them a second opportunity?

2. If one wants to establish a proud new tradition of practice for the profession, do you (or any profession) offer any amnesty to wrongdoers or those who committed misconduct as a profession? Surely not disciplining (again?) could do more harm to the profession than offering amnesty at a public level, albeit as a carrot?

3. Would not re-establishing the ethics of the profession require and encourage the profession’s disciplinary bodies actively to influence and seek out those who have brought the profession and their role into disrepute – and then possibly at the stage of penalty allow some mercy to enter the arena?

The third leg of the Commission deals with the giving of reparations after recognition that the new State would not be able to afford damages on the scale ordinarily given by our courts. That may well be the position of the State, and also may well be what was necessary so as to enable the new State not to be too burdened with the damages actions of the past.

The reparations offered by the Truth and Reconciliation Commission have not yet been decided upon – they may well be sound in money or in kind – and that Committee is busy seeking ideas for reparations. It may well be that the carers sitting here could make suggestions to that Committee for long term reparations.

I would also go further to suggest that the optimum reparations that could be made by health carers for our whole community are to create a profession of which the country can be proud, and which will never again be reluctant to take steps against those who breached its ethical base.

I would like to suggest that part of the reparations will be that the medical profession move us across to a society based on reconciliation, a society in which your medical profession’s actions enable us to reach the objectives stated in the postscript of the interim constitution that set up the Truth Commission, and in which it is stated that it was to: “... lay the secure foundation for the people of South Africa to transcend the divisions and strife of the past, which generated gross violations of human rights, the transgression of humanitarian principles in violent conflicts and a legacy of hatred, fear, guilt and revenge.

These can now be addressed on the basis that there is a need for understanding but not for vengeance, a need for reparation but not for retaliation, a need for ubuntu (spirit of humanity) but not victimisation.”

I trust that the above has prompted some ideas, some challenges, possibly even some answers to your difficult deliberations that will follow for the rest of today.

Again I wish to remind you that Christian Pros chal- lenged all of us when he said: “It would be a great achievement if you could break the silence among your own medical profession so early after the end of apartheid.”

References
4. Veriava and others v. President, SAMDG, and others 1985 (2) SA293.
Effective implementation of the Principles of Medical Ethics

Erik Holst, MD, Professor*

Fifteen years ago the General Assembly adopted Resolution 37/194 containing *Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, and called on all governments to give these principles the widest possible distribution among medical and paramedical associations, and institutions of detention or imprisonment.

It also invited all relevant intergovernmental organizations, in particular the World Health Organization, to bring the *Principles of Medical Ethics* to the attention of the widest possible group of individuals, especially those active in the medical and paramedical field.

The background for adopting this resolution was the realization that health care personnel involved in the care of prisoners and detainees were at special risk of becoming directly or indirectly involved in acts and practices other than those dictated by their professional obligations to their patients.

The purpose was therefore to underline the duty of such health professionals to provide prisoners and detainees with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

The *Principles of Medical Ethics* contain the strongest possible wording of its condemnation of failure to respect these principles: "It is a gross contravention of medical ethics as well as an offense under applicable international instruments for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment."

And further:

"It is a contravention of medical ethics for health personnel, particularly physicians:

a) to apply their knowledge and skills in order to assist in the interrogation of prisoners and detainees in a manner that may adversely affect the physical and mental health or condition of such prisoners or detainees and which is not in accordance with the relevant international instruments;

b) to certify or to participate in the certification of, the fitness of prisoners and detainees for any form of treatment or punishment that may adversely affect their physical or mental health and which is not in accordance with the relevant international instruments, or to participate in any way in the infliction of such treatment or punishment which is not in accordance with the relevant international instruments."

As a final principle it is stated: "There may be no derogation from the foregoing principles on any grounds whatsoever, including public emergency."

Now, fifteen years after the adoption by the UN General Assembly of this unambiguous stand on the *Principles of Medical Ethics* – established with a view to protecting the human rights of prisoners and detainees – it seems justified to examine their implementation on the ground.

- Have health care professionals involved in the care of prisoners and detainees been able to act according to these high expectations?
- Have health care professionals been able to stand against pressure to disregard these principles?
- Have governments of the member states taken appropriate steps to distribute information about and enforce respect for these principles adopted by the General Assembly?

Unfortunately there are many examples to demonstrate that individual health professionals, willingly or unwillingly, have been acting contrary to these *Principles of Medical Ethics*.

This is obviously the case when physicians have been directly involved in torture or in surgical mutilations such as amputations – a practice that has been successfully resisted by some national medical associations. And more recently, surgical removal of organs for transplantation from prisoners in connection with capital punishment has attracted justified attention and concern.

There are also well documented examples of cases where physicians are asked to certify prisoners' fitness for treatment and punishment that must be characterized as torture or cruel, inhuman or degrading.

Finally, the practice of requiring physicians to classify violent death in detention as due to natural causes is widespread.

It may further be assumed that most of such practices or even systematic abuse go unreported.
The role of the UN and the WMA
In spite of this, there are only few examples of cases when sanctions have been applied against health professionals who have committed even “gross contravention of medical ethics”, as defined by the UN General Assembly – and such sanctions have been applied more often by professional associations than by public authorities or the judicial system.

This regrettable situation may to some extent be explained by lack of proper information about the rights and duties laid down in the Principles of Medical Ethics, but there can be no doubt that such behaviour on the part of health professionals is in most cases dictated by fear – fear for themselves and even for their families if they refuse to participate, and fear for their patients if they speak out on their behalf. The courageous refusers all too often meet with more or less drastic reprisals – even including death for themselves or family members.

The World Medical Association has called on the national medical associations to support those members who stand up for established principles of medical ethics set out in a number of declarations, among which the most relevant for this debate is the Tokyo Declaration of 1975.

However, in many situations, especially under repressive regimes that practice or tolerate the practice of torture, the professional associations of the health professions in a country are unable to, discouraged from or directly prevented from providing effective protection of members who try to uphold principles of medical ethics against local or central pressure from authorities.

The World Medical Association has further called on the national medical associations to investigate all allegations of medical involvement in torture, and to apply appropriate sanctions to members found guilty of such involvement.

Again, in many situations, especially under repressive regimes that practice or tolerate the practice of torture, the professional associations of the health professions are unable to, discouraged from or directly prevented from taking appropriate action against members who act in contravention to the Principles of Medical Ethics.

Court action against such failures to uphold the Principles of Medical Ethics are often – even after the fall of repressive regimes – blocked by legislation that affords impunity to perpetrators of human rights violations.

The challenge for the UN Commission now
In the face of this situation what could and should the United Nations, and especially its Commission on Human Rights, do to enforce respect for the Principles of Medical Ethics?

The Vienna Declaration and Programme of Action in its operative paragraph 58 states: “Special attention should be given to ensure universal respect for, and effective implementation of, the Principles of Medical Ethics Relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment adopted by the General Assembly of the United Nations”.

The challenge is before the Commission: the United Nations has requested full respect for the human rights of prisoners and detainees. In adopting the Principles of Medical Ethics the United Nations has placed explicit duties on the health professionals, thus enlisting them in an attempt to protect some vital human rights for prisoners and detainees. However, at the same time the UN has failed to protect the right of these health professionals to refuse participation in contraventions of these Principles of Medical Ethics, and has failed to stress the duty of the authorities to respect such refusals without direct or indirect sanctions against such health professionals.

The resolution of the General Assembly also failed to spell out explicitly the Principles of Medical Confidentiality as a right of the patient and a duty of the health care provider, and as a principle that must be maintained, also in relations between health professionals and prisoners or detainees.

In placing itself as the global guardian of detainees’ right to freedom from torture, cruel, inhuman or degrading treatment, the United Nations General Assembly also has a duty to provide effective protection for those health professionals who try to act according to the Principles of Medical Ethics, which were aimed at insuring the human rights of prisoners and detainees.

The Danish delegation invites the Commission and the High Commissioner for Human Rights to consider ways to ensure through legislation and administrative practice full respect for these principles, including sanctions against individuals and institutions failing to respect the right of health professionals to refuse to participate in contraventions of the Principles of Medical Ethics.

Given the many and important medical aspects of torture, the Danish delegation also takes this opportunity to call for the appropriate involvement of health care professionals, particularly physicians, in the proposed initiative, as well as in all other torture-related activities that fall under the auspices of the High Commissioner for Human Rights. This seems particularly necessary as part of the shift from a more re-active to a more pro-active UN human rights policy, which has been promoted by the first High Commissioner for Human Rights and which has the full support of the Danish delegation.
Need for international funding of rehabilitation services for torture victims worldwide

Prepared by IRCT

The tables reflect the number of existing centres and programmes for torture victims worldwide in 1996. Furthermore, they show the estimates of the International Rehabilitation Council for Torture Victims (IRCT) for the expected increase in the number of centres and programmes for 1997, 1998, and 1999. Finally, it depicts the amount of international funding required to adequately meet the costs of centres and programmes working in this field.

A well-functioning and expanding network currently renders possible the dissemination of methodical knowledge about the rehabilitation of torture victims and technical and basic financial assistance during the initial phases of establishing rehabilitation programmes. However, the need for funding of the growing number of centres and programmes working with victims of torture by far exceeds the funds currently available for this work.

The 1997, 1998, and 1999 figures are based on the centres and programmes that are expected to continue to operate within this field, and on expected new rehabilitation services. It must be emphasized that all the figures are based on known existing services and new expected services, and not on a general assessment of the far more extensive need for rehabilitation of torture victims in the various regions. Furthermore, it should be noted that the total number of existing centres and programmes in 1996 represents a reduction in relation to what IRCT had previously expected. Among other factors, this reflects the limited financial resources that are available for this type of work. Consequently, expectations for 1997, 1998, and 1999 have also been adjusted downward.

The common denominator for the centres and programmes depicted in this overview is that they offer rehabilitation services to particular target populations within a specific scenario. In the following, the activities, target populations, and scenarios for provision of rehabilitation services are outlined.

The activities that are carried out by the majority of these centres and programmes focus mainly on:
• medical, physical, and psychosocial therapy and rehabilitation of victims of torture but may also lie within the following areas:
• research, methodological development, and documentation
• education and training of personnel
• information activities.

The target populations include:
• primary victims of torture and other cruel, inhuman, or degrading punishment
• secondary victims of torture, i.e. immediate relatives of primary victims of torture, extrajudicial execution, and forced disappearances.

Finally, there are three different scenarios for the provision of rehabilitation services:
• rehabilitation services for victims of torture among refugees from countries with repressive regimes or traditional practice of torture
• rehabilitation services for victims of torture in countries

Table 1. Estimated global need for international funding of rehabilitation services for victims of torture. The individual countries, by their distribution in 1996, are shown in IRCT's 1996 annual report.

