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EDITORIAL

THE STRENGTH
OF A FOCUSED EFFORT

When a journal clearly states its field of interest in its title, it is not surprising that its content is highly selective. This is further underlined by the fact that the journal is attached to and financially supported by RCT/IRCT, an international organization whose aim is to spread knowledge about torture and the rehabilitation of its victims.

There should be no doubt that the interests of TORTURE are the same as the ideas and development initiatives that were behind the creation and extension of RCT, and later IRCT. However, the editorial board has clearly defined its aim to be the mouthpiece not only for RCT/IRCT, but also, and even more pronounced, for the viewpoints of others, in order to further a dialogue and thus bring forward the facts that can partly reveal the deeds of the torturers, and partly serve as an attempt to restore the injuries caused by them.

Confronted with this editorial statement, the readers of TORTURE may still feel that the journal publishes relatively much research and documentary material from the work of RCT/IRCT themselves. The answer to this is that specific research and documentation about torture has been a partly inaccessible and thus limited field of interest in the professional literature. Apart from some outstanding monographs about torture, this subject has, ipso facto, been covered mainly by reports from Amnesty International, by the international work of RCT/IRCT and by others. This should not be an excuse for stressing, once again, one of the hobbyhorses of the editorial board: we welcome many, various, and well-documented manuscripts, also from circles and individuals that are not necessarily based in an organization or network which selectively works with torture. This invitation should, however, be accompanied by the editorial board's attitude, so far unchanged, that the aim of the journal is to publish specific and well-documented reports on government sanctioned torture, on where and how it is practised, and on how it can be treated and prevented.

In a thought-provoking and fascinating essay by Chinua Akukwe on page 82, the author brings forward some innovative arguments for organizations such as RCT/IRCT and Amnesty International to extend their fields of interest by directly involving themselves in the prevention not only of government sanctioned torture, but also of the violations and inhuman treatment in homes, at work places, and in other connections. This is such a big task that an organization with a specific work could easily overreach itself by taking it on. Furthermore, it might dilute the effect of an already well-established field of work, with which this organization has been identified by its collaborators and supporters. However, rehabilitation, which is still the primary task, will create awareness about the existence of the torturers, and thus have a continuously preventive effect. In the context of strengthening the focus on a selective field of work, initiatives, groups, and information on an individual level will fertilize the field for a collective effort, aimed at the abolishment of torture as its first priority, followed by a cascade of initiatives aiming to re-establish human rights.

The introduction and acceptance of human rights are prerequisites for the disappearance of torture. Therefore, the abolishment of torture should be a logical consequence of the introduction of a wide range of the elements that guarantee human rights. This ought to take place, it does take place, and is an ongoing process that takes place particularly through the international relations within the diplomatic system and through various treatment initiatives. Many people are involved in these efforts, and this in itself furthers understanding, thus increasing the strength, the engagement, and thus the pressure for the implementation of human rights. But this process must be considered a one-way communication since the understanding and insight of the necessity only exist in those who also want to communicate the message. At best, the receiver is passive.

It is different with the extension of rehabilitation of torture victims, which at its best will also put local pressure on those in power, will bring the torturers' atrocities to light, and increase opposition to their continued presence. As an important side-effect, this extension may help to further the understanding of the other components that are important for the establishment of human rights. In this connection we consider the abolishment of torture the main prerequisite.

H.M.
Aspects and problems associated with the use of interpreters in psychotherapy of victims of torture

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General preliminary remarks
Since our patients speak a wide variety of languages, we employ interpreters on a freelance basis. In most of our treatment contexts, we are aided by interpreters. We take care that it is always the same interpreter who comes to each of the regular, usually weekly, sessions with a patient.

To date little has been published on the role of the interpreter and its significance in psychotherapy. The publications that have dealt with this subject have generally been restricted to summaries of general observations made during practice, and resulting recommendations. For example, reference is made to the importance both of providing the interpreters with information and training and of the information that the interpreter can furnish, if they are compatriots, on cultural, historical, and social backgrounds in the patients' countries of origin. While it is well known that the sex, nationality and ethnic origin, personality, and continuity of the therapist are of essential significance for promoting trust and openness in the patient, it is pointed out that these attributes in the interpreter also play a significant role. Mention is, of course, also made of the interpreter's emotional involvement in the therapy, the necessity of regular debriefings immediately after each therapy session, and the desirability of the interpreter's regular attendance in Balint or supervision groups. A few authors have in fact drawn attention to the fact that the presence of the interpreter as a third person extends the conventional doctor-patient dyad, forming a triadic relational system so that a complex web of transference and countertransference is created between the therapist, patient, and interpreter. However, no reference is to be found to the enormous influence of the personality, nationality, ethnic origin, and personal history of the interpreter on the therapeutic process, or to what positive and negative changes the entire relational triad can be subject as a result. The aim of the present article is to give a brief overview of these influences and of some of the effects they can have, as illustrated by some brief case reports.

The patients usually come to us complaining of multiple problems associated not only with the physical and psychological sequelae of previous torture and persecution, but also with current family, social, and living circumstances and residential status. Thus, in addition to dealing with all these other questions and problems, we were initially unable to take into account the influence of the interpreter on the relationship between the patient and the therapist. We followed a "trial and error" model during the first few years after the establishment of our centre. We soon found that there were patient/therapist/ interpreter triads that were stable and conducive to the progress of the therapy, while there were others that were not, in which it was sometimes uncertain whether the cause of the stagnation was to be sought in the patient, the therapist, the interpreter, or in all three. Discussions of the problem in supervision usually focused on the therapist/patient relationship rather than on the interpreter/patient and interpreter/therapist relationships. On occasion an interpreter would suddenly give in his or her notice, and we were unfortunately unable to establish the reasons and problems involved. Conversely, we had to dismiss interpreters if it became evident that they were interfering too much in the therapy and it proved impossible to change this solely by asking them to stop it. On the other hand, we also observed how the course of a therapy and its dynamics could suddenly change after a change of interpreter.

It takes time for an interpreter to translate each verbal exchange. This is sometimes an advantage for the therapist, in so far as he can use the time for his own thoughts and considerations about possible interventions. On the other hand, the loss of spontaneity associated with the time lag can constitute a considerable disadvantage. The information conveyed indirectly by the patient through bodily, emotional, and facial expression and gestures reaches the therapist faster than the corresponding words. Often therefore the therapist is able to ask about the background to an emotional reaction of the patient only after it has already passed.

If the patient and interpreter come from the same country, this has the great advantage that the therapist can question the interpreter on relevant cultural and historical factors immediately after the sessions. However, the fact that patient and interpreter are compatriots can be a disadvantage if the interpreter has been living safely in Germany for a longer period and feels under an obligation to the patient because of conscious or unconscious feelings of guilt or solidarity. If this occurs the interpreter becomes psychologically enmeshed and is not free in the relationship. This can lead him to undermine the stance of the therapist by being overtly judgmental, or by more covert means. On the other hand, patients sometimes ask for German interpreters if they have reason to be distrustful of compatriots as a result of certain experiences in their home country.

I present some brief case examples to illustrate how the personality of the interpreter influences the patient/therapist relationship, and, conversely, how an interpreter can be affected by a therapy which he is interpreting, and how both can partly determine the course of the therapy.
Effects on the patient of the personal history and personality of the interpreter

All words are filtered during translation, i.e., they are conveyed through the medium of the interpreter. They are thus coloured by the ideas and value judgements that the interpreter consciously or unconsciously adds to them. Therefore not only the lives and histories of the therapist and patient play a role in the contact within the therapeutic relationship, but also those of the interpreter.

Example I

Interpreter C came from the same country as the patient. Having been granted asylum, he had already worked as an interpreter in Germany for many years. Previously he had been committed to political work for the freedom and independence of his people, for which reason he had to leave his country. He continued his political activities in exile, in addition to his work as interpreter. It is thus perfectly understandable that, having been through experiences similar to those of the patient, he rapidly came to feel very close to him. The resulting distance to the therapist was expressed in a lack of understanding for the therapist's manner of relating to the patient. While the therapist showed an interest in the patient and his entire personal history, the interpreter was mainly interested in the parts of the patient's life that related to the political circumstances and the political struggle. The patient was validated in his militant role by the interpreter, which prevented him from consciously re-experiencing the personal and narcissistic injury that he experienced under torture.

Example II

Interpreter A was German. Whenever the emotional tension increased during pauses in the dialogue, or the patient expressed feelings, he started to shift back and forth restlessly on his chair, to clean his glasses, or to look in his diary. This illustrates how an interpreter can have a very disturbing effect on a therapy if he is not accustomed to dealing with his own feelings.

Effects on the interpreter of the patient's traumatic experiences

In the domain of psychotherapy of torture victims there has long been a special interest in the particular forms of countertransference, i.e., thoughts, fantasies, value judgements, sensations and feelings, that therapists experience in contact with the patients, and there is now an extensive literature on the subject. Nightmares, anxiety states, depression, paranoid ideas, and psychosomatic symptoms of the patients can also occur in the therapist, showing that he or she is too close empathically to the patient (vicarious traumatization). Conversely, when the therapist becomes bored, angry, mistrustful, or disdainful, or fails to arrive on time, this can be a sign that he has withdrawn too far and is feeling too little empathy towards the patient. It is well known that the probability of exposure to extreme forms of countertransference, ranging from too great an empathic closeness to a too cool and rejecting distance, is particularly great in the psychotherapy of torture victims and of patients who have been through other kinds of extreme trauma.