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<tr>
<td>Global total</td>
<td>163</td>
<td>173</td>
<td>200</td>
<td>212</td>
</tr>
</tbody>
</table>

Table 2. Existing and expected number of centres and programmes worldwide.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Centres in developing countries</td>
<td>55</td>
<td>60</td>
<td>82</td>
<td>91</td>
</tr>
<tr>
<td>Centres in Central and Eastern Europe</td>
<td>17</td>
<td>20</td>
<td>24</td>
<td>26</td>
</tr>
<tr>
<td>Centres in OECD countries (European Union)</td>
<td>91</td>
<td>93</td>
<td>94</td>
<td>95</td>
</tr>
<tr>
<td>Global total</td>
<td>163</td>
<td>173</td>
<td>200</td>
<td>212</td>
</tr>
</tbody>
</table>

Table 3. Estimated need for international funding in USD.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding centres in developing countries</td>
<td>11,000,000</td>
<td>12,000,000</td>
<td>16,400,000</td>
<td>18,200,000</td>
</tr>
<tr>
<td>Funding centres in countries of Central and Eastern Europe</td>
<td>3,400,000</td>
<td>4,000,000</td>
<td>4,800,000</td>
<td>5,200,000</td>
</tr>
<tr>
<td>Contribution to centres in OECD countries 20%</td>
<td>9,100,000</td>
<td>9,300,000</td>
<td>9,400,000</td>
<td>9,500,000</td>
</tr>
<tr>
<td>Total need for international funding in USD</td>
<td>23,500,000</td>
<td>25,300,000</td>
<td>30,600,000</td>
<td>32,900,000</td>
</tr>
</tbody>
</table>
with previous or current repressive regimes or traditional practice of torture
• rehabilitation services for victims of torture during international or national armed conflict.

IRCT hopes that the presentation of this overview will serve to clarify the need for international funding of services for victims of torture, and will serve to open the eyes of new donors to the necessity of supporting rehabilitation services worldwide.

The calculation of the total annual need for international funding has been based on the experience of IRCT:

1. That the average annual cost of rehabilitation centres and programmes for victims of torture in developing countries and in countries of Central and Eastern Europe is now about USD 200,000, which have to be provided mainly from international donors.

2. That the average annual cost of rehabilitation centres and programmes for victims of torture in OECD countries is now about USD 500,000, of which an average of USD 100,000 has to be provided by international donors.

Selected list of publications

received in the IRCT International Documentation Centre


Post-traumatic stress disorder and GI endoscopy : a case study / Grober, Marcia ; Byrd, Rebecca. – In: Gastroenterology nursing ; vol. 16, no. 1. –19930000. – p. 17-20.


Torture survivors, dental and psychological aspects – illustrated by two case stories

Birna Jerlang**, John Orloff** & Peter Jerlang**

The dental treatment of torture survivors is not very different from the treatment of ordinary patients. However, there are certain aspects that require special attention in torture survivors.

Examination
Apart from the ordinary dental history, special information is required concerning the torture, and general information on the survivor's physical, mental, and social status. This information is most easily available when the treatment of the torture survivor is carried out by a structured team of doctors, psychologists, physiotherapists, nurses, social advisors, and dentists, who continuously discuss the survivor's general situation and progress. In this way, the torture survivor knows that the examiner is already familiar with the history of his torture and his present mental state. The dentist can thus spare the patient another account of the torture experience.

Diagnosis
This follows normal dental practice. However, the long-term effects of certain forms of torture, including electric torture to the teeth and jaws, are unknown. The people exposed to these kinds of torture often complain of hyperesthesia of both teeth and gums, and it is difficult to know whether this is somatic or psychosomatic in origin.

Plan of treatment
The choice of treatment may depend very much on the form of torture, and the subsequent mental trauma. Basically, the treatment should be conservative; extraction of teeth, for instance, may be experienced partly as similar to the torture, partly as a direct consequence of it, and thus as a permanent mutilation. As a general rule, the dentist should try to save as many teeth as possible, giving the highest priority to the mental aspects. All treatment strategies should be discussed with the patient, and if other therapists are involved, they should be informed about the choice of treatment. Despite careful preparation, especially difficult cases may need direct psychological support during the treatment.

Communication
It is obvious that the instrumental part of the dental treatment should be secondary, i.e. priority should be given to creating good contact with the patient. The experience of having been mistreated by a fellow human being may easily lead to an understandable mistrust of other people, especially those in authority. At the same time the language barrier has to be overcome.

A torture survivor is in a state of crisis. It is typical for a mental crisis that the individual's normal ability to protect himself and to adapt to the outer world has been weakened. In practice, even very small events that may recall the torture can provoke violent reactions. It is therefore necessary, at the start of treatment, to demonstrate the function of the instrument to be used, e.g. the operation lamp, water jet, suction, the drill. The use of electrometric pulp testing is in principle contraindicated, and ultrasound dental cleaning, even under anaesthesia, can provoke serious mental reactions. The patient's initial defence mechanism also contraindicates laughing-gas or analgesia, since the patient may feel that he loses control over the situation, and the risk of anxiety manifestations will be increased. The experience of being "tied down" between instruments, the operating lamp, and two persons can easily reanimate aspects of the torture process, and make the patient lose control. The dental chair should not be made horizontal before good contact has been established, not before perceptual adaptation to the clinical environment has taken place.

The fact that there is a structured agreement about the course and the content of the treatment and appointments, etc. makes the patient feel in control of the situation. In the formulation of the agreement to collaborate, the patient's anxiety should be considered legitimate and understandable.

The state of crisis often leads to poor sleep and nightmares. The torture survivor is frequently in a permanent state of motor tension that may provoke hyperactivity, for instance in the chewing muscles, leading to tension headache that reduces the patient's general level of function, including his ability to concentrate. Therefore, in order to release the muscles, most survivors will need a reflex-releasing stabilizing splint with multiple contacts in the occlusion position, and in all the eccentric positions of the lower jaw. Early treatment with occlusal splints, combined with physiotherapy, is an important part of the overall therapy, since this symptom-oriented treatment improves the survivor's overall physical state. In this way he will get more resources to strengthen other mental and/or social functions, such as concentration, and thus to strengthen his learning and adaptation capacities during the integration process.

Follow-up examination and after care
These phases correspond in principle to those applied to ordinary patients. However, we would like to point out that,
following successful treatment, the dentist often becomes the person in the team of therapists who secures continuity because of the six monthly follow-up visits. He/she may therefore be contacted by the torture survivor for reasons other than dental. The patient may perhaps not expect to have his problems solved, but he needs somebody who will listen and give an opinion. We have perceived such contacts as manifestations of confidence from someone who has lost vital parts of his supporting social network and therefore only has few people to whom he can turn for advice.

To illustrate the above aspects, we present two case histories.

Case I
Because of student political activities, a 29-year-old woman from a middle-class family in the Middle East was imprisoned and tortured; she was kicked, especially in her face, humiliated, raped, and given electric shocks to her genitalia. While she was still in her home country, her family helped to pay for dental rehabilitation with metal-ceramic crowns on her front teeth and a bridge to replace 22 (Fig. 1A and B).

However, she had lost several premolar and molar teeth in both upper and lower jaws. The teeth had been fractured in prison, and were later removed.

After arriving in Denmark, she contacted a dentist and complained of poor chewing. The dentist did not know anything about her traumatic background and made two partial dentures for her, with a cast (moulded) frame. When trying them she told him in despair that she could not use them — but she never mentioned her previous sufferings. The treatment stopped there.

Later, the young woman received treatment at RCT in Copenhagen. She completed one year of treatment by a team of therapists; the dental treatment was normal, without reconstruction of her dentures, but it included attention to the biting function because of muscular tension. A new plan of treatment was then worked out. In the meantime, psychotherapy had revealed the problems of the partial dentures.

During torture, her mouth had been forced open with knives and forks in connection with oral sexual humiliation, and the thought of having to remove and clean two metal dentures every day was now unbearable. The dentures represented a “trigger zone” that reactivated the torture experience. The team of therapists agreed that reconstruction of the missing teeth would be an essential part of her mental rehabilitation; a full bridge was made in the upper jaw from 17 to 26, and in the lower jaw from 33 to 35 (Fig. 1C), a solution that proved satisfactory for the patient.

The choice of treatment by the first dentist was in principle correct professionally, based as it was on the dental history, but the metal dentures had a symbolic value that was only revealed by the psychotherapy. There were probably several reasons for the patient not to reveal her traumatic experience to the dentist.

We have given thought to the following: It is possible that the relationship of trust between the patient and the first dentist could not overcome the feeling of shame by talking about the torture. Another possible explanation is that the patient was unaware of the dynamic connection between the metal dentures and the torture experience. The connection between them was established only through the psychotherapy, which made her understand her own reactions. During rehabilitation, she started doing an education which she finished successfully, and today she can be said to be functioning very well.

Case II
A 30-year-old man from Africa had suffered severe physical torture, including dental torture, during 3 years in prison, where he also developed diabetes. During the last months in

![Fig. 1. Case I. A, the occlusion right side before treatment. B, occlusion left side before treatment. C, occlusion after treatment. The vertical height has been raised 2 mm by means of a ceramic bridge from 17 to 26. Further, a ceramic bridge has been made from 33 to 35.](image-url)
prison, he was exposed to mental torture related to special sociocultural factors: important persons from his tribe were forced to come to the prison and proclaim a curse to make him lose his soul forever; this ritual should deprive him of all personal identity, during life and after death. This confrontation broke his will to live and led to long periods of deep depression that continued after his release. His main dental problem was a severe periodontal disease, and the interplay between somatic and psychological factors can be demonstrated as follows: During his depressive periods he stopped taking care both of his diabetes and of his parodontal problems. The decrease in his general resistance caused by the uncontrolled diabetes can also be considered to have impaired his parodontal resistance. Because of these coincidental processes, more and more of his teeth became irreparable and had to be extracted, causing him still more misery and guilt. His psychologist was usually present during these treatment sessions; and had practised relaxation procedures with the patient beforehand.

Apart from the fear of the extractions, which recalled the torture, the loss of even more teeth strained his self-esteem: the fundamental losses that he had experienced in almost all aspects of his life took on a symbolic as well as a real perspective through the loss of teeth.

A detail of importance for the communication between him and the dentist was that they could speak French together. He had studied in France before the imprisonment, and the French language apparently gave him momentary contacts with “the forgotten part of himself”, i.e. with the perception of himself that was the nucleus of his personal identity before the torture, but that had been made “invalid” and lost its strength to function after the mental torture. However, in his periods of deep depression it was not always possible to make contact. Because of the multiple extractions, it gradually became necessary to reestablish the chewing function with a denture. Because of his overall general condition, partial dentures were suggested as a possible solution. At first he resisted the thought of a removable solution, but when the dentures were ready he found them acceptable, better than expected. Three years later the dentist received a letter from the patient, thanking him for the good treatment. Shortly afterwards the patient committed suicide, thus fulfilling his symbolic expulsion by the curse, according to his cultural attachment. In the light of this action, the dentist understood that the letter had been a farewell. The patient’s fate tells us that torture survivors may carry such deep wounds in their inner universe that the word treatment, in the sense of healing, is utopian. But it also tells us that what various therapists can give as relief is an important and honourable goal. We have tried to present some aspects of such a process.