Interpreters who are involved in the psychotherapy of torture victims are similarly affected. Like the therapist, they can also be included in the patient's transference. On the other hand, they may develop countertransference reactions and feel devalued or over-valued by the patient and can also experience helplessness, anxiety, powerlessness, anger, aggression, and guilt, or feelings of failure. All these feelings are signs that they have become too close empathically to the patient. Communication problems between patient and therapist, for example, may often not be due to bad translation by the interpreter, but have their source in the contact between the therapist and patient, i.e., either the patient or the therapist cannot or does not want to understand something. However, at such moments the interpreter often begins to feel inadequate and to have the impression that he has not interpreted something clearly enough and has thus "failed". In other words, interpreters, like therapists, can also be subject to countertransference reactions that make them feel incompetent. Another possibility is that, as a result of being too close empathically to the patient, the interpreter begins to suffer from the same symptoms as the patient. Interpreters are no more immune than therapists to the danger of vicarious traumatization, as is illustrated by the following example.

Example III

Interpreter I, a young woman from Kurdistan, had been complaining of sleeplessness, depression, nightmares, and disturbed concentration for some time. In the therapy sessions she appeared absent-minded, and it was often necessary to repeat things. This reaction was triggered by the fate of a young patient of the same age who had been subjected to severe mental and physical torture, including sexual torture, and who had been reduced to a physical and mental wreck. The interpreter who translated during the therapy was so upset by this and had identified so strongly with the story of the young patient from her own country that she had lost all distance and had begun to suffer the same symptoms.

The therapist-interpreter-patient relationship triad

The patient, therapist, and interpreter form a relationship system together (fig. 1), in which each develops conscious and unconscious feelings, value judgements, thoughts, and fantasies towards the other two that are reactions not only to the individuals as they are now and to the present situation; the reactions can also be influenced by older relational forms stemming from their respective earlier lives, which affect the nature of the transference-countertransference matrix.

The following examples are drawn from our clinical work. When a therapeutic relationship has been extended by the

![Fig. 1. The therapist-patient- interpreter relationship.](image-url)
introduction of an interpreter, the examples show how important it can be for the therapeutic process to take into consideration not only the patient's transference to the therapist and the therapist's countertransference, but also the transference and countertransference related to the interpreter.

**Example IV**

The patient was a 21-year-old Kurd who gave the impression of being younger. The interpreter was an older Kurd from the same country who was very well known and had great authority among his fellow compatriots. The young patient arrived extremely punctually for his appointments. However, his concentration and attention were reduced and his verbal and mental expression restricted, and taking his history thus proved to be a long and arduous undertaking. The therapist began to suspect that not merely agitation, anxiety, and mistrust, but possibly also an organic brain disorder might be responsible for the patient's reduced verbal expression. However, these speculations were based only on the nature of the contact between himself and the patient. That the interpreter was the main obstacle to the patient's relating more openly only became evident after a chance change of interpreter that occurred when the first interpreter was unable to come to a session. In the presence of a different interpreter, this time a rather motherly woman, the patient was quite different. With a marked sense of relief the words began to spill out of him, as though a spell had been broken, and all he had previously held back could now pour out without reserve.

In terms of the transference/countertransference model, in the patient's transference the first interpreter had represented his strict, patriarchal father, while the woman interpreter was perceived as similar to his emphatically concerned mother.

**Example V**

Interpreter A came from the same country as the patient and had been living in Germany for the past ten years. As a result of chance meetings with the patient on the way to or from the Treatment Centre, the interpreter entered into closer contact with him outside the therapy session. The therapist was unaware of this. The patient was dissatisfied and annoyed because in his opinion the therapist was doing too little for him in terms of providing social support. Instead of expressing his annoyance in the therapy sessions, the patient turned to the interpreter. The interpreter accompanied the patient on visits to German authorities, helped him to move flats, obtained second-hand furniture for him, and even once answered a telephone call to him at two a.m. The interpreter then became annoyed with the therapist, whom he considered was not prepared to look after the patient well enough.

In this last example the therapist's distance to the patient, whether appropriate or not, was circumvented by the fact that the interpreter was swayed by the patient's demands and adopted an overprotective attitude towards him, thus getting too close and allowing the boundaries of his sphere to be violated, which made him annoyed with the therapist. Since there were no agreements between the therapist and the interpreter, the patient manoeuvred them into opposing positions since he was able to act out the two opposing sides of his transference, splitting them between them, to the extent that one was too close, the other too distant. The patient was thus able to delegate his aggression towards the therapist to the interpreter. This led to a splitting of the therapist and the interpreter as a treatment team, such as can easily happen with patients with dissociative disorders. In such cases the patient can avoid expressing his impulses towards the therapist, and thus also his fear in dealing with the therapist's reaction. The relational triangle is no longer equilateral, as in fig. 1, but has become elongated, as in fig. 2.

In terms of the nature of the transference in the last example the therapist may have become to a certain extent part of the patient's perpetrator transference. The patient did not then dare to reveal his annoyance and anger towards the therapist owing to the feelings of anxiety, powerlessness, and defenclessness associated with this kind of transference; instead he acted out the theme outside the therapeutic setting, with the interpreter in the role of "the good rescuer".

This shows clearly how important it is for interpreters to be open to the concerns of psychotherapy and also to have some knowledge of it, or even to have undergone psychotherapy themselves. It is by no means sufficient to restrict interpreters to the mere task of mechanical translation, which can in fact lead to a therapeutic dead end. In the regular therapy sessions, conducted continuously over an extended period, interpreters can become equally important as significant others for the patient as the therapist himself.

As the following example shows, the therapeutic process can also be decisively interrupted by a transference developed by the interpreter towards the therapist.

**Example VI**

Interpreter G was highly impressed by the therapist, admired him, made no secret of this, and began to tell him her life story in instalments during the discussions after the end of the therapy sessions. During the week she thought about him a lot and brought him small presents when she came. At the same time in the therapy sessions she revealed a deprecatory attitude towards the patient through her tone of voice and gestures.

Here the interpreter's paternal transference onto the therapist had taken up so much room and developed a dynamic that threatened to push the relationship between the therapist and the patient into the background. In the patient the interpreter had seen her brother, with whom she had competed for the attention of their father in a jealous struggle, and whom she now wished to oust as patient. That she was partially successful in this was due to the therapist's countertransference to her. The therapist had not only uncritically accepted the interpreter's strong admiration for him, but had also even basked in it somewhat, as a result of his very difficult, strenuous and erratic relationship to the patient. This of course was bound to have negative consequences for his relationship to the patient. Fig. 3 shows the relationship configuration that developed in this last example.

The last two examples in particular reveal how closely knit the relationship system of the three participants is, and how...
The changes in one relationship can immediately lead to changes in the other two. It is therefore by no means sufficient to consider only the relationship between the patient and the other two respective protagonists; what takes place between the interpreter and the therapist must also be taken into account.

Example II for instance reveals not only influences of the history and personality of the interpreter on the therapeutic process, but also that the demonstrative acting out of the interpreter can also be taken as a sign that something important in the relationship between the therapist and the interpreter has not been expressed in words.

**Conclusion**

It is necessary to provide post-session discussions and Balint or supervision groups for interpreters. But it is also of prime importance that the case supervision should not only include the relationship between the therapist and the patient, but also investigate the entire relationship system of all three participants. Just as in our experience the best seating arrangement for the three in the therapeutic setting is an equilateral triangle, with the same distance between each participant, care should be taken that the same geometrical pattern should also be repeated on the relationship level and in the transference-countertransference configuration (fig. 1). The changes in the relationships described in the examples can lead to the asymmetric changes in the relationship configuration shown in figs. 2 and 3. Such asymmetries should be clarified and resolved. If they remain static or even become consolidated, the therapeutic process comes to a standstill.

**References**


**Literature**


a) Balint group (developed by Michael Balint, 1896-1970) is a working group in which professional helpers like medical doctors, psychotherapists, social workers, nurses and other professions report and share their experiences with their patients or clients in regular sessions under direction of a designated group leader. The aim of a Balint group is to make evident the thought, feelings, value judgments of the helpers toward their clients, to prevent enmeshment and to provide an anxiety-free communication with their clients.

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**Selected list of publications**

received in the IRCT International Documentation Centre


EE UU reconoce que la Escuela de las Américas enseno a torturar y asesinar : miles de militares latinoamericanos recibieron instruccion en sus aulas / Cano, Antonio. - In: El País ; domingo 22 de septiembre. - 19960922. - p. 4.


Rwanda: political conflict and genocide

Roxana Ferllini Timms, MA*

Introduction
Rwanda, a small nation in the Great Lake region of Central Africa, is slowly recovering from the most intense genocide of our times, when 800,000-1,000,000 Tutsi died under savage attacks carried out by Hutus from April to June 1994.