**Literature**


The above is a shortened version of an article published in Danish in Tandlægebladet [Danish Dental Journal] 1995; 99:906-9.
The self-concept and the alienation of Palestinian adults: a comparative study between Gazans and returnees

Ramadan T. Kodaih, Clinical Psychologist, PhD*

Introduction
The concept of "self" includes the individual's self-consciousness and his ability to distinguish between his own traits and those of others. It is a developed phenomenon, not biological or metaphysical. The "self" consists of integrated traits that develop through social experience and activity. Self-growth comes from an individual's perception of his relationship with others, their social roles, and his/her relation to these roles. Personality is a product of life-long social relations that involve general traditions and conventions. The individual is not a beginning or an end, but part of a series in the continuity of life, and this is a socio-biological reality.

The individual's "self" is the "self-group" or group spirit. In psychology a "group" refers to a community from which traits emerge that differ from the individual traits in the community. Self-consciousness disappears, and all the members of the group feel in the same way, resulting in a "self-group". Members of the self-group do not necessarily have to be in one place, nor large in number; it is more important for the group's emotions and ideas to be directed towards one aim, and for each member's emotions to mix with those of the others.

Objectives
This study aims at determining how the Palestinian conceives his own identity, the identity of those around him, and his feelings of alienation.

This research involves or embodies several questions concerning the concept of alienation and identity:

- Did the returnees find that Gaza was different from when they left it, or from what they imagined it to be?
- Have their goals, dreams, and hopes been fulfilled after their return?
- Have their feelings of alienation disappeared after their return?

Concepts used in the study
1. The concept of "self": the individual's ideas about his inner ego.
2. Alienation: a feeling of separation from the "self" and "others".

Hypotheses
1. There is a connection between the Palestinian's self-perception and his perception of others.
2. There is a correlation between the Palestinian's self-perception and his feelings of alienation.

Methods
The empirical technique was used for the study.

Sample
200 Palestinian adults divided into two groups:

Group I: 100 permanent residents of Gaza - 50 males and 50 females, 30-50 years old.
Group II: 100 adults, 50 males and 50 females, who, because of the Israeli occupation in 1948, were forced to flee and live in other Arab countries, mainly Jordan, Syria, Lebanon, Algeria, and Tunisia. They returned to Gaza after the Oslo peace agreement between the PLO and the Israeli government. They will be referred to as "returnees" or "Palestinians in the Diaspora".

Tools of the study
1. Testing the adults' self-perception by Iamid Addin Ismail.
2. Rosenberg self-estimation scale.
3. Extremism of results by Moustafa Swiff.

Results
1. There was a significant link between the Palestinian's self-perception and his perception of others.
2. There was a significant positive link between the methods by which the Palestinian compares his ideas and views of himself with his perception of others.
3. There were significant differences in the confidence levels between the resident Gazans and the returnees, and in their self-acceptance and acceptance of others. This may be a result of the intensity of the sufferings experienced by the Palestinians in the Diaspora. It may also be due to the residents' feeling that Israeli policy is treating them as victors, with the exclusion of the defeated. The vanquished are obliged to assist the victorious and cooperate with them because the latter's will has the upper hand. This cooperation is based on coercion and compulsion. These differences may have resulted from disturbances in interaction between the residents and the returnees, and aversion between individuals in both parties.

The process of communication is a social process in which individuals cooperate for mutual benefit, or they reach a point of conflict and maladjustment. This may be caused by the lack of needs of satisfaction, which may interfere with the individual's feeling of satisfaction or frustration.

4. It is not necessary for the individual's self-acceptance to be connected with his acceptance of others. Although

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TORTURE Volume 7, Number 2 1997
he/she may have a significant degree of self-esteem, his/her relation with others does not fluctuate. This self-esteem may increase his humbleness in the social sense.

5. There was a greater sense of alienation in male returnees than in the permanently resident male Gazans. This can be attributed to the gap between the image the Palestinians formed of their home land while in the Diaspora and the reality of the situation since the Intifada.

6. However, the female returnees - who were living in Gaza originally - felt less alienated than their husbands. This is due to the status of the Palestinian women in the host country, where they tended to feel isolated. Thus they felt more at ease on return to Gaza.

7. With respect to the women, we found a strong similarity between the self-perception and feelings of alienation of the residents and the returnees. This can be attributed to the women's natural tendency to feel home-sick.

8. The concept of alienation among the women who originated in other Arab countries, but later moved to Gaza, was higher than that of female returnees to Gaza. This is probably a result of the women's ties to their home countries, and their aversion to the ambiguities and tensions of life in Gaza, compared with the security and stability of life in their home countries.

Finally, we found that the returnees had feelings of alienation and worry, were withdrawn and isolated, and showed social aggression. These are negative factors and require further study. The final aim of these studies should be to construct a concrete plan to support the concept of Palestinian identity and to bridge the gap between his self-perception and his sense of alienation.

Selected list of publications

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Health care for refugees and survivors of torture is becoming a growth industry, experts sadly say / Skolnick, Andrew A. - In: JAMA ; vol. 274, no. 4. - 19950726. - p. 288-290.


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Human rights in Iraq and Iran / Summerfield, Derek. - In: British Medical Journal ; vol. 308, no. 6927. - 19940219. - p. 536-537.

Home study course in training family physicians as counsellors for torture survivors / Muddas, S.P. (ed.). - Indian Medical Association ; IMA. - New Delhi : IMA, [19960000]. - 250 p. - Correspondence course material.


The role of the physician and the medical profession in the prevention of international torture and in the treatment of its survivors / Audet, Anne-Marie ; American College of Physicians. - In: Annals of internal medicine ; vol. 122, no. 8. - 19950000. - p. 607-613.


Muscle tension and articular dysfunction in torture victims / Aker, M. ; Moore, Ch. - In: Journal of manual medicine ; vol. 6. - 19920000. - p. 173.

Psychological effects of torture: a comparison of political detainees and non-political prisoners in Malawi

Prof. Karl Peltzer*

Introduction
Lwanda's conservatively estimates that the total number of short- and long-term detainees during the period of Dr. Banda's rule is well in excess of 250,000. In a small country with only 24 districts and a population of 8.5 million (now more than 10 million) this meant that no village was left untouched by detention or disappearances. Historically, after 1964, in the first twelve months of independence alone, over 1000 supporters of the ex-cabinet ministers were detained. Waves of detainees then followed each twist and turn in Malawi's political fortunes, Chipembere's rebellion, ... Jehovah's Witnesses, Mwalo's removal in 1977, the purge of intellectuals in the 1980s, the thousands detained following the Lenten letter in March 1992, followed by the massive 'fax machine' arrests of 1992 (ibid.). The list of detainees is long - political, economic, ethnic, religious; even mental illness was no protection from detention.

Apart from torture under political detention, torture has also been commonly used in the treatment of criminal prisoners. Human Rights Watch reported that, particularly since the early 1980s, persistent criminal offenders have been subjected to a brutal punishment regime called "hard core" programme, when they were stripped naked, chained to the floor of their cells, and denied food. Many are reported to have died as a result.

The change in Malawi came on 14 June 1993, when at the first national referendum Malawians chose a system of government in favour of political pluralism. Thereafter enormous democratic changes have taken place, e.g. political detainees have been released, exiled people started coming back, many free newspapers demonstrated freedom of press. Malawi signed the UN declaration against torture. Although political detention has ceased, torture of criminals seems to continue.

Under the leadership of the International Rehabilitation Council of Torture Victims (IRCT), treatment and rehabilitation services for torture survivors and their families began in January 1996.

Başoğlu et al. have compared the psychological effects of torture in tortured and non-tortured political activists in Turkey. In Malawi most political detainees (93%) cannot be defined as political activists. Paker et al. compared the psychological effects of torture in tortured and non-tortured non-political prisoners in Turkey. They found that a positive history of torture predicted higher scores on a number of mental disorders. Therefore it seems to be a new study to compare tortured political detainees (PDs) with tortured non-political prisoners (NPPs) (in Malawi). Guðjónsson notes that very little information is available about the psychological effects of police arrest, confinement, and interrogation in criminals.

Methodology
The study design included political detainees (n=120) (in detail Peltzer and non-political prisoners (n=60). The et detainees were identified by snowball sampling in various parts of Malawi. Interviews were conducted by the author and/or a research assistant from February 1994 to March 1996. The main research strategy was the narrative interview. A semi-structured questionnaire, based on the study by Foster et al. in South Africa, formed the second part of the interview. The third part applied the following standardized assessment instruments: information on personal history and details of prison, torture, and trauma experiences were obtained using the Harvard Trauma Questionnaire (HTQ) (Mollica et al.), after adapting it to the Malawian cultural context. Measures of torture severity were derived from the Exposure to Torture Scale (Basoglu & Paker) and the IRCT/ICAR International Client Monitoring Programme, which consists of a list of forms of torture commonly used throughout the world. Psychiatric status was assessed by the Symptom Checklist-90-R (SCL-90-R) (Derogatis) and the HTQ before and during detention, after release, and now. Other measures included a 28-item abbreviated Ways of Coping Scale (Folkman & Lazarus) and a self-rating social support measure.

Results
SAMPLE CHARACTERISTICS
The mean duration of captivity for PDs was 29 months (SD=39), and for NPPs 11 months (SD=20). The majority (69%) of the PDs were detained only once, and 16 (13%) three or more times, whereas NPPs were generally detained more often (one third three or more times). All PDs had undergone at least one transfer, and more than half at least two transfers, whereas the NPPs had even more transfers.

The mean time since release in the group of political detainees was 13.5, and in the criminal group 5.8 years.

Physical/psychological torture and distress of torture
Information was obtained on the types of torture experienced, the number of exposures to each type during all the periods of police custody, during/after detention, the duration of each exposure (e.g. restriction of movement, house arrest, after release from prison once for six months), and the subjective distress experienced for each type of torture (Table 2).

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Table 1. Sample characteristics and detention information of political detainees (PDs) (n=120) and non-political prisoners (NPPs) (n=60).

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>PDs (n=120)</th>
<th>NPPs (n=60)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (mean)</td>
<td>35 (SD=9)</td>
<td>35 (SD=9)</td>
</tr>
<tr>
<td>below 30 years</td>
<td>63</td>
<td>33</td>
</tr>
<tr>
<td>30-50 years</td>
<td>61</td>
<td>61</td>
</tr>
<tr>
<td>51 above years</td>
<td>39</td>
<td>06</td>
</tr>
<tr>
<td>Male (female)</td>
<td>85 (15)</td>
<td>77 (33)</td>
</tr>
<tr>
<td>No/Primary education</td>
<td>73</td>
<td>67</td>
</tr>
<tr>
<td>Secondary/above education</td>
<td>27</td>
<td>33</td>
</tr>
<tr>
<td>Lower class (upper class)</td>
<td>67 (33)</td>
<td>88 (12)</td>
</tr>
<tr>
<td>Married (Single/divorced/widow(er))</td>
<td>80 (20)</td>
<td>41 (39)</td>
</tr>
<tr>
<td>Number of detentions</td>
<td>1 time</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>2 times</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>3 times+</td>
<td>34</td>
</tr>
<tr>
<td>Duration of detention</td>
<td>0-6 months</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>7-11 months</td>
<td>52</td>
</tr>
<tr>
<td>[Mean 29 ms for PDs, 11 ms for NPPs]</td>
<td>28</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>6-9 years</td>
<td>00</td>
</tr>
<tr>
<td></td>
<td>10+ years</td>
<td>00</td>
</tr>
<tr>
<td>Number of transfers (from prison to prison)</td>
<td>40</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>twice</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>thrice/+</td>
<td>12</td>
</tr>
<tr>
<td>Time of release</td>
<td>1964-69</td>
<td>05</td>
</tr>
<tr>
<td>[Mean time since release 13.5 years for PDs, 9.8 years for NPPs]</td>
<td>00</td>
<td>00</td>
</tr>
<tr>
<td></td>
<td>1970-74</td>
<td>09</td>
</tr>
<tr>
<td></td>
<td>1975-79</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>1980-84</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>1985-89</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>1990-93 (96')</td>
<td>35</td>
</tr>
</tbody>
</table>

1 for NPPs

*Charged with the following crimes, according to their rank: Physical assault and causing bodily harm, robbery, found in possession of cannabis, rape, gambling, smuggling, arson, other.