It is documented as the most intense genocide of our times, because it lasted only six weeks. When compared with other atrocities that have taken place during this century in different parts of the world, the time factor combined with the number of victims is different; such is the case of Argentina, where it is calculated that 9,000-30,000 civilians disappeared during a period of six years. In Bosnia, some 200,000 people were killed between 1992 and 1995. And in the most dramatic genocide the world has known, that carried out by the Nazis, 6.4 million Jews were killed from 1936 to 19451.

Many questions have arisen as to why such a tragedy took place in Rwanda. In order to begin to understand the reasons, it is necessary to review some important historical aspects of the relationships that have existed between these two ethnic groups, the Hutu and the Tutsi, and how some political actions affected these relationships.

Historical background
Rwanda, during colonial times, was first under German control and then under the Belgians. It was populated by different ethnic groups: Hutu, Tutsi, and Twa. The Hutu ethnic group forms the vast majority of the population; the Tutsi are a minority, and the Twa form only 1%2.

These ethnic groups are wrongly called tribal groups. In fact they all share the same Bantu language, and intermarriage between them occurs1. Thus, since precolonial times they have lived together side by side in harmony, and at times in conflict.

The Hutu have always comprised the majority of the population, as well as the poor and illiterate who worked the land. To a Westerner their physical appearance is typical for an African negro: broad nose, thick lips, dark skin, stocky. On the other hand, the Tutsi, originally dedicated to cattle raising, are considered by many as foreigners from Ethiopia; they were classified by the Belgians as the “Super Race”, due to their Caucasian facial features, such as a long thin nose, thin lips, lighter colour of skin, and being taller.

These physical characteristics have to be seen in a general manner, since intermarriage has occurred between the ethnic groups; those born from an interethnic relationship could have the characteristics of a given group, or have a mixture of characteristics.

Nevertheless, due to those differences in characteristics, the Tutsi held a preferential status with the Europeans; they were the literate and the business people who managed money. This situation created a feeling of inferiority among the Hutu, whose situation was that of underprivileged citizens, while the Tutsi held a special place in society, being able among many things to go to school and hold special jobs.

The ethnic superiority status of the Tutsi changed when Rwanda gained independence from Belgium on 1 July 1962, after a period of violence that started at the end of the 1950s. During the violence, the Tutsi were the main victims, as the Hutu began their quest to gain power and keep control of it. This change in ideology was due to new support for the Hutu, with the purpose of bringing back equality between the two ethnic groups; but the wedge created during the Belgian colonial times was deeply entrenched, and the feeling among the Tutsi was that even a simple Tutsi peasant felt “superior”. When the Hutu were in power, the feelings were the same among the simple Hutu peasants.

By the mid-1960s, under President Kayibanda, many Tutsi had fled the country due to the violence; the number of refugees in the neighbouring countries was estimated at 600,000-700,000.

At the beginning of the 1970s, the nation became one of the poorest in the world, isolated because of the government’s policy of not developing important relationships with other countries. At that time Rwanda was ready for a change. It was needed in order to survive in a changing world economy.

Juvenal Habyarimana became President in July 1973, a post he held until his death in April 1994. It was a time when the Tutsi continued to live in a marginalized way, no longer with the benefits they had in colonial times, and out of government positions, leaving them without power within the system. With the new government, military men were not allowed to marry Tutsi women. On the other hand, the Tutsi, although a minority and without power, had an edge over the Hutu because of their education. They had knowledge of business matters in dealing with foreigners, and this did not go down well with the Hutu.

During the Habyarimana regime the citizens were under strict control; everyone had an identity card that indicated his or her ethnic group. Based on that information, jobs were allocated, decisions were made as to who would go to school, and even where someone could live. If a person wanted to move from his or her residence, permission had to be granted. An example of the latter point is that if permission was not granted, he or she was forced to live in the prefecture assigned.

With respect to the economy, in the 1980s Rwanda had a per capita income similar to that of the neighbouring countries, and the socioeconomic situation in general was improv-
ing in line with the many foreign NGOs that were in Rwanda at that time. But as time passed, the Hutu government began an internal struggle for the resources that could give power and money; the economy was suffering from the low prices paid for coffee on the world market at the end of the decade.

President Habyarimana, under such internal pressure, and advised by foreigners with a more liberal political outlook, took a different course. In 1990 he began to favour a multi-party government, which included Tutsis in government posts. This course brought disagreement within the country at different levels.

Meanwhile, the Tutsi living abroad, especially in Uganda, were organizing themselves to take advantage of the fragile situation in Rwanda. Rumours began to circulate about a planned Tutsi invasion by the Rwandese Patriotic Front (Tutsi army) in Uganda.

The genocide
At the beginning of 1990, the atmosphere between the Hutu and the Tutsi was very hostile. Confrontations took place, with many casualties, until 1994, when a well organized attack took place.

President Juvenal Habyarimana was assassinated on 6 April the same year. There is still controversy as to who was really responsible for his death. Some have suggested the Hutu extremists, who were against the multiparty system, which was already in place in 1994. The Hutu power took upon themselves to send the Hutu leaders throughout Rwanda to gather forces to carry out a slaughter of the Tutsi. This was because the Tutsi were blamed for the President's death.

It is a reality that the genocide took place because of the well organized and planned task, taken by a few Hutu extremists in a systematic way under the interim government.

It is important to realize that for the Rwandans, as part of their world view, an order coming from a person in authority is to be followed without any questions or hesitation; this played an important role in the genocide, since the orders given to the Hutu were not questioned. In fact, the orders were taken and applied to neighbours, co-workers and even relatives.

During meetings the Hutu leaders would talk with the peasants in a metaphorical way, by instructing them to clean the fields which meant to "clean Rwanda from the Inyenzi (cockroaches)". The instructions then were not direct, but were well understood by the Hutu and carried out with efficiency, using pangas, a type of machete used to kill by striking the victims in the cranial and facial regions.

This tool was also used to torture and mutilate the Tutsi during the genocide. The victims' malleoli were struck with such force that they were completely severed; the tibiae were also cut at the distal end but not severed, and the Achilles tendon was damaged; the victim was thus left on the ground unable to get up and escape from inevitable death. The attackers would leave the victims lying around while they went off to torture and kill more people, or get drunk on banana beer, and then come back later and finish them off with the pangas. Other ways of killing included throwing victims alive into latrines or shooting them.

The Tutsi who held government positions were among the first victims of the genocide. One of them was under the protection of 10 Belgian Blue Helmets (UN force), but these were overpowered by the Hutu military men. They not only killed the minister; the Blue Helmets were also taken, tortured and then killed.

It was a time of blind hatred. The victims were attacked by gangs of youngsters, who would roam through the capital city of Kigali and other areas of the country, drunk on cheap liquor, wearing the clothing they looted from their victims.

The Interahamwe, which means "those who work together", formed by young people who are said to have belonged to the MRND - Mouvement Révolutionnaire National pour le Développement - youth movement, were also considered as main participants of the genocide. Many were unemployed.

But the victims were also attacked by their own co-workers, colleagues, neighbours, teachers, classmates and religious leaders. The attackers were of all ages, including children.

This created grotesque scenes throughout the country; the rivers in Rwanda, such as the Akagera River along the Tanzanian border, were tinted red and littered with thousands of bodies that had been thrown in. The streets in different communities, as in the capital city of Kigali, were littered with bodies of women, children and men mutilated by pangas. As time passed the bodies started to pile up.

In different hospitals Tutsi patients were brutally taken out of their beds, dragged outside and killed one by one. In some cases the bodies were buried in ditches near the hospitals.

Other accounts of what happened in different neighbourhoods throughout the country include breaking into the homes of Tutsis by brute force, gun fire or both. Once inside, the victims were massacred, and in some instances thrown alive into latrines. It is surprising to note that survivors of the genocide indicate that many took a passive attitude, just waiting to be killed without putting up resistance.

Some tried to survive by hiding in their homes, for example by seeking refuge between the roof and the false ceiling. The Hutu used machetes to poke holes in the false ceiling to detect hiding people. Others sought refuge in hotels, as was the case at the Mille de Colline in Kigali, where about 500 Tutsi gathered.

The Tutsi were told to go to the stadiums or to Roman Catholic Churches in order to be safe from the Hutu. The idea was to gather them in concentrated areas to facilitate their extermination. One example of this was the situation presented at the town of Kibuye in the west of Rwanda at the border with Zaire [since May 1997 the Democratic Republic of Congo] - editor's note], along the shores of Lake Kivu (fig. 1). There, thousands of Tutsis went to the Gatarwo stadium or the Roman Catholic Church.

Some survivors have stated that as many as 18,000 Tutsi refugees gathered at Gatarwo stadium. Once inside, they were attacked from above by gun shots and grenades. Many, not immediately dead, were killed later with pangas. The few who survived fled to other areas, such as the parish church or the Home Ste. Jean, nearby.

It is estimated that as many as 6,000 refugees were gathered at the parish church; once indoors, they were locked in, and a fire was started at one side; some Hutu went up on the church's roof and started to shoot at them; grenades were also thrown through the windows. Later, the Hutus went in and killed the rest, which were the majority, with pangas.