The PDs were subjected to 40 different forms of torture with a mean of 18 forms of exposure (SD=7.5), whereas NPPs reported exposure to 36 types of torture with a mean of 15 types. The mean number of total torture exposures was 153 (SD=95) for PDs and 204 (SD=168) for NPPs. This shows that NPPs were more often exposed to fewer different forms of torture, while PDs were less often exposed to slightly more different forms of torture.

Comparing the political with the non-political prisoners, there were specific forms of torture that were preferably used for PDs, and others preferably for NPPs. For PDs: electrical torture, sleep deprivation, perceptual deprivation, threats of death, house arrest, misinformation (rumours), smearing mud on face, destruction/confiscation of property, threats against family. For NPPs: pulling by hair, forced labour, witnessing torture, food/water deprivation, infested surroundings, forced to write statement. In general, psychological methods were used slightly more often for PDs than for NPPs.

It seems that the more unpredictable and uncontrollable the torture, the more distress was perceived. The former are a) real or perceived threats to life (e.g. beating, electrical torture, threats of death, threats of further torture), and b) restriction of movement (e.g. solitary confinement, binding with rope (nykulua), handcuffs, or chains, and house arrest). Another form of perceived loss of control and helplessness was felt in humiliating torture (e.g. condemned cell, twisting of testicles, fondling genitals, food/water deprivation, contaminated food, destruction/confiscation of property, prevention of personal hygiene, denial of privacy (house search), forced nakedness), especially coupled with the inability to act out anger or hostility.

The application of torture with prominent features of uncontrollability and unpredictability was often accompanied by complete isolation of the detainee from other inmates and the outside world. The effect of isolation was compounded by verbal induction of helplessness and hopelessness, e.g. by suggestions, threats, and bluff during interrogation. Another form was stripping the detainee naked, inducing a sense of helplessness and imminent danger by depriving the detainee of the sense of protection and illusory security that clothing affords. Because of the sexual connotations of nakedness, stripping also raises a possible, but uncertain threat of sexual assault. Another particularly stressful experience was the anticipation of torture; non-political prisoners in particular were made to witness others being tortured, thus increasing their anticipation of being (further) tortured.

Mental distress

It seems in general that PDs and NPPs experienced similar stresses (Table 3). The PDs had experienced more trauma events (8) than the NPPs (5.8), and a longer period of captivity (29 compared with 11 months), whereas the NPPs reported a higher total frequency of torture (204) than the PDs (153). The higher class PDs had experienced more trauma events (9.9) than the lower class PDs (6.8). Also the more highly educated PDs experienced more trauma events (10.5) than the less educated (6.9). This may be explained by the increased repression by government-sanctioned torture against the elite in the country. NPPs received more social support in captivity than the PDs; NPPs could be visited freely whereas PDs could often not be visited by relatives. Social support after captivity was low in the NPPs since they were highly stigmatized as crimi-
Table 2. Physical/psychological torture and distress of torture reported by political detainees (n=120) and non-political prisoners (n=60) (forms of torture before detention are marked with "bd", in police custody with "pc", in detention with "id" and after detention marked with "ad").

<table>
<thead>
<tr>
<th>Physical torture</th>
<th>% of survivors (mean PD NPP)</th>
<th>Total N of exposures mean (PD NPP)</th>
<th>Total duration mean (PD NPP)</th>
<th>Distress (1-4) (PD NPP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Beating (pc &lt; id)</td>
<td>94 (97)</td>
<td>38 (45)</td>
<td>3.8 (3.8)</td>
<td></td>
</tr>
<tr>
<td>2. Pulling by hair (pc &lt; id)</td>
<td>51 (78)</td>
<td>05 (06)</td>
<td>2.6 (2.2)</td>
<td></td>
</tr>
<tr>
<td>3. Water on floor (pc &lt; id)</td>
<td>46 (34)</td>
<td>1.8 (2.2)</td>
<td>2.2 (2.6)</td>
<td></td>
</tr>
<tr>
<td>4. Cold showers (pc &lt; id)</td>
<td>45 (18)</td>
<td>1.8 (1.8)</td>
<td>2.2 (2.1)</td>
<td></td>
</tr>
<tr>
<td>5. Binding with rope (Nyahuliji) (id)</td>
<td>17 (06)</td>
<td>2.3 (1.8)</td>
<td>3.2 (2.8)</td>
<td></td>
</tr>
<tr>
<td>6. Exposure to (extreme) cold (id)</td>
<td>16 (11)</td>
<td>8.6 (4.5)</td>
<td>1.8 (2.1)</td>
<td></td>
</tr>
<tr>
<td>7. Forced standing (pc)</td>
<td>7 (12)</td>
<td>4.5 (5.2)</td>
<td>1.6 (1.7)</td>
<td></td>
</tr>
<tr>
<td>8. Forced labour (id)</td>
<td>10 (75)</td>
<td>6.2 (8.6)</td>
<td>2.8 (3.2)</td>
<td></td>
</tr>
<tr>
<td>9. Blues on ears (pc)</td>
<td>39 (17)</td>
<td>6.2 (3.2)</td>
<td>3.1 (2.1)</td>
<td></td>
</tr>
<tr>
<td>10. Electrical torture (id)</td>
<td>08 (00)</td>
<td>4.5</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td>11. Twisting of testicles (pc)</td>
<td>08 (03)</td>
<td>3.5 (4)</td>
<td>3.7 (2)</td>
<td></td>
</tr>
<tr>
<td>12. Handcuffed, chained (id)</td>
<td>06 (09)</td>
<td>1.4 (1)</td>
<td>3.1 (2.9)</td>
<td></td>
</tr>
<tr>
<td>13. Exposure to bright light (id)</td>
<td>05 (11)</td>
<td>25.3 (18)</td>
<td>2.3 (2.2)</td>
<td></td>
</tr>
</tbody>
</table>

Psychological torture

14. Verbal abuse (pc < id) | 95 (100) | - | 1.5 (2.3) |
15. Interrogation/coercion (pc < id) | 85 (100) | 4.4 (4.6) | 2.5 (2.6) |
16. Sleep deprivation (overcrowding in cell >20, be woken up at night) (id) | 84 (37) | 2.2 (0.5) | 2.2 (2.7) |
17. Perceptual deprivation (no access to pers. comm/media) (pc, id) | 78 (49) | - | 2.2 (2.1) |
18. Threats of further torture (pc, id) | 75 (51) | 4.2 (3.5) | 3.4 (3) |
19. Threats of death (pc < id) | 66 (17) | 4.0 (3.2) | 3.7 (3.6) |
20. Spitting saliva on face (pc) | 64 (63) | 2.1 (11) | 1.8 (1.6) |
21. Prevention of personal hygiene (to bath) (pc, id) | 62 (69) | 4 (4.2) | 3.0 (2.2) |
22. Restriction of movement (house arrests, id) | 54 (00) | 1.2 (3) | 3.2 |
23. Forced nakedness (pc < id) | 45 (40) | 1.6 (1.6) | 2.5 (2.8) |
24. Every response provokes the opposite effect (pc < id) | 41 (63) | 5 (6) | 2.2 (2.9) |
25. Solitary confinement (pc < id) | 41 (40) | 4 (3.6) | 3.4 (3.4) |
26. Food/water deprivation (pc, id) | 33 (69) | 3.5 (3) | 3.2 (3.5) |
27. Deprivation of medical care (pc, id) | 24 (14) | 2 (2) | 3 (3) |
28. Contaminated food/water (id) | 22 (28) | 2.5 (2) | 3 (3) |
29. Infected surroundings (pc, id) | 21 (54) | 3 (3) | 3.5 (4) |
30. Misinformation (rumours) (pc, id) | 19 (09) | 1 (1) | 1.8 (3.1) |
31. House search without warrant (bd) | 17 (07) | 1 (1) | 2.1 (2.3) |
32. Searching rag on face (Nyuju) (bd) | 15 (03) | 2 (0.5) | 2 (2) |
33. Destruction/confiscation of property (bd, id) | 15 (00) | 1 | 3.6 |
34. Threats against family (pc, id, bd) | 14 (00) | 5 | 2.2 |
35. Alternative gentle/harsh treatment (pc < id) | 09 (23) | 10 (2) | 1.5 (1.7) |
36. Foiling of genitals (pc < id) | 07 (13) | 1 (1.3) | 2.2 (2.6) |
37. Forced to write statement (pc, id) | 07 (51) | 3 (2.8) | 2.4 (1.9) |
38. Forced dancing (pc) | 06 (03) | 4 (2) | 1.5 (2.4) |
39. Witnessing torture | 04 (34) | 1.6 (1.6) | 2.8 (3.1) |
40. Other | 12 (11) | - | - |

*Other* included heterosexual rape, threats of rape, sham executions, throwing of faeces/urine at detainees, sexual advances, "Ndege" (= psycho- plane, plank rope bondage), condemned cell (not to be released), hanging by legs, torture with animals.

Table 3. Stressors and clinical ratings in PDs (n=120) and NPPs (n=60).

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>PDs</th>
<th>NPPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma events experienced</td>
<td>38 (SD=6.2)</td>
<td>5.8 (SD=1.4)</td>
</tr>
<tr>
<td>Duration of captivity (mean/months)</td>
<td>29 (SD=59)</td>
<td>11 (SD=20)</td>
</tr>
<tr>
<td>Total no. of forms of torture</td>
<td>1.8 (SD=8)</td>
<td>15 (SD=6)</td>
</tr>
<tr>
<td>Total frequency of torture</td>
<td>153 (SD=95)</td>
<td>204 (SD=168)</td>
</tr>
<tr>
<td>Social support (captivity)</td>
<td>3.2 (SD=1.9)</td>
<td>3.9 (SD=1.8)</td>
</tr>
<tr>
<td>Social support (post-captivity)</td>
<td>5.1 (SD=2.2)</td>
<td>3.7 (SD=1.7)</td>
</tr>
<tr>
<td>Problem-focused coping</td>
<td>38 (SD=13)</td>
<td>47 (SD=7)</td>
</tr>
<tr>
<td>Emotion-focused coping</td>
<td>41 (SD=12)</td>
<td>49 (SD=5)</td>
</tr>
<tr>
<td>Total torture distress (mean)</td>
<td>53 (SD=65)</td>
<td>40 (SD=17)</td>
</tr>
<tr>
<td>HTQ/Trauma symptoms before detention</td>
<td>40 (SD=9)</td>
<td>36 (SD=8)</td>
</tr>
<tr>
<td>during detention</td>
<td>63 (SD=12)</td>
<td>68 (SD=17)</td>
</tr>
<tr>
<td>after release</td>
<td>81 (SD=18)</td>
<td>69 (SD=19)</td>
</tr>
<tr>
<td>now</td>
<td>43 (SD=8)</td>
<td>48 (SD=10)</td>
</tr>
<tr>
<td>SCL-90-R, total, after</td>
<td>179 (SD=50)</td>
<td>165 (SD=32)</td>
</tr>
<tr>
<td>SCL-90-R, total, now</td>
<td>60 (SD=30)</td>
<td>66 (SD=19)</td>
</tr>
</tbody>
</table>
after release than during detention (Table 3). PTSD was present in 33% (n = 36) of the PDs and in 28% (n = 17) of the NPPs.

Since no significant differences regarding measures of severity of trauma/torture and clinical ratings were found between the two groups during cross-tabulation analysis, only findings concerning PDs are described in the following.

**Measures of severity of trauma/torture and clinical ratings in PDs**

The measures for trauma and severity of torture were: (1) number of trauma events experienced, (2) number of forms of torture, (3) number of total exposures to torture, (4) total distress score from torture, and (5) duration of captivity.

The clinical measures consisted of (1) the number of HTQ-PTSD symptoms, (2) the number of HTQ symptoms (before, during, after detention, and now), and (3) the SCL-90-R General Symptom Index and its 9 subscales (after detention and now).

The total distress score for exposure to torture was only correlated at a level of 0.28 with SCL-90-R (after), 0.21 with HTQ symptoms (after), and 0.13 with HTQ symptoms during detention. Furthermore, social support by church and family, and older age, seemed to have reduced the distress of torture in detention (Table 4).

Further correlations found that emotion-focused coping and social support by friends/neighbours reduced HTQ symptoms after detention and now. Problem-focused coping reduced SCL-90-R (GSI) symptoms after detention and now.

In general, the stress measures of number of forms of torture, trauma events experienced, number of exposures to torture, and duration of captivity were related to increased levels of psychopathology. However, the extent of subjective distress with torture seemed not to be significantly correlated with increased symptom levels.

Trauma events experienced, torture, and detention experience seemed to have various short-term psychopathological effects after release from detention (increased interpersonal sensitivity, psychosis, depression, paranoid ideation, obsessive-compulsiveness) and long-term effects of increased currently-reported levels of depression, hostility, HTQ symptoms, and interpersonal sensitivity.

By stepwise multiple regression, clinical measures were related to stress measures at a significance level of 55%. As a result, the number of forms of torture were more related to HTQ symptoms SCL-90-R General Severity Symptoms than to the number of exposures to torture, duration of captivity, and total distress from torture (Table 5).

**Discussion**

In South Africa, Foster et al. found that 93% of a sample of PDs spent less than one year in detention, compared with a mean of more than two years’ captivity in Malawi. In comparison with Malawi, where 94% of the PDs had a history of physical torture and 50-70% a history of severe mental torture, London and Dowdall found corresponding figures of 72-89% and 78-83% when they reviewed three studies of torture victims in South Africa. PDs and NPPs in Malawi were similarly subjected to physical and psychological torture, though PDs served longer sentences than NPPs. Paker et al. found that only 15.4% of Turkish NPPs reported no form of torture.

When psychological methods of torture are divided in this sample into weakening techniques and personality-destroying techniques, it seems that the former (teaching the victims to be helpless, and creating “exhaustion”) were more often used than the latter (induction of guilt, fear and loss of self-esteem) (cf. Sommers & Genekse). Gudjonsson notes that by the 1980s interrogation methods that relied on physical coercion were replaced by more psychologically-oriented approaches that employed deception, trickery, and manipulation. Many police interrogation manuals have been produced to illustrate these “modern” techniques of interrogation. Gudjonsson also notes that interrogation can go wrong when interviewees suffer from PTSD as a result of being interviewed by the police.

Most torture methods are similar cross-culturally, e.g. beating and solitary confinement are equally often used for both PDs and NPPs in Turkey and Malawi (cf. also Başoğlu & Paker). However, torture in Turkey seems to include a number of methods that are not practised in Malawi, including blindfolding, flanga, suspension, exposure to loud music, asphyxiation, forced standing when carrying a heavy weight, burning, stretching of extremities, and the forcing of needles under toenails or fingernails. Specific Malawian forms include nyakula, smearing mud on the face, and forced labour.

Paker et al. diagnosed PTSD in 39% (81) of tortured Turkish prisoners while still in prison; their sample included

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**Table 4. Significant correlations between measures of severity of traumatic torture and clinical ratings.**

<table>
<thead>
<tr>
<th>Measure of severity</th>
<th>HTQ symptoms (during detention)</th>
<th>SCL-90-R GSI (after release)</th>
<th>SCL-90-R Interpersonal sensitivity (after release)</th>
<th>SCL-90-R Psychotism (after release)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; N of forms of torture</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; Trauma events exper.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; N of exposures to torture</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of captivity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; Total distress score</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Table 5. Clinical measures as related to stress measures in order of importance.**

<table>
<thead>
<tr>
<th>Measure of distress</th>
<th>HTQ symptoms (during detention)</th>
<th>SCL-90-R (GSI) (after detention)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of forms of torture</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td>Duration of captivity</td>
<td>(2)</td>
<td>(2)</td>
</tr>
<tr>
<td>Trauma events experienced</td>
<td>(3)</td>
<td>(3)</td>
</tr>
<tr>
<td>Number of forms of torture</td>
<td>(4)</td>
<td>(4)</td>
</tr>
<tr>
<td>Duration of captivity</td>
<td>(5)</td>
<td>(5)</td>
</tr>
<tr>
<td>Number of exposures to torture</td>
<td>(6)</td>
<td>(6)</td>
</tr>
<tr>
<td>Total distress from torture</td>
<td>(7)</td>
<td>(7)</td>
</tr>
</tbody>
</table>

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TORTURE Volume 7, Number 2 1997
42% murderers with a mean expected duration of imprisonment of 17.1 years. Murderers are executed in Malawi. PTSD was present in 33% (n = 36) of the PDs and in 28% (n = 17) of the NPPs in Malawian torture survivors.

Descriptive examples of interrogation and torture

A) POLITICAL PRISONERS:
The interrogator/torturer (T)
The victim (V)

T: How old are you?
V: 28 years.
T: (laughing) You want to become the president?
V: Tell me what I have done?
T: You did not collect anything. (They grasped me by the neck and beat me) If this is the way you behave ...
V: I was in tears and kept quiet.
T: Do you have friends abroad?
V: No.
T: You are rude. The one to whom you sent a certain feature story.
(After 5 hours they stripped me naked)
T: (threatening) If you do not tell us, we shall use these pliers on your private parts.
V: I said I did not do anything.
(Then they used an electric thing) I screamed.
T: (another day) Where did you go to school?
V: I went to X and Y in England.
T: So you went to England, look here ..."

"At the police headquarters they slapped me, my eyes were swollen. They asked, "Do you know why we are arresting you?"

"No, I do not", I said. "You should know! Do you think you can overthrow the government?" They slapped me again.

"Tell us anything that happened at your seditious office! Why did you not go to the Kamuzu stadium? You were distributing letters and did not go to the stadium! Now, tell us who is behind writing all these letters? You are wasting our time, you know this is a police station, we can kill!" I had heart palpitations, they took something like pliers and an electric stick. Then they took off my jacket, blouse, shirt; started beating me, took off my bra and pushed me down to lie on my back, three other guys, legs up, one holding both arms, another one leg, the third the other leg, and one was pressing on my breast forcing me to "tell us", and I said, "I do not know." They took the pliers as if they were going to cut my throat. They said, "This is your last chance, you can live, but we cut your intestines. We will kill you here and nobody will question us." I was crying, feeling pain from the electric shock. I said, "Leave me, I am going to tell something." I was bleeding. Someone very senior saved me and asked them to stop doing all this. I put on my clothes – pants and bra were not to be seen – and had to go into another room: alone, very dark, completely lost, thinking they will kill me.

Then it started again, I was introduced to a list of names.

"You are working with them! You can die!" I said, "I do not know their names." They said, "Put your head into this thing (like a helmet)!" It was in the fireplace for 5 minutes. They pulled me off and yelled they want to cut me now. I had terrible sounds in my ears. The senior officer came to stop them and ordered me to be taken into another cell. I was still bleeding. The guy on duty came and called one by one out in the night to continue interrogating us for the names. We had sleepless nights, were not allowed to talk or whisper."

"We were all ordered to take off all our clothes completely, without even a pair of underpants on. In that condition we were ordered to lie down with faces facing the ground. Then all of a sudden all these Youth Leaguers leapt down on us, lashing our bare bodies with all the viciousness they could muster. We were all wailing with tearing pain while they screamed with joy and excitement. After five or six blows many of them felt pain in their thick boots. For us the time seemed endless. Our bodies were swollen and bleeding, but they were still pouncing us. We were crying like mad men, but they never took heed of our extreme agony. After this kind of welcome we stayed three to four days without a shower, and the blood congealed on us. In fact the first seven days we were beaten every day. The old, the sick and the weak started to die off and they were unceremoniously carted off."

"Very often the porridge and the nshima (stable food) were soaked with flour from rotten maize and had a bitter taste in the mouth. The cowpeas had traces of DDT and were full of weevils. Most of us had running tummies."

"The warders used to get a lot of happiness by subjecting us to the lowest forms of humiliation imaginable. For example we had this totally depraved Malawian Young Pioneer woman who used to walk into our cells, order us to strip completely naked and then move from person to person fondling our genitals. She would stoop a little and hold the penis between her fingers, toss it about and speak to it with silly words: "You, how can you rebel against the Ngwazi? Look, where you are now", she mocked and teased. She did that from person to person, young or old."

B) NON-POLITICAL PRISONERS:
- Male (fighting in a public place, 6 months): In the interrogation room there was mockery, beating and general torture. I was stripped naked and whipped on my back, teased to make love with a hole in the wall, slapped and kicked. We worked like animals pounding maize every day except Sundays.
- Male (common assault causing bodily harm, 6 months with hard labour): Two detectives came to finalize my statement. They were very aggressive. C. hit me with a club on my head that swept away all my thinking leaving stars in my eyes. I fell down. I was sent for a cold shower with my clothes on. When I came back I was whipped on my buttocks up to the point that I had bruises. There were others who were witnessing me being tortured. I was forced to punch blows to a brick wall since they said I was powerful.
- Male (burglary suspect, 3 months): In the interrogation room there were hose pipes, sisal whips and sticks for whipping culprits. I automatically knew that the room was meant for people to plead guilty even if they were not — through torture one was able to say "yes". During interrogation there was no food and water. The three days I spent at the police cell I did not eat anything.
- Male (rogue and vagabond, 3 weeks): After denying the allegation I was beaten on the head with a club ... In another room there was somebody (a victim) who was being beaten and I was ordered to witness this.
- Male (theft, 3 years): Interrogation from 2:30 pm to 4:00 pm. At first it was simple, but later it turned to be very harsh. There were four non-uniformed policemen who took turns in harassing me. I was beaten, had water
poured over me, was forced to stand and dance, slapped on
the face, spat in the face, whipped and mocked at. In the
room, there was a desk and a chair where their boss sat
enjoying the juniors ill-treating victims. Sometimes even
ordering the beating as he wished; when the victim was
crying in agony he laughed with satisfaction. During inter-
rogation I was sent to solitary confinement, it was com-
pletely dark. There was no food and no water.