By chance some did survive, and in order to keep alive they had to go out at night to search for food and water along the slopes and shore of Lake Kivu, returning later to the church to hide among the dead bodies. Testimonies indicate that the smell of the decomposing bodies was more than they could tolerate, but if they did not remain there, they would be kil-
led. When the situation with the bodies became a problem for the community and there was talk about removing them, the people in hiding were forced to leave and go to other communities, with the danger of running into Hutu patrols. Some were caught on the slopes and killed. A few were lucky enough to run into some Hutus who would let them escape and get away from the area; others died from the wounds they had received during the attacks\textsuperscript{5,11}

Another tactic used to locate the Tutsi was to ask to see their identity cards, in which the ethnic group is stated, at road blocks. At the road blocks, the CRD (Coalition pour la Défense de la République, considered an extremist party that would not support President Habyarimana's moderate position at the beginning of the 1990s, and blamed for organizing the genocide) would stop the travellers and request their ID card.

If someone did not carry the ID card, the chances of not being killed, even for a Hutu, were slim, because of the practice of killing anyone whose ethnic affinity was not confirmed\textsuperscript{13}.

It should be pointed out again that these two ethnic groups have been intermixed in the past, with intermarriages; so to identify someone as Tutsi by physical characteristics was not a sure thing. Some Hutus were therefore victims of the genocide. The luck varied of families of ethnic intermarriage with children. The children were sometimes spared together with the Hutu parent; in other cases, if they turned in Tutsi relatives, their family would be spared. In other words, there was no rule about the policy to be taken; in fact, the CRD would act as they saw fit, as long as they got rid of the **Inyegi**\textsuperscript{5,11,16}.

At the end of the genocide, on 19 July 1994, the Rwandese Patriotic Front (Tutsi army) took control of the government. Among other factors, this was possible because of their well organized operations, the irrational fear of them on behalf of the Hutu, and the withdrawal of foreign support for the Hutu forces\textsuperscript{14}.

In turn, the Hutu, from peasants to the leaders of the genocide, left Rwanda. It is estimated that nearly 1.7 million people fled. Those heading for Zaire, believed to be over one million\textsuperscript{15,16}, managed get there in less than a week. Many refugee camps were set up; one is in Goma, near the border with Rwanda. The situation has been critical there, and cases of cholera have occurred\textsuperscript{7}.

There are now attempts to send these refugees back, but there are political conflicts, apart from the fact that many fear for their lives if they return\textsuperscript{8}.

In reflecting on such a horrible episode, one must understand that the cause of the genocide was the radical position taken by Hutu extremists\textsuperscript{9}, and that Hutus who did not agree with such radical political stances were also killed. The Hutu who supported the Tutsi, or who were against radical positions and for an integration of both ethnic groups in the government were known as *ibyitso*, an accomplice of the enemy\textsuperscript{10}.

**The Rwandan tribunal**

In November 1994, in order to bring justice to the victims of the genocide and to prosecute those guilty on an individual basis, the United Nations Security Council created the International Criminal Tribunal for Rwanda.

Those responsible were divided into three groups according to Rwandan officials:

1. Those who were at the core of the genocide, giving instructions and organizing, estimated at 100-300 people.
2. Those who were not the organizers, but had authority in the areas where they worked and lived to order mass killings; their numbers run into thousands.
3. Those who carried out the killings because they "had to do it" as they would be killed otherwise, or because they believed in the Hutu extremists and killed in their region, but have left the country, or because it is not easy to identify them as killers during the civil war and so arrest them\textsuperscript{16}.

The first group will be tried in Arusha, Tanzania. In order to accomplish this task, UNAMIR (United Nations Assistance Mission to Rwanda) has collaborated with different international organizations in order to provide the resources needed to gather the information necessary under international law, to demonstrate that a genocide took place, and so to prosecute those responsible. Upon the request of Judge Goldstone a group of forensic experts, comprising forensic anthropologists, archaeologists, and pathologists from different nations, including Costa Rica, Germany, Scotland, and the United States investigated the murders that have taken place, and offered to the tribunal an official account of them\textsuperscript{16,17,18}.

The field work started in December 1995 and ended in February 1996, at the Kibuye community. This site was chosen for several reasons. It was the area most affected by the genocide because it had the highest Tutsi population of the entire country. It is also representative of what had happened during the civil war, and was the area where the majority of the killings took place; it had not been changed by civilians as much as in other communities\textsuperscript{19}.

Several skeletal remains were recovered at Kibuye along the slopes between the Roman Catholic Church and Lake Kivu. These were certainly the ones that survived the massacre at the church, only to be caught later searching for food.
and water, or trying to escape from the area. In a particular case, the body of an adult man was found in a banana grove presenting different types of injuries in his body, including those that indicated self-defense14.

Injuries indicating self-defense, although present in some individuals (fig. 2), were not the norm, emphasizing that many took their fate as it came15.

When a mass grave by the church was opened, about 500 victims of the church massacre were found16. These bodies were nearly skeletonized, although most still had some sapponified flesh. The bodies were recovered using forensic archaeological techniques, obtaining a well detailed account of the position of the bodies; together with the detailed analysis of the forensic anthropologists and pathologists, a register was made of the clothing, personal effects, sex, age and cause of death of each victim. Most had died from blunt trauma to the head16, and it is estimated that 45% were under the age of 18 years.

In order to carry out the forensic analysis, a provisional morgue was set up next to the church. It included an inflatable structure with all the necessary implements. An x-ray developing machine was installed next to the morgue. Alongside the church, tables with the skeletal remains were set out for analysis. The x-rays were taken inside the church and the bodies were stored there after autopsy. In February 1996 when the analysis was concluded, the bodies were buried next to the church1.

The bodies recovered at Kibuye were of both sexes and of all ages; the majority died from trauma to the head. These findings, based on scientific analysis of soft tissue and skeletal remains, demonstrated that genocide did take place, and not, as some tried to claim that the deaths were due to cholera17.

The clothing and personal effects found with each cadaver were systematically recorded, given the same number as the body, photographed, and recorded; after cleaning, they were photographed again. When dry, these effects were taken to a storage room and kept in paper sacks18. The purpose of this process was to give the survivors an opportunity to identify particular items that would help to identify the dead.

The clothing and personal belongings were displayed outside the church in February 1996 (fig. 3). Some bodies were identified because some items were unique, e.g. a priest’s vestment19.

Not knowing when they would come back, these victims wore as much clothing as possible when they fled their homes. The women were found as a general rule wearing panties, a slip, one or two skirts, two or three blouses or a combination of blouse and T-shirt, and a sweater. The men wore shorts, one or two pairs of pants, two or three shirts or a combination with T-shirts, and a jacket or sweater20.

The personal effects included bracelets, religious paraphernalia, such as rosaries, and money21.

After the forensic analysis, it is estimated that 45% of the victims were under the age of 18 years, mostly girls22.

After the genocide

Two years after the genocide, Rwanda is slowly recovering from the civil war; and in the process of re-establishing the
psychological health of the survivors, the national economy, and the sociopolitical balance.

The economic situation is serious. Rwanda needs all the support it can get from the international community; it is still a poor nation without an infrastructure to enable it to compete on the world market. It is recovering slowly, the fields are being put to work again, and the crops are being used to feed the population. But since it is one of the African nations with the most rapid increase in population there is not enough land to produce what is really needed for the country. In Kigali urban agriculture is easy to see; in some sectors of the capital, people have to walk in the streets because the pavements are used for planting. The nation continues to produce coffee and tea for export, but it is not enough to get back on track, or even to come up to the level of the 1980's.

The slowness of the recovery, which will last for years, is due to several reasons. An important one is that the bank reserves were stolen by the people in power at the time of the genocide. The banks in Kigali are closed, and when a foreigner has to change money, this is done on the black market or at one of the few remaining hotels.

The World Bank will not give any aid until the debt left by the Habyarimana regime is paid, but, due to the circumstances given above, this will be extremely hard to accomplish for the new Tutsi government.

On the personal level, the Rwandans are continuing to bury their dead; two years after the genocide human bodies are still being found in fields and near churches. Those who were buried in mass graves will probably remain there.

From a judicial point of view, the jails are now extremely overcrowded. It has been calculated that there are some 100,000 inmates, including children, living in some of the worst conditions the world has ever seen. Diseases such as dysentery and conditions such as dehydration are common in those places, killing about four or five inmates daily; due to absence of hygienic conditions, some inmates begin to lose their dignity. There is no room to sleep normally; many try to sleep sitting up. During the day they crowd around, with little room to move. To ease the situation it has been suggested that the prisoners who were underage at the time of the genocide, or who are still underage, should be freed and not tried.

The process of a trial through the Tribunal is slow, and the survivors want to see justice done now. There is therefore some frustration within the population.

Conclusion

The Rwandan government was against the United Nations staying beyond March 1996, but in a resolution signed at the beginning of that month, it was decided to grant the UN permission to stay; since then, the situation has changed due to new political policies in the country.

The Rwandan government has trialled as many as 29 individuals up to May 1997, but Human Rights Watch organizations have indicated that the trials have not been done in a fair way, as many have been sentenced to death.

In the meantime, the International Tribunal for Rwanda continues its work in Arusha, Tanzania, with the aim of bringing those responsible to trial.

Due to political events in Zaire, the Hutu population that fled Rwanda after the genocide is being forced to return to Rwanda. As a result, ethnic violence has once again flared up between the Hutu and the Tutsi, creating a volatile situation where many have lost their lives, including representatives of human rights organizations who are caught between the fighting parties.

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Torture in the Basque Country (Spain)

Deficiencies in the medical forensic examination of incommunicado detainees

Recommendations – an analysis of CPT’s reports

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The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) recently published reports on their visits to Spain in 1991 and 1994. The Spanish Government had not agreed to their publication before. The conclusions are quite disappointing for a democratic European country. As CPT states positively, in view of the persistence of a certain number of allegations of very recent torture or severe ill-treatment, it would be premature to conclude that the phenomena of torture and severe ill-treatment have been eradicated. These allegations were made in particular (but not exclusively) by persons being held with respect to their relationship with the Basque armed group ETA. The CPT also censured the existence of a special law to judge those offences, and made some recommendations and comments in this area, e.g. reduction of the period during which a person can be held incommunicado, improvement in access to legal assistance, etc. Having observed important failures in the forensic examinations of people detained under the Anti-terrorist Law, CPT’s reports point out important recommendations for the medical profession in order to enforce the rules for a medical examination.

Torture today in Spain

Spain still continues to appear in reports on torture, specially cases of Basque citizens detained under the Anti-terrorist Law, though the dictatorship finished almost 20 years ago. Before the CPT reports, the torture practiced by Spanish policemen and prison officials on people accused of helping or belonging to ETA had also been mentioned by the Special Rapporteur on Torture of the United Nations, Amnesty International, and so on. Torturaren Aurrakako Taldea (*a non-governmental organization of the Basque Country) and Asociación Contra la Tortura (**a Spanish non-governmental organization) received over 500 allegations of torture and ill-treatment from 1992 to 1996. So CPT’s reports confirm the statement based on the analysis of the report made by Amnesty International for the year 1990, in the sense that, in some countries such as Spain, torture is used more usually against highly selected groups of persons charged under the “anti-terrorist legislation”, and this practice continues during the last years of the 20th Century.

During CPT’s last visit to Spain, in June 1994, eight of 24 persons detained in the Basque Country by the Civil Guard (six in prison and the other two released) were interviewed. All eight alleged having been beaten with the flat of the hand, particularly on the head, but also on other parts of the body such as the testicles, back, abdomen, and arms. Seven alleged suffocation with a plastic bag over the head. Four alleged malpractice from electric shocks delivered through their clothes with different devices. Several alleged being forced to stand for prolonged periods, and two were forced to make exhausting physical exercises. Most said that they had been submitted to verbal abuse and threats.

The methods alleged in June 1994 were quite similar to those reported in two recently published articles based on the analysis of torture that occurred in the Basque Country between 1992-1993. One article, after the analysis of 87 allegations of torture, states the high frequency of physical methods of torture such as beating (100%), suffocation caused by a plastic bag (84%), overtaxing (76%), and electrical torture (40%) in people detained by the Civil Guard (N=64), comparing them with people detained by the Policía Nacional (N=23). The frequency of threats was 98%, and humiliations 71%. The second article describes the high prevalence of sexual torture, particularly of women.

With respect to the medical information and findings, some of the persons detained in June 1994 displayed haematomas/ ecchymoses compatible with their allegations of having been beaten. By contrast, the forensic doctor attached to the Central Examining Court had reported having observed marks of apparently recent origin in some cases, but thought that they could well have been caused by events other than ill-treatment. In other cases, CPT’s experts found a mark on the temple fully compatible with the allegation of having received electric shocks there. In another case, the extensive bruising observed and the very high CKP level recorded were, in the Committee’s opinion, prima facie evidence of ill-treatment. It is remarkable that in four cases the forensic doctor did not notice or write down in her report some marks and injuries that were afterwards found by other medical doctors in hospitals or prisons.

Special attention can be drawn to the truthfulness of the allegations. The Spanish Government often affirms that all allegations of torture and ill-treatment made by Basque detainees are false, due to a policy of lies arranged by the...
Basque armed group ETA. By contrast, the CPT stated that the allegations were not stereotyped, but were detailed and largely concordant, while displaying variations that were credible in view of the personal circumstances. CPT recommended avoidance of the temptation to consider all such allegations as necessarily part of a strategy to undermine the reputation of the law enforcement agencies. The two reported articles and CPT’s report confirm the truthfulness of the allegations of torture made by people detained under the Anti-terrorist Law in the Basque Country.

Some aspects of the forensic activity.
CPT recommendations
The medical examination of detainees in a risk situation (incommunicado) has been considered a useful instrument for the prevention and detection of torture. Detainees in Spain under the Anti-terrorist Law are medically examined by a forensic doctor, usually attached to the Central Examining Court. Such examinations should adhere to some rules in order to be considered effective. But it seems that the forensic activity in the cases of incommunicado arrests is quite deficient. On the other hand, it is necessary to keep in mind that some methods of torture do not leave any visible marks, and it can be very difficult to obtain medical evidence of their use.

Due to the important deficiencies observed in the forensic examination of people detained under the Anti-terrorist Law, CPT made some recommendations concerning the role played by Spanish forensic doctors.

1. A person detained by the police or the Civil Guard who is being held incommunicado and who requests a medical examination should be examined by the relevant forensic doctor and, if he so wishes, by a doctor chosen from a list of doctors drawn up in agreement with the appropriate professional body.

Examination of the detainee is normally made only by the forensic doctor, and the Spanish Government does not foresee that the detainee should be assisted by a medical doctor of his/her own choice. Before being taken to the forensic doctor, the detainee could be advised not to say that he is suffering ill-treatment, because he will be severely tortured after the medical examination in the next interrogations. The detainee cannot be sure that the unknown person who claims to be a forensic doctor is not a policeman or a physician working for the police. So it would be good to ensure confidence between the medical examiners and the detainee by having a doctor of his/her choice present during the medical interview.

2. The forensic doctors should identify themselves correctly to the detained persons.

Although there is perhaps no exception to the practice in which forensic doctors identify themselves as such to detainees, it is difficult for the detainee to believe it. In some cases, he/she has been examined previously by a police doctor, or someone with medical knowledge during or after the interrogations. So when the real forensic doctor appears, the detainee is usually apprehensive. The detainee therefore does not usually trust the person who identifies himself as a forensic doctor, or does not believe in his activity, even when the forensic doctor displays his identity or professional card.

3. All medical examinations of detainees should be conducted out of hearing and preferably out of sight of police or Civil Guard officers.

The conditions under which the medical examination takes place make it difficult for the detainee to trust the forensic doctor. The interview is carried out after several hours of incommunicado imprisonment, sometimes one day after, inside the police station, in a room near the interrogation room. Some detainees have claimed that there was a mirror in a wall of the room where the medical examinations by the forensic doctor were carried out.

4. The facilities (both premises and equipment) offered to forensic doctors who are asked to examine persons arrested in connection with terrorist-related activities should be substantially improved. Forensic doctors should be entitled to have specialist examinations performed, and to reserve their conclusions until such time as the results of these examinations are available.

The Committee mentions that the place and the instruments used by forensic doctors, and the resources they have available, are quite insufficient and should be improved. The Spanish Government answered that they would comply, but two years have passed and no changes have been made.

Specialist examinations are not usually made. Complementary examinations such as X-rays are never made on the initiative of the forensic doctors, though in fact they can request a specialist examination and other tests they consider necessary. Blood or urine analyses for determination of CPK or myoglobin, etc. are not made by the forensic doctors. The absence of complementary examinations has meant that, in some cases, signs of injuries compatible with the allegations of torture have been detected by medical doctors in prison or hospitals, but not by the forensic doctor.

Photo-documentation is not made of visible marks, and descriptions of them are very poor.

CPT concluded that the poor facilities at the forensic doctor’s disposal might in part have led to the following: injuries not observed by her in two persons arrested between 2 and 7 June 1994; more extensive injuries than those previously recorded by her in another case; and in a fourth case, discrepancy between the extent of the injuries recorded by her and their extent subsequently observed in hospital. But we think that CPT’s statement is quite generous to the forensic doctor involved in those cases.

5. The form currently used by forensic doctors to record their findings should be replaced by a more developed document in order to ensure that the following information is systematically recorded: a) statements made by the person concerned, b) the doctor’s objective medical findings based on a thorough examination, and c) the doctor’s conclusions.

One of the deficiencies in the work of the forensic doctors of the Central Examining Court is the quality of their medical reports. After analysing some of the reports, it is concluded that the method of torture alleged by the detainees is poorly described, that the symptoms claimed by the detainees are not written down, and that the description of the injuries is sometimes deficient.

6. Given the pressures that can be brought to bear on a detained person, forensic doctors should not necessarily accept at face value statements by such persons to the effect that they are being treated well. Particular attention should be paid to a detained person’s psychological state during the period of the arrest.