- Male (rape, 1 year): A woman constable came who de-
manded to see my genitals if at all I could impregnate a
girl. Then I was ordered to undress and she started playing
with my testicles and penis. She joked about my circumci-
sion and puberty hairs. After this she slapped my face. The
two male constables started beating me saying that I was
too ugly to have been a boyfriend of the chairman’s daugh-
ter. Later on I was given the statement to sign which read
“I raped the girl because she is beautiful.”

- Female ( arson, 2 years): I was stripped naked by female
constables, they played with my private parts, slapped me,
spat saliva into my face and cursed me for being so jealous
and cruel.

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Acknowledgements
I thank the Health Sciences Research Committee in Malawi for
giving me permission to conduct this study. In addition, I would like
to thank the International Rehabilitation Council for Torture Victims
(IRCT) for its financial contributions, my research assistant Moffat
Mongola, and the interviewees.

Selected list of publications
received in the IRCT International Documentation Centre

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From helpless victim to empowered survivor : oral history as a
Torture inside and outside police stations in Egypt 1993-1996

El Nadim Center*

The torture of citizens in police stations is a persistent crime that is taking place in the different governates of Egypt from Alexandria to Aswan. The widespread phenomenon strongly questions the credibility of the official explanations of the torture as individual malpractice of some police officers. The size of the problem, its geographical spread inside and outside police stations, and the availability of instruments of torture, including those for electric shocks, point to the contrary.

Legislative procedures are also in complicity with the violators. Cases of torture are usually prevented from going to court in the District Attorney's office, where there is legal power to close the file before it goes to court. This continues to be a major obstacle to holding violators accountable for their crimes.

Torture takes place not only in police stations; it is also practised by police officers on the streets, in homes, etc. They use the limitless authority given to them by virtue of the emergency laws. Organized state violence comes next in order of frequency as a form of violence against its citizens, an example of which is the violent confrontation of peaceful workers' strikes and protests.

Another example is the violence practised against peaceful citizens to implement administrative decisions to remove illegal buildings, clean up slum areas, or force vendors to leave certain areas.

The report of the Egyptian Organization for Human Rights, published in March 1997, recognizes the same phenomenon where it documents a sample of 57 cases of torture in police stations, of whom 12 died under torture. Nine of the 57 were women, some of whom were raped and detained for no declared reason.

<table>
<thead>
<tr>
<th>Year</th>
<th>All forms of violence</th>
<th>Torture</th>
<th>State violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>65</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>1995</td>
<td>65</td>
<td>19</td>
<td>5</td>
</tr>
<tr>
<td>1996</td>
<td>131</td>
<td>43</td>
<td>18</td>
</tr>
<tr>
<td>Total number of clients</td>
<td>261</td>
<td>76</td>
<td>33</td>
</tr>
<tr>
<td>Non-Egyptian tortured outside Egypt</td>
<td></td>
<td></td>
<td>45</td>
</tr>
</tbody>
</table>

The following report includes the cases who have received psychological rehabilitation at El Nadim Center during August 1993 – December 1996.

The reasons for torture show a similar spectrum in the majority of cases:
- Initially a number of arrested people are tortured at random on the basis of being “suspects”, to force them into confessing that they or others have committed a crime, which they frequently have not (15 cases).
- Then there is torture as a favour to a friend of the police officer or one of his relatives (8 cases).
- Setting accounts or disputes between a police officer and an "ordinary" citizen (4 cases).
- Pressuring one of the suspects by torturing one or more of his family members, especially women, children, and the elderly (23 cases).
- Torturing members of the family or holding them hostage until they inform about a suspect or until he gives himself up (4 cases).
- Being forced to give up an earlier complaint against the police (5 cases).

Methods of torture, and its after-effects:
- Beating with sticks, whipping, kicking with boots: bruises, subcutaneous bleeding, swelling of injured areas (all cases).
- Hitting with sharp instrument: cut wounds and fractures, some severe enough to give permanent disability and handicap (16 cases).
- Food and water deprivation, deprivation from necessary medication (most cases).
- Burning with cigarette butts or other objects: deep burns, lacerations (4 cases).
- Electric torture: burns, local nerve injury (25 cases).
- Suspension by one or both arms (14 cases).
- Burning the skin of the hands by forcing them into boiling water (one case).
- Dragging along the floor by both hands or feet (3 cases).
- Stripping, verbal and tactile sexual insults (15 cases, 7 of them women).
- Threats, insults, humiliation (all cases).
- Threat of rape and sexual harassment (7 women).
- Rape (one case).

Dangerous injuries:
- Extreme weakness of both arms as a result of brachial plexus injury to the point of inability to work (mostly due to suspension by both arms from behind the back) (4 cases).
- Epilepsy as a result of head injury (3 cases).
- Amnesia as a result of severe blows to the head (one case).
- Compound fractures, one involving the fissure at the base of the skull, ocular haemorrhage, retinal tear.

* El Nadim Center for the Management and Rehabilitation of Victims of Violence
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Cairo
Egypt

54
Psychological after-effects of torture:
All survivors of torture, and sometimes a member of their families, suffered one or more of the following psychological sequelae:

- Depression
- Post traumatic stress disorder
- Acute polymorphic psychotic disorder
- Paranoid reactions
- Enduring personality change.

All the children whose houses were raided, or who had witnessed the torture or maltreatment of family members, have developed attacks of terror and panic, and many have developed nocturnal enuresis.

Death was registered as a result of torture.

State violence
During the Kafir El Dawar workers’ riots in October 1994, security forces and special police forces surrounded the city of Kafir El Dawar and randomly shot live ammunition (outside the factory where the workers were rioting), leading to the injury of dozens of citizens and the death of four. El Nadim Center followed up the management of 10 victims of that attack, 9 of whom lost one eye, and the tenth both eyes. In addition, a number of citizens were shot by buckshot. Moreover, a pregnant woman was shot in one eye and in her abdomen, with the result that she and the foetus both lost an eye, the abdominal shot having penetrated the uterus.

It is important to stress that these citizens were admitted to Alexandria University Hospital, where no operations were performed on them, and they were refused medical reports about their conditions.

Sporadic violence
Such violence, causing injury, psychological trauma, and the death of three persons, has been reported.

CENTRE PRESENTATIONS

El Nadim Center, Egypt*

Premises
El Nadim Center is based at 9 Wezareet El Zera’a street, sharing premises with another organization “the New Woman Research Center” since July 1995. A contract for the agreement and the rationale for this step were elaborated in an earlier document that was forwarded to DANIDA.

Working hours
The centre is open 6 days a week.

Staff working at El Nadim
Two full-time psychiatrists, a general practitioner, an executive director, an administrative resource person, and a cleaner constitute the permanent staff of the centre. An accountant and a lawyer are contracted by El Nadim to be appointed on request of the centre.

Clients visiting El Nadim
Table 1 shows the number of clients visiting El Nadim at the end of November 1996.

The need for hospital admission and referral to other specialities and investigations has been on the increase, especially in cases of major injury. It is interesting to note that the use of legal aid is increasing as more clients give up the role of victim. The request for legal aid is considered by El Nadim as a positive sign of taking another attitude toward the individual trauma.

Sources of referrals
As in the previous report these involve personal contacts, lawyers, and a number of friends. The legal aid centre has developed into the main referring source, especially with the two branches of the legal aid in Alexandria and Aswan. The two centres have agreed on a specific contact person at the legal aid centre who is in charge of El Nadim cases. This process has facilitated cooperation between the two centres. Another source of clients has been developed in the communities where El Nadim has been regularly working during the past period.

Outreach activities
The outreach activities of El Nadim are mainly through contacts in the communities. Occasional visits are made by El Nadim staff to other communities, sometimes outside Cairo, to provide acute crisis intervention, establish contact be-

<table>
<thead>
<tr>
<th>Violence</th>
<th>Men</th>
<th>Women</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Torture</td>
<td>53</td>
<td>18</td>
<td>8</td>
</tr>
<tr>
<td>State violence</td>
<td>28</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Social/domestic violence</td>
<td>5</td>
<td>25</td>
<td>11</td>
</tr>
<tr>
<td>Rape/sexual abuse</td>
<td>0</td>
<td>17</td>
<td>8</td>
</tr>
<tr>
<td>Institutional violence</td>
<td>0</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>Total Egyptians</td>
<td>86</td>
<td>66</td>
<td>50</td>
</tr>
<tr>
<td>Non-Egyptians</td>
<td>37</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>123</td>
<td>75</td>
<td>50</td>
</tr>
</tbody>
</table>

* El Nadim Center for the Management and Rehabilitation of Victims of Violence
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Egypt
tween victims, and give other needed services. Such visits have been made to Alexandria, Port Said, Zagazig, and Ismailia. The two psychiatrists who had been regularly attending clinics in two communities have reduced their presence to instances where they are being called upon.

**Media contacts**

The last year has seen an intensification of El Nadim’s relationship with the media. “News” about torture victims and stories are regularly sent by El Nadim to the newspapers, which frequently make cover stories of the event. This procedure has further expanded information about the centre, and has contributed to the increase in the number of torture victims seen by the centre.

**Conferences and campaigns**

The centre has attended several conferences, and there has been a number of campaigns in which El Nadim was a party or was working alone.

*El Nadim Center is situated in Cairo in Egypt.*

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**DE JURE, DECLARATIONS, ETC.**

The need for a Special UN Rapporteur on Health Professionals and Human Rights

Health care is a fundamental human right that is guaranteed in international human rights law and humanitarian law. It encompasses two primary issues: 1) Right to medical care as stated in the *Universal Declaration of Human Rights* and the *International Covenant on Economic, Social and Cultural Rights*, and 2) Protection of health care workers, health facilities, and medically needy persons in armed conflict situations, as guaranteed in the *Geneva Conventions and Protocols Additional I and II*. Despite the protection of health care, violations of this right continue to occur in conflict and peacetime situations.

The Johannes Wier Foundation for Health and Human Rights held a conference at which the proposal for this item was discussed, based on a document by Coes Flinterman, Robin M. Lofton, and Alese L. Smeulers from the International Centre for Criminal Law and Human Rights, University of Limburg, The Netherlands. Below follows an excerpt from the draft proposal for the conference.