At present, the forensic doctors never examine the psychological state of the detainees. The only thing they write in their medical reports is whether the condition of the de-
taine is good enough for him/her to make a declaration in front of the judge.

In conclusion, the medical activity of the forensic doctors in Spain when people are detained under the Anti-terrorist Law presents a lot of deficiencies, from the examination to the reports. This makes the forensic examination in the Central Examining Court practically useless in the fight against torture. The CPT’s recommendations should immediately be put into practice in order to guarantee adequate forensic activity. Moreover, in the interests of preventing torture, it would be better for the Spanish Government to comply with the recommendation of the United Nations Human Rights Committee in the sense that incommunicado detention should be abolished.

References

A good example of documentation and treatment service for survivors of torture

The Human Rights Clinic in the Bronx

Douglas Shenson, MD, MPH* & Gabrielle Silver, BA**

A small number of specialized clinical services have been established in the United States as referral centres for the treatment of torture survivors. These initiatives are generally located in cities where there are large numbers of recent immigrants. In the spring of 1993, the Human Rights Clinic was established at a public hospital in the borough of the Bronx, New York City. Unlike initiatives dedicated solely to providing clinical services, the Clinic has considered the treatment and documentation needs of patients to be of equal importance. Efforts to assess the veracity of an individual’s claims are essential to assuring the person’s safe haven in the United States, and are therefore an integral part of the Clinic’s mission. The name “Human Rights Clinic” was selected to emphasize the affirming and humanitarian nature of medicine’s response to survivors of torture. The name is also appropriate because the Clinic is receptive to documenting and treating the health consequences of other kinds of fundamental violations, such as “bias” crimes and child, spouse and elder abuse.

The Human Rights Clinic is administered by a director and staffed by participating house officers. It is integrated into a primary care internal medicine residency programme. The Clinic is co-sponsored by three organizations: the humanitarian group, Doctors of the World, USA (a group associated with the French association Médecins du Monde), Montefiore Medical Center, and North Central Bronx Hospital. Each sponsor contributes an essential component to the Clinic by providing, respectively, a source of referrals through the human rights advocacy network, a cadre of primary care physicians-in-training that function as Clinic staff, and a medical care system designed to accommodate


Ministerio de Justicia e Interior (Gobierno de España). Responses of the Spanish Government to the reports of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on its visits to Spain from 10 to 22 April 1994 and 10 to 14 June 1994. CPT/Inf (96) 10. Strasbourg: Council of Europe, 1996.

individuals of limited financial means. The programme, which has been able to function without any start-up funding, is the first of its kind in New York City.

Patients and Methods
Referrals to the Human Rights Clinic are accepted from organizations serving the legal and social service needs of torture survivors. These include The American Civil Liberties Union, Amnesty International, Physicians for Human Rights, The Lawyers Committee for Human Rights, Church World Services, and Catholic Charities, and several private law firms providing legal services on either a fee or a pro bono basis. An appointment is made through the Clinic Director's office after the patient's medical and documentation needs have been discussed with the referring party. For individuals who are being held under local detention by the U.S. Immigration and Naturalization Service (INS), a Clinic physician can visit the patient for an interview and physical examination at the place of incarceration. Eleven of the Clinic's patients have been seen while under INS detention.

An initial interview with the patient focuses on current health status and documentation needs. The provider reviews the trauma experience, and a directed physical examination is performed. The extent of any medical problems or injuries and the need for ongoing treatment or counseling are assessed. Standard interview forms are not used in the interest of encouraging residents to develop their own interview styles, and because such psychometric instruments have been found to be of limited value in torture survivors. The physical examination is reviewed with an emphasis on analysing its details in relation to the history of torture. The resident provides continuity of care by incorporating the patient into his or her own patient panel.

Patients have access to the full range of hospital-based subspecialty services. Bilingual English-French and English-Spanish interpretation are available on-site. As in most American hospitals, patient care is not free. Charges are handled as they would be for other patients, with the possibility of a sliding payment scale and an evaluation for Medicaid enrolment.

Results
There are 33 countries represented among the Human Rights Clinic's first 89 patients (table 1). Many of these individuals come from areas where abuses are routine. Some have migrated alone and do not speak English. Almost all such refugees are without financial resources and have difficulty navigating the city's public health and social services. The breadth of the patients' backgrounds reiterates the fact that torture is geographically widespread. The types of trauma described by patients at the Human Rights Clinic are consistent with the kinds of torture and abuse documented elsewhere in surveys in the human rights literature (table 2). Political repression around the world influences the flow of U.S. immigration patterns, but no information is routinely collected on the number of persons seeking political asylum (or permanent residence) whose application includes a history of torture. The extent of torture-related trauma in the United States is difficult to estimate, but the size of this population is likely to be significant. One advocacy group calculates the number to be approximately 200,000 persons nationwide.

Of the 89 patients seen at the Human Rights Clinic, 38 have had their cases adjudicated. Although it is not possible, in the absence of a control group for comparison, to know whether patients for whom affidavits have been submitted fare better than those who lack medical documentation, the fact that 90% of Human Rights Clinic patients with adjudicated cases have been granted asylum suggests that such reports are helpful. The annual INS approval rate for adjudicated cases as of July 1995 was 19%.

Discussion
The Human Rights Clinic takes as a starting point the problem each patient identifies as his or her most pressing concern: possible forced repatriation. Deportation to the country of persecution can place the patient in grave danger, and drafting an affidavit therefore represents an exercise in the secondary prevention of torture. Medical affidavits are intended to evaluate the relation between the patient's trauma experience and associated signs and symptoms. To be complete, these reports include a biographical statement establishing the physician's competence; a review of the patient's narrative of persecution, including methods of torture; a description of any injuries, reactions, and symptoms immediately after torture; a review of symptoms at the time of the examination; and a physical examination and detailed mental health assessment. Most importantly, the report includes an exposition of how and in what way these ele-

Table 1. Patient Profile, Human Rights Clinic, May, 1997.

<table>
<thead>
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<th>Country of origin</th>
<th>Number of patients</th>
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</tr>
<tr>
<td>Haiti</td>
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</tr>
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<td>Guinea</td>
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</tr>
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ments form a mutually supporting whole. An analysis can add important credibility to the asylum application.

To qualify as an expert witness in an immigration proceeding, it is not necessary for a physician in the United States to have previously treated or examined torture survivors. None of the Human Rights Clinic residents who have submitted affidavits to immigration court have been turned away as unqualified experts. Experience in related fields, such as training in the recognition of sexual abuse, rape counselling, or work in the trauma room of an emergency department, adds to interviewers’ qualifications. Even providing a single previous medical assessment of a torture survivor gives the physician more clinical experience in this area than most other practitioners.

An unusual aspect of the HRC is its emphasis on physician training. A didactic curriculum that includes lecturing and precepting sessions has been incorporated into Clinic activities. Before seeing patients in the HRC, primary care residents receive an introductory lecture on medical and psychological aspects of the treatment of torture survivors, including case examples. Residents are introduced to particular problems facing the clinician in taking a history of persecution. During the course of the year, scheduled didactic time at each HRC session covers topics on human rights and medicine, including burn and wound recognition, the differential diagnosis of closed head injuries, musculo-skeletal examination of torture survivors, cultural identity and treatment in post-traumatic stress, sexual trauma, and medicolegal-care for immigrants. They are also instructed in the forensic approach to the patient and the recognition of inconsistencies between the history and physical examination. Residents are encouraged to discuss their own feelings in treating torture survivors and to articulate any difficulties they may have in exploring with their patients what are frequently deeply disturbing experiences.

Many American medical schools and schools of public health have brought the study of human rights issues into their curricula. Despite expanding opportunities, however, the overall level of institutionalized commitment to human rights issues in the medical curriculum is low. Although courses are sometimes available as independent study electives, medical schools do not consistently teach students about the role they can play in responding to human rights abuses. The Human Rights Clinic offers the first standing programme in a primary care internal medicine residency in which all residents are trained to document torture and are able to include survivors in their patient panels. Without such preparation many health professionals will find themselves in contact with torture survivors without having developed the necessary skills to address their needs. Moreover, the US government tacitly recognizes the importance of this challenge, because it has pledged to train physicians (and other health professionals) to recognize the sequelae of torture by ratifying in 1987 The United Nations Convention Against Torture.

**Conclusion**

The medical consequences of human rights abuses are an unrecognized dimension of America’s urban health care needs. In the first two years of the Human Rights Clinic’s work, primary care physicians have concentrated on providing documentation assistance as well as delivering clinical services. This approach reflects the conviction that such activities serve legitimate health prevention and treatment needs, and can be effectively carried out by medical generalists. The incorporation of a clinical service for torture survivors into a primary care internal medicine residency programme represents, in our view, a constructive contribution to an evolving clinical field. It is our hope that the Human Rights Clinic will function as a useful model for health professionals in large American urban areas.

**References**

4. Fact Sheet: The Center for the Victims of Torture, Minneapolis Minnesota.

\(^a\) The term “patient” is used in the text as a matter of convention. This phrasing implies no disregard of the issues raised by the “medicalization” of the consequences of torture.

Table 2. Types of physical torture reported, May 1997. (Total number of patients = 89).

<table>
<thead>
<tr>
<th>Type of maltreatment</th>
<th>Number of patients reporting this type of maltreatment</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beatings (fists and blunt instruments)</td>
<td>82</td>
<td>70 M, 12 F</td>
</tr>
<tr>
<td>Cuts from sharp instruments</td>
<td>27</td>
<td>24 M, 3 F</td>
</tr>
<tr>
<td>Heat and chemical burns</td>
<td>23</td>
<td>18 M, 5 F</td>
</tr>
<tr>
<td>Sexual assault and rape</td>
<td>15</td>
<td>4 M, 1 F</td>
</tr>
<tr>
<td>Limbs pulled/stretch/suspensions</td>
<td>10</td>
<td>10 M, 0 F</td>
</tr>
<tr>
<td>Electric shocks</td>
<td>8</td>
<td>8 M, 0 F</td>
</tr>
<tr>
<td>Crushing muscle injuries</td>
<td>6</td>
<td>6 M, 0 F</td>
</tr>
<tr>
<td>Whipping</td>
<td>6</td>
<td>5 M, 1 F</td>
</tr>
<tr>
<td>Noxious chemical exposure</td>
<td>2</td>
<td>2 M, 0 F</td>
</tr>
<tr>
<td>Genital mutilation</td>
<td>2</td>
<td>2 M, 0 F</td>
</tr>
<tr>
<td>Beatings of the soles of the feet (falangas)</td>
<td>1</td>
<td>1 M, 0 F</td>
</tr>
</tbody>
</table>
Torture in the 21st century

The need to move from the focus on programmes and services to strategic prevention issues and policy development

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The recent editorial by the editor of this journal on the need for a new structure for RCT and IRCT is timely. Most organizations and entities move from “second generation” relevance. Organizations in the “first generation” mode focus on documenting issues of interest, assisting victims and their families, and exposing unjust practices. If an organization meets or satisfies the objectives of the “first generation”, then such an organization must move to the “second generation” level of presenting issues of interest, framing the policy, research and programme questions, and developing consensus agendas on ending unjust practices. Many organizations have faltered because they failed to make this transition when their primary mission is completed or satisfied, or needs to link to overarching issues. As brilliantly stated in the editorial, the end of the cold war and the emergence of global trade are changing the entire world landscape. Health, human rights, and social justice around the world may never be the same. With the end of the cold war, states that used threats of “communism,” “socialism,” and “defence of capitalism” to justify state-sponsored terrorism are now in retreat. Many henchmen of totalitarian regimes are now self-styled “Western style” reformers and “Democrats” and are now enjoying unprecedented leadership and economic positions, especially in Eastern Europe. The scramble for economic prosperity and the need for Western countries to promote trading relations with most countries of the world suggest that the issue of state-sponsored torture may also be undergoing major transformations. The Truth Commission of South Africa, where one can “kiss and tell” but suffer no consequences, is remarkable for its novelty, but it is also a pointer to future directions. The inability to bring major war criminals in the Bosnian conflict to justice “in the interests of peace and stability” is another illustration of global transformation that is focusing on stability and prosperity. That alleged state-sponsored high-handedness in China, Indonesia, and Singapore is only attracting feeble responses from Western capitals is also instructive.

Even more remarkable is the conscious recognition that resolutions of conflicts demand a spirit of "compromise" regarding atrocities of the past. This is often a code word to go easy on human rights abuses, murder, mayhem, and disruption of lives and properties. It is no coincidence that the Israel/Palestinian Oslo Peace Accord did not directly address the torture problems of the past. The peace talks between North Korea and South Korea, and the ongoing collaboration and cooperation between Bosnia, Croatia, and Serbia, play down egregious human rights abuses in the interests of "peace and stability". The operative phrase is "forgive and forget". However, for the families of human rights and torture victims, it is too late for their loved ones who perished protecting their "freedom". Thus in the emerging new "World Order", concerns for necessary conditions that promote trade will outweigh considerations for vituperative ideological or nationalistic conflicts, two potent grounds for human rights abuses and state-sponsored terrorism. It is likely that countries that facilitate "free trade" and "market economy" will get a slap on the wrist if they torture their citizens or endanger their human rights. Torture as a subject of individual, state, national, and regional proportions will become "manageable" and of "low intensity" if the engine rooms of economic productivity are kept open and free trading opportunities increase job creation in industrialized countries.

Thus, in a cynical way, population-based democracy in industrialized countries may unwittingly promote anti-democratic and torture-prone practices in the developing countries: politicians in industrialized countries need to create jobs and promote economic prosperity in their countries to...
get elected or reelected, and by vigorously promoting foreign trade and overlooking human rights abuses and torture practices of trading partners, they will probably encourage antidemocratic practices in their trading partners. The major challenge for human rights and anti-torture organizations is to develop strategies and policies that prevent torture. Calling attention to existing or past torture practices is still very important, but will not enjoy the significance it had during the cold war years. States that are good trading partners or have strategic importance for industrialized nations will simply not have the necessary pressure to change their torture practices or policies. According to the editorial in the journal Torture, advocating for the prevention of torture "in more general terms" will become a major function for the restructured RCT and IRCT. I believe that prevention of torture is a fundamental strategic, policy, and programme issue for anti-torture advocates for the 21st century.

The recent Amnesty worldwide plan of action against torture highlighted the need for legal reforms, inspection visits, and end to impunity for perpetrators of torture. Perhaps, more important, the plan of action focuses on the role of non-government organizations (NGOs) in preventing the occurrence of torture or acts of impunity by the perpetrators of torture. The plan of action, with the recognition of the invaluable role of NGOs in providing health and other human services in developing countries, calls on NGOs to prevent the transfer of torture technology, to oppose all forms of sexual abuse by state agents, and to ensure that torture perpetrators are caught and punished. According to the plan of action, NGOs should also pressurize governments to pass anti-torture laws and assure their implementation. Another important provision of the action plan is the call for the establishment of an International Court by 1998. The plan of action is both innovative and extensive, especially the tacit recognition of the central role of prevention programmes. However, the plan fails to address direct and indirect issues that can lead to torture or facilitate the practice of torture.

What is torture?
Any serious discussion of the direct and indirect causes of torture must include an understanding of what torture is. Defining the concept of torture is problematic, as shown in an editorial of this journal. According to the editorial, which quotes the two major definitions of torture (the Tokyo Declaration of 1975 and the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984), torture covers a wide field of human endeavour and is not limited to physical or brutal acts. Torture includes the use of threats, deceit, and temptations to obtain information or confessions. It also transcends political "offences" and political prisoners/detainees. No institution, civil or non civil, is immune from torture practices.

The definition of torture used in the Tokyo Declaration focuses on state-sponsored "deliberate, systematic, or wanton infliction of physical or mental suffering ...", while the UN 1984 Convention focuses on "... severe pain or suffering, whether physical or mental, ... intentionally inflicted on a person ...". The 1984 UN Convention applies only to governments while the Tokyo Declaration can conceivably apply to individuals and non-government entities. The basic problem with these definitions is that they focus on physical aspects of torture, which is often the last line of action in the torture process. Nearly all societies that have experienced state-sponsored terrorism and torture endured initial economic, social, demographic, and environmental abuses before the onset of physical actions. Denial of legitimate rights regarding economic pursuits, free enterprise system, and press freedom and social injustice and environmental degradation could have major mental consequences for the victims, and can constitute severe mental suffering. Deliberate and intentional state or individual policies that harm the socioeconomic status (SES) of communities and individuals can lead to severe mental suffering. State-sponsored terror and torture apparatus usually emerge when individuals or communities protest against harsh living conditions. It seems logical that any theoretical or practical definition of torture must consider equally the mental and physical aspects of torture. More important, the importance of potential torture policies that lead to physical practices of torture deserve critical attention.

A key strategic objective for the 21st century anti-torture movement is to delineate non-physical acts of torture that can lead to the final acts of torture, the cause of bodily harm. Since torture from personal, community, and national perspectives is highly traumatic, with major biological, psychological, economic, demographic, and social implications, it is necessary to focus on why disadvantaged individuals with social, economic, demographic, biological, and psychological problems often end as victims of individual and state-sponsored terror and torture (SSTT) activities. What can "second generation" organizations such as RCT, IRCT, Amnesty International, do to eliminate or reduce conditions that lead to SSTT? How can the emerging global community, with a focus on trade issues, recognize the importance of eliminating SSTT practices around the world?

Conceptual strategic framework for 21st century anti-torture activities
Welsh and Rayner, writing on the evils of torture in non-political cases, made the case that certain "standard" police shakedowns and interrogation techniques for apolitical, criminal elements may constitute torture or gross ill-treatment. They also made the important contribution of reviewing what encourages torture and the purposes of torture practices. The need for political and social control can lead to a "culture" of torture. Welsh and Rayner, with their focus on law enforcement issues, moved the torture question to a new level: how to protect individuals and the society from excesses of legal law enforcement. This is very important in developed countries with population-based democracies and citizen-based law enforcement statutes. In developing countries, with little or no population-based democracy, it is probably futile to analyse torture practices from a law enforcement angle, since most law enforcement institutions are also used as instruments of SSTT.