This document focused on the violations of the right to health care as they are found by the United Nations special rapporteurs and working groups, to determine whether the creation of a Special Rapporteur on Health Care and Human Rights would be useful in developing a systematic method of monitoring violations of the right to health care. Hence, most of this paper is devoted to listing the violations of the right to health care, where they have occurred, and, if possible, the context in which they have occurred. However, it is first
necessary to define the right to health care under international human rights law and humanitarian law, and to discuss the two aspects of this right.

Useful definitions and statements were suggested in this paper.

The international community has not yet developed a sustained and organized system of monitoring violations of the right to health care, which is the first step towards effective implementation of universal norms.

Initiatives have been taken to organize a monitor system. The International Commission on Medical Neutrality (ICMN) has made a classification scheme for monitoring, which distinguishes 13 violations. They provide a useful reference for a discussion of the mandate of a United Nations Special Rapporteur on Health Professionals and Human Rights. The classification scheme of violations of the right to health care includes:

1. Killing: The deprivation of the life of a wounded or sick person, or of medical personnel, directly or indirectly caused by one of the parties to the conflict.
2. Disappearances: The disappearance of a wounded or sick person, or of medical personnel, directly or indirectly caused by one of the parties to the conflict.
3. Torture, inhuman and degrading treatment: Failure to treat sick and wounded persons or medical personnel in a humane fashion.
4. Arrest or detention of wounded and sick: Arrest or detention of sick and wounded persons leading to the interruption of necessary medical care, including the use of the patient's medical condition as an excuse for the arrest or detention.
5. Punishment of medical personnel: Punishment of medical personnel for having carried out acts in compliance with medical ethics or for refusing to carry out acts which are not in compliance with medical ethics.
6. Military attacks on medical personnel or units: Attacking medical personnel or clearly marked or identified medical units.
7. Denial of access: Deliberate delays or obstruction in the collection, transport, or provision of medical attention to the sick and wounded, or in the provision of preventive medical services to the civilian population.
8. Harassment: Overt or implicit threatening behaviour intended to result in the provision of inadequate medical care or in the failure to provide any medical care at all.
10. Disruption of training programmes: Disruption of health-related teaching programmes, including training for medical professionals, lay health promoters, relief workers, and health education for the civilian population.
11. Using medical personnel or units for military purposes: Using medical personnel or units for military purposes, including patrolling in or around medical units and using medical units as command posts, observation posts, troops or weapons transport, or for other military operations.
12. Improper use of the medical emblem: The improper use of the medical emblem includes the use of the red cross or other easily recognizable medical symbols to identify units or personnel used for military or other non-medical purposes, such as attacking the other party, transporting uninjured troops, or re-supplying combat units with weapons and ammunition. It also includes the failure to identify medical personnel or medical units properly with any distinctive medical emblem.

13. Violations committed by medical personnel: Participation of medical personnel in any violation listed in the foregoing categories; use of medical skills in unethical ways in order to further the cause of a party to the conflict. This category includes unethical medical experimentation and involvement of medical personnel in inflicting or concealing signs of torture.

The authors stressed that, in addition to developing a classification scheme for monitoring, many other issues remain unresolved. For example, who is in the best position to monitor? Should monitoring be limited to armed conflict situations? What should be done with the results? Although a classification scheme and monitoring system are useful, there are inherent difficulties and obstacles to the monitoring of armed conflicts, resulting in inaccurate reports on violations of the right to health care.

One method for establishing a reliable and efficient monitoring system is through the appointment of a Special Rapporteur on Health Professionals and Human Rights. In the 1980s, this approach towards monitoring and reporting on human rights violations was initiated by the United Nations Commission on Human Rights with respect to consistent human rights violations such as torture or disappearances.

A Special Rapporteur on Health Professionals and Human Rights could serve a useful role in monitoring and reporting on violations of the right to health care. We have seen that there are sufficient and adequate norms for protecting this right. The major problem is the implementation of and compliance with these norms. A special rapporteur could therefore undertake to document any human rights violations occurring in a medical context.

The substantive mandate of the Special Rapporteur on Health Professionals and Human Rights should focus primarily on violations of the right to health care in areas of armed conflict and prison situations, since most of the violations occur in these contexts. In these situations, the special rapporteur should be aware of the two main aspects of the right to health care: the right to medical care and the independence, inviolability, and protection of medical personnel, facilities, and patients. The legal basis for the substantive mandate is derived from humanitarian law, human rights law, and, to a lesser degree, the regulations concerning the rights of prisoners.
ANNOUNCEMENT

Professor Bent Sørensen's Travel Grants

Professor Bent Sørensen's Travel Grants in Support of Medical Doctors' and other Health Professionals' Participation in International Activities to Combat Torture and its Consequences were established under the RCT at the occasion of former president of RCT (1984-90) Bent Sørensen's 70th birthday, March 8, 1994. A number of travel grants will be available this year to enable medical doctors and other health professionals from all parts of the world to participate in international activities aiming at combating the practice of torture and providing appropriate care and assistance to victims of torture. These travel grants will be awarded to cover the cost of participation in scientific or professional meetings as well as in fact finding missions and study trips relating to torture and its consequences. Travel grants may also be awarded to allow participation in relevant education and training activities either as faculty or student.

The grants will be awarded by a review committee appointed by the board of the RCT and will be based on written applications received before September 1, 1997. The applications should contain:

1. Purpose
2. Budget
3. C.V.

and should be sent to:

Professor Bent Sørensen's Travel Grants
Rehabilitation and Research Centre for Torture Victims
Borgergade 13
DK-1300 Copenhagen K
Denmark

CONFERENCE REPORTS

Report from the Education Department, RCT

Quality Course for Advanced Therapists in Copenhagen

Description
A five day seminar organized by IRCT on debriefing*, relaxation, and team building, and, as a very substantial part of the course, clinical supervision** took place at RCT 9-13 December 1996. To rehabilitate torture survivors is mentally very demanding for many therapists. This has been well known for several years at RCT, and at centres around the world. In March 1995 therefore a working group discussed how to deal with this matter. The group discussed the various signs of stress in the therapists, created by transferred traumatization. The work resulted in a 2-day seminar as a continuation of the symposium in Cape Town in November 1995. The seminar, which was well attended, mainly concentrated on exchange of ideas about methods to prevent "burning-out" of therapists. The second seminar was held in Copenhagen in 1996, and the aim was to focus on improving team functioning as an important answer to the needs of the therapists, and to give the participants the means to act as supervisors in their teams in the future.

Teachers
The course in Copenhagen was prepared by Johan Lansen, MD, psychiatrist and former Medical Director of the Sinai-Centrum in the Netherlands. Johan Lansen is well known at RCT because he has been working as a consultant for IRCT/RCT for several years, and has been giving supervision to the RCT treatment staff.

Herman Eikendroort, psychologist at the Institute for Psychotrauma in Utrecht, and Willem Lammers, also a Dutch psychologist, now working at the Institut für Angewandte Sozialwissenschaften (IAS) in Mainfeld, Switzerland, assisted as lecturers. Most generously, they both
gave their lectures free of charge. The RCT senior physiotherapist, Karen Prig, conducted the relaxation exercises.

Participants
The 12 participants, psychiatrists and psychologists, came from 9 different countries and from centres with which RCT has been working.

To be accepted on the course they had to belong to a team working intensively with torture survivors, with some years’ experience in treating them.

As the basis for the teaching, the participants were asked to bring case material, and to describe their work situation in their team. They were asked to describe some characteristics of their clients, the therapy process, and the process of supervision.

The course
There was an introductory meeting the evening before the actual seminar, so that the participants could get to know each other and the teachers could explain the aim of the course. The participants already considered themselves a group at the Monday morning start of the course.

Each day’s programme included debriefing, supervision, and, at the end of the day, relaxation exercises.

The combination of theory and practice constantly involved all the participants. The course was simplified in such a way that everyone was able to take an active part all the time.

The participants agreed that the course had been inspiring and very useful. Those who had not yet implemented the use of supervision and debriefing would do so in the future. Most of the participants also considered using the concept of team building, as well as relaxation exercises.

It was recommended that RCT should continue to plan such seminars in the future. They could be held in different countries or in Denmark. All the participants agreed to help in the organization of such seminars. As someone said in the evaluation: “It will make the treatment of torture victims better.”

Annette Hart Hansen
Chief Coordinator
Education Dept./RCT
Copenhagen
Denmark

*DEBRIEving, as described by Herman Elienbroek, is a structured intervention intended for normal people with traumatic experiences to stimulate healthy coping and to prevent disorders. It can be used with groups or individuals by professionals or trained non-professionals. Debriefing is not psychotherapy.

**CLINICAL SUPERVISION, as described by Willem Lambers, is a contracted activity between an expert (the supervisor) and another professional (the supervisee) with the primary goal of helping this person and/or his team to acquire more professional competence and autonomy through a discussion on content, methods, and relationship in the working process. In short: supervision is social self-reflection.

Participants and staff members at the “Quality Course for Advanced Therapists”, Copenhagen, December 1996.
LETTERS TO THE EDITOR

Pentagon admits torture education

Sir,

I have been receiving your journal TORTURE for some time now, and find it most informative, if somewhat disturbing. I compliment you on making the truth known to the world.

However, either I have not received it long enough, or I am missing certain copies, but it has always amazed me that so little was written about torture in the so-called democracies of the world. I always read about Turkey, China, Israel, South Africa, South America, and I am sure that, however terrible the situations are in those countries, they are not exaggerated. I simply feel that there seems to be a bias, and it disturbs me.

I enclose an article that I came across recently*. Very possibly you are aware of it, but I would like a wider audience to be aware of it, and your journal would be an excellent vehicle.

A concerned citizen of the world

TORTURE’s editorial board sent the above letter to the centre “Equipo Argentino de Trabajo e Investigación Psicosocial”, EATIP, in Buenos Aires, Argentina. Dr. Lucila Edelman and Dario Lages, both members of the Executive Committee of EATIP, sent the following comment:

There was an article in the New York Times on 28 January 1997 about CIA’s teaching of mental torture in Latin America.

The CIA taught techniques of mental torture and coercion to at least five Latin American security forces in the early 1980s, but repudiated the interrogation methods in 1985. It advised against physical torture, as being counterproductive. Instead it discussed forms of psychological duress against a subject as ways of “destroying his capacity to resist” his interrogator.

The 1983 manual, under the heading “Coercive Techniques”, advised against direct physical brutality, which it said “creates only resentment, hostility and further defiance in a prisoner. On the other hand, pain which he feels he is inflicting upon himself is more likely to sap his resistance”.

The manual stated: “The immediate source of pain is not the questioner but the subject himself”; all with the aim of breaking the subject’s will to resist, to “drive him deeper and deeper into himself, until he is no longer able to control his responses in an adult fashion”.

“The use of force is not to be confused with psychological ploys, verbal trickery, or other non-violent and non-coercive ruses employed by the interrogators in the successful interrogation of reticent or uncooperative sources”.

The public recognition by the CIA only confirms the repeated denunciations made this century about the role played by the American secret services, both in the organization of coups d’etat in Latin America and in the support and “teachings” given to the bloody dictatorships.

These practices were also introduced into the rest of Latin America by the American army in its multiple direct military interventions, as in Mexico, Guatemala, El Salvador, Panama, Santo Domingo, Grenada, etc.

The public recognition stresses again the importance of the struggle against torture. In this struggle all forms of advocacy are important.

Simultaneously, an ethical problem is present: to receive “solidarity” funds from a government that promotes torture, i.e. funds for the centres that are assisting torture victims, implies contributing to the secretiveness of those governments with respect to their more illegal and atrocious actions. It implies simultaneously a double message for the clients: the ones who promote torture also “pay” for the treatment of their victims.

This last problem which causes the failure of treatment at rehabilitation centres created after the fall of a dictatorship: the state approves laws that guarantee impunity for the oppressors.

On the other hand, this public confession restates the importance of the psychological assistance for affected people, the work of support tending to recover the aspects of personal identity that were damaged by the traumatic experiences.

*The enclosed article states that the Pentagon admits that it taught Latin Americans how to torture – editor’s note.
OBITUARY

Erik Karup Pedersen, consultant surgeon

One of the pioneers of the medical work against torture has died at the age of 71.
Erik Karup Pedersen was among the very first to come forward when an attempt was made to include the work for torture victims, and against torture, within a professional medical framework. From our first meeting he became a critical advisor, an engaged colleague, and he and his wife Liuba opened their beautiful home for the necessary meetings and working groups.

Erik Karup Pedersen graduated in 1952 and became a specialist in surgery in 1966. He worked at most of the big Copenhagen hospitals, and was chief surgeon at the Falke County Hospital on Zealand from 1976 to 1989. He was a lecturer at the University of Copenhagen, and was appointed as surgeon and lecturer at the Danish Teaching Hospital in Kinshasa, Zaire, in the early 1960s. Erik Karup Pedersen was always deeply involved in international work; he was a medical delegate for the International Red Cross in the Mekong Delta following the cease-fire in Vietnam in February 1973, and also for the Danish-Vietnamese Friendship Association in 1978.

He was also deeply engaged in Amnesty International's medical work, and after the creation of the Danish Medical Group of Amnesty International he became a member of the Medical Advisory Board. Throughout the years he took part in numerous medical missions, e.g. in South Korea, Spain, France, and the USA, to spread the knowledge about people who had been tortured - and how best to help them.

Based on the new knowledge about torture and its sequelae, it was quite natural for Erik Karup Pedersen to become one of the main founders of the Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen in 1982. He was a member of the RCT board from 1982 to 1989, and with his wide international experience his contribution was highly valued; he was listened to because of his deep involvement, his exrovert personality, his natural authority.

Erik Karup Pedersen's deep understanding of the work with torture victims may well be due to his having taken part in the Danish resistance during World War II, when he was imprisoned and deported, but, since it was near the end of the war, lucky "only" to the German internment camp in Denmark, the Freslev Camp.

It seems meaningless that such an active, dynamic, clear-sighted, and creative person should suffer from disease throughout his last years that made his existence very difficult and inhibited his creative abilities.

Erik's intellectual attitude to life, his knowledge of literature, which poor sight did not prevent him from pursuing to the very end, were a natural part of the serenity with which he faced the enormous difficulties we met in our common work, and with which he faced his illness.

Inge Genetke & Henrik Marcussen
RCT
Copenhagen
Denmark

BOOK REVIEWS

Helping to integrate the torture experience


Those who have the courage to share the horrors of the unspeakable may recover. It is up to us to offer the right framework.

This book is an account of the activities of the first four years of the Treatment Centre for Torture Victims in Berlin. Its 12 chapters present different approaches to therapy, expertise, and social work. The differing theoretical and technical points of view of the individual authors can be seen clearly. Approaches such as the psychoanalytic (Lansen), Ericksonian hypnotic (Gurris), and corporeal physiotherapeutic-rehabilitative approaches (Karcher, Wenk-Ansohn), history and metaphor telling (Ahmad), political consciousness-raising and testimonial work (Pross) are presented. The healing processes can be made easier by the surroundings, for example via social work or via specific attention paid by the secretary at the phone or in the waiting room. How to handle expertise and witnessing in an ethical way is also dealt with (Graessner/Ahmad/Merkord).

Clarity about the difficult position of the expert who is asked to establish an expertise is necessary. As soon as therapy is taking place, expertise (expert statements for third
The pain of the priest


Father Michael Lapsley is well known among protagonists of the anti-torture cause. He took part in the foundation of the Trauma Centre for Victims of Violence and Torture in Cape Town, and before that was a vehement opponent of the apartheid regime in South Africa.

He is now the subject of a book by the prominent South African theologian Michael Worsnip, published in Australia, Father Michael being a New Zealander by origin. The title is somewhat misleading, because Father Lapsley in no way fought violently during the campaign against apartheid. He was, however, a member of the African National Congress (ANC), the foremost black organization fighting apartheid.

Father Lapsley was a strong supporter of the fight for equal rights for the blacks, who were suppressed for almost 50 years by the white minority in South Africa. He lost both hands when a letter bomb was sent to him in Harare, the capital of Zimbabwe, in April 1990. Father Lapsley had temporarily left South Africa for security reasons. No wonder that he became a living symbol of all the sufferings after that.

The author is no big writer, I am sorry to say. He describes at length what Father Lapsley has been doing, but gives no vivid picture of his personality. Was he the only white priest to join the ANC? – the book does not tell us. Would the book have been written had he not suffered this terrible fate? It was indeed a wonder that he was not killed.

Father Lapsley, who comes from New Zealand, arrived in Durban, South Africa, at the age of 24 in 1973, was originally a true pacifist. But on arrival his humaneness was lost, and he became a white man in the political sense. He tried hard to remain a believer in non-violence, but the black protest against compulsory school education in Afrikaans, the language similar to Dutch that the then government had decided upon, gradually changed his mind. A demonstration in 1976 against this in the black township of Soweto outside Johannesburg was brutally suppressed, and several hundred blacks lost their lives. These dramatic events forced Michael Lapsley to revise his original opinion.

Father Lapsley later joined the ANC, saying that: “Christians need to do more than analyse ... They need to act.” His various quarrels with bishops over where he should work in South Africa, or elsewhere, are conscientiously accounted for in the book, but they make rather tedious reading. When he returned to South Africa, to Cape Town, in 1992 he was offered indemnity by the new government. He truly suffered. He was not a torture victim, but a victim of the widespread violence and terror. In South Africa, violence and torture cannot be separated.

The Trauma Centre for Victims of Violence and Torture in Cape Town, which employs the popular and respected Father Lapsley as chaplain, still deals with the victims of apartheid, but nowadays it also treats many victims of actions committed by other South African citizens. Michael Worsnip’s book tells a personal story of a courageous man, devoted not only to God, but also to humanity. But it is just a small part of the big drama, encompassing millions of people, forced from their land, persecuted, terrorized, tortured, killed ... by the white man.

Gisela Perren-Klingler, MD
Visp/Lausanne
Switzerland

Theodor Dörner
Editorial Board
Torture
BOOK REVIEWS

Indian physicians and medical aspects of torture


The report is the result of a study conducted by the Indian Medical Association (IMA) to assess the knowledge, attitude, and practice of IMA members concerning medical aspects of torture, and to find out what they know about it.

The study is part of the implementation of the plan of action to mobilize doctors in India to provide treatment and care for victims of torture; it was conducted as a postal survey in June–December 1995.

Four thousand doctors were randomly selected from the list of IMA members, but only 743 questionnaires were returned. The authors claimed that one of the reasons for this could be that the doctors who did not answer were not interested in the subject. But other reasons could be that doctors were afraid to answer, that they did not have confidence in the anonymity, or that some of them collaborate with the torturers.

Among the respondents, 15.7% had witnessed the infliction of torture, 5% had administered drugs to facilitate interrogation, 6% had withheld treatment, 8% had given treatment without consent, and 18.2% knew of health professionals who, knowingly, had participated in torture. But almost 72% would offer treatment if a torture survivor was brought to them; the rest would not, mainly because they did not deal with medico-legal cases.

I agree with the authors, who found it important to publish the report, even though it was subjected to a rather important selection bias.

An important finding was the need for IMA to help in the establishment of rehabilitation services for torture victims (69% of respondents), and to educate all members (76%). Another important result was that a majority of respondents thought that the medical association should take the responsibility of protecting the doctors who fearlessly testify in cases of torture, besides disciplining doctors who facilitate torture. Further, respondents felt that the reasons for doctors' participation in torture need further study.

The results are not surprising. I imagine that the results of a similar study would be the same in many other countries. It is the first of its kind -- and perhaps with a higher rate of participation, the results would have been even worse.

It is the first step in the right direction if the intentions of the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Articles 10 and 14, are to be followed.

The report, including the questionnaire, can be obtained by contacting the Indian Medical Association, IMA House, I.P. Marg, New Delhi-110002, India, or The International Rehabilitation Council for Torture Victims, Borgergade 13, P.O. Box 2107, DK-1014 Copenhagen K, Denmark.

Soren Bechholm, MD
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NEWS IN BRIEF

Selection of a new High Commissioner for Human Rights

On 26 February 1997, the Secretary-General of the United Nations announced that he had accepted with regret the resignation, effective 15 March, of Mr. Jose Ayala-Lasso, who is to become Minister of Foreign Affairs of Ecuador, and that he had appointed ad interim and with immediate effect, Mr. Ralph Zucklin, Director of the Office of the Legal Counsel and Deputy to the Under-Secretary-General for Legal Affairs, as Officer-in-Charge during the selection process for a new High Commissioner for Human Rights.

Selected list of publications

received in the IRCT International Documentation Centre


El Salvador reconoce que la Escuela de las Americas enseña a torturar y asesinar : miles de militares latinoamericanos recibieron instrucción en sus aulas / Cano, Antonio. -- In: El País ; domingo 22 de septiembre. -- 19960922. -- p. 4.


FORTHCOMING CONFERENCES AND SEMINARS

Copenhagen, Denmark
29 September - 3 October, 1997

20th International Training Seminar on Rehabilitation of Torture Survivors and Their Families

First Announcement

This seminar is, as were the previous 19 seminars, addressed to two groups of people:

1. Persons planning or already engaged in rehabilitation of torture survivors, whether medical, psychological, socio-therapeutical or equivalent.

2. Administrative persons or decision-makers with substantial plans for, or already working with, rehabilitation of torture survivors.

The content will focus on experiences from the rehabilitation of torture survivors taking place at RCT, Copenhagen, supported by ethical and judicial considerations.

Further information:

RCT – Education Department
Borgergade 13, P.O. Box 2107
DK-1014 Copenhagen K
Denmark
Phone: +45 33 76 06 00
Fax: +45 33 76 05 00

Gaza City, Gaza
13-15 October 1997

Third International Conference on Health and Human Rights

Organized by the Gaza Community Mental Health Programme

First Announcement
Call for Papers

Further information:

Gaza Community Mental Health Programme
PO Box 1049
Gaza City
Palestine
via Israel

Tel: +972 7 865949
Fax: +972 7 824072

Att: Mr. Husam El-Nounou, Public Relations Coordinator

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

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