Thus, the fundamental questions are still: what is torture, what causes (not encourages) torture, and what can be done to prevent its occurrence (the three Ws of torture)? I believe that we can divide torture into two fundamental issues: the causes of torture (mostly non-physical and mental) and the act of torture (mostly physical). I believe that anti-torture activities for the 21st century will focus on the causes of torture and how to prevent them, since most global trade-conscious nations may not be interested in applying sanctions against acts of torture. An important conceptual and strategic question is what makes a human being become
PERSONAL COMMUNICATION

cruel and inhuman, and leads him or her to practice degrading acts or punishment against another human being. Documenting what triggers change in the knowledge, attitudes, and perceptions (KAP) of an individual or community against another individual or community is critical. What causes a national government, acting "in the best interests" of its citizens, to turn around and subject them to harsh and inhumane practices in the name of "national security"? Why do "civilized societies" and the industrial nations continue the failed policy of "pragmatic relations" with morally corrupt governments in many developing countries? Why should a foreign country attempt to "select" the leaders of civil authorities and military authorities in another country? These are questions that may provide answers to the future directions of anti-torture practices. Torture practices do not occur in isolation or without a long history of social, economic, demographic, or environment problems.

For the Conceptual Strategic Framework, seven important issues merit the attention of anti-torture advocates and constituencies:

1. Develop strategies that emphasize primary prevention of torture.
2. Expand torture issues to include an appropriate focus on mental aspects of torture.
3. Promote the notion of tolerance.
4. Continue the present focus on physical aspects of torture.
5. Use the advantages of free trade and decentralized government to promote anti-torture activities.
6. Use the NGOs as a major promoter of anti-torture activities.
7. Promote population-based democracies around the world.

Strategy one: primary prevention of torture

Madariaga recently wrote a brilliant piece in this journal on the need to see torture as a public health problem. Torture as the most common and frequent violation of human rights in Latin America led to the emergence of liberation theologies that pitted the Catholic Church against the poor and dispossessed that the Church had sworn to protect. The devastating biological, psychosocial, and economic consequences associated with torture are not in doubt. However, I am looking at primary prevention of torture from a broader perspective of the wellbeing of the society. By primary prevention, I simply mean preventing all potential causes of torture before the act of torture is committed.

Important primary prevention issues include: assuring economic security; improving social conditions; access to education opportunities; independent judiciary; environmental justice; and treating torture as a public health problem.

Assuring economic security

We must recognize the primacy of economic inequalities as a fertile ground for SSTT activities. Economic inequalities at local, state, and national levels can lead to long-term struggles that can translate to "states of emergency" and SSTT. Corruption is endemic in countries and situations where resources are scarce and need is plentiful. Corrupt institutions and individuals often resort to torture and violence to maintain control as the needs of the population increase and scarcity of resources continues. The recent fallout from the failed pyramidal schemes in Albania is a typical example of how angry, economically deprived citizens can mobilize and fight back against oppressive state policies. Without major economic and state reforms in Albania, the stage is now set for savage reprisals against the "perpetrators" of the massive uprising. Predictably, anti-torture advocates may soon become active, documenting abuses and pushing for release of prisoners and detainees in Albania. However, the fundamental question is whether the intolerable harsh economic climates of many developing countries could improve with the adoption of just economic conditions that promote free enterprise, create jobs with fair wages and good working conditions, and improve the standard of living of their citizens. Poor people can recognize the differences between their standard of living and the "economic sacrifices" of affluence that their leaders and business leaders make. Conglomerates and single monopolies that maximize profit at the expense of poorly-paid workers, and maintain working anti-labour conditions, will also incur the wrath of the populace. These private sector giants may, unwittingly or unwillingly, become drawn into the "law and order" policies of their host nations.

On the other hand, assuring economic security will allow private small-scale businesses to flourish and create jobs. A policy that avoids shakedowns of private businesses and excessive taxation of the populace will probably encourage economic activities and minimize the need to use SSTT to control populations. National governments of developing countries, just like all industrialized countries, should take steps to protect their natural resources, regulate the "free market," protect their environment, safeguard their national security, and protect the rights of their workforce even when opening their market to foreign investment.

Thus, for anti-torture advocates, economic security should occur at four distinct levels:

a. INDIVIDUAL — passing laws and regulations that promote the rights of individuals to engage in legitimate free enterprise, own properties, and avoid draconian government bureaucratic regulations and taxation. This guarantee should transcend cultural, ethnic, social, and economic differences.

b. COMMUNITY — no communities because of their ethnic origins, economic, social, and political beliefs should suffer from individual or state-sponsored isolation or terrorism, or be prevented from participating in free enterprise.

c. GOVERNMENT — the government must provide basic safeguards for the economic empowerment of its citizens who can work or are willing to work. No government can guarantee full employment in the public and private sectors. However, as currently practised in developed countries, government policies to protect the weak, the sick, and the disabled should be in place.

d. CORPORATE — National governments should recognize indigenous corporate sectors as legitimate partners at local, state, and national levels. In developed countries, the private and public sectors maintain an uneasy, but working relationship that provides checks and balances; this should happen in developed countries. The key is that national governments must allow the indigenous corporate sector to develop and form partnerships with foreign corporate entities to promote free enterprise. The ultimate objective of this partnership is respect for the strategic interests of host nations.
Improving social conditions
No jurisdiction can function properly with most of its populations lacking necessities of life such as water supply, good sanitation, roads and means of transportation, electricity, public safety from crimes and violence, and access to modern means of communication such as radios and televisions. In many closed societies that practice egregious human rights abuses and SSTT, the first instrument of control is isolation from the outside world and the use of state megaphones to promote anti-foreign government messages. Torture practices flourish when we compromise the social conditions of communities and we curb or take individual rights away. Promoting the improvement of social conditions should be a major primary prevention issue.

Access to education opportunities
Literate and sophisticated societies cannot tolerate SSTT activities. Teaching populations around the world the ability to read and write, and to have access to reading materials, may represent one of the most potent anti-torture strategies. Literacy is associated with reduction in infectious disease conditions, infant mortality, and maternal mortality, and with improvements in life expectancies. No government, no matter what its military intelligence and military hardware, can subdue a population that is sufficiently literate to understand options available to them to seek redress and obtain justice, according to existing laws. More important, education of women is one of the most important investments a nation can make for its future generations. With lower rates of infant and maternal mortality associated with literate women, children, the future leaders of the society, have a chance to reach their full potentials. Education of women will also lead to reduction of what I think is one of the most pervasive forms of torture: spousal abuse and torture because of limited economic opportunities for women in many countries, today.

Independent judiciary
A free and independent judiciary is a major bulwark against SSTT. It is an essential condition for preventing torture practices. Even in the developed countries with population-based democracies, the judiciary plays an indispensable role in protecting the rights of individuals and the society from the inherent tyrannical tendencies of government operatives who wield extensive powers of national security. The wanton corruption and compromise of the judiciary in many developing countries are traceable to their total dependence on the executive (or is it the military?) branch of government for their appointments, salaries, emoluments, and retirement benefits. No judge or judicial officer with families to protect, and children to take care of, will risk his or her life or promising “careers” to protect the lives or liberties of anonymous torture victims and their families. Instead of focusing on establishing international courts of justice, anti-torture advocates should continue their push for independent judiciaries at local, state, and national levels in all countries of the world. Independent judiciaries are the bedrock of any democratic society that eschews SSTT activities.

Environmental justice
Pollution of forests and farmlands will lead to health hazards that will force more people to move to the cities and swell the shantytown ranks of malcontents and unemployed. As the population of shantytowns grows, crime and juvenile delinquency will rise. State authorities, overwhelmed with crimes and public insecurity, may respond with draconian law and order practices that may condone torture practices. Brazil is a typical example of reported extrajudicial torture and murder of street children. As the traditional farming systems of many countries disappear, the incidence of shantytowns and associated problems will rise.

Thus, the issue of environmental justice goes beyond the traditional concerns of the “Green” movement regarding pollution of the environment. It involves rippling socioeconomic effects and law and enforcement responses. Segregation of communities by poverty and other SES conditions are fertile ground for rebellions and draconian responses from government agencies. Children who grow up in environments where the men do not work or cannot work are unlikely to imbibe strong work ethics necessary for survival today. The easiest way to make a living without strong work ethics is to embark on short-lived careers in crime and other anti-social behaviour. Increase in crime usually leads to increase in state-sponsored security apparatus and emergency powers that are not subject to normal judicial processes.

Strategy two: focus on mental aspects of torture
The various definitions of torture include mental aspects of cruel and inhuman treatment. However, physical aspects of torture continue to hold the centre stage. This may unwittingly allow major perpetrators of cruel and inhuman mental torture to escape scrutiny and punishment. Defining what is mental torture is important. Expanding mental torture to include spousal abuse, work place problems, and economic and political abuses that have mental consequences are useful concepts that deserve consideration.

An appropriate focus on mental torture will broaden the scope of non-physical policies and practices that constitute torture and thus attract the appropriate attention of anti-torture advocates and constituencies. Use of underage factory workers working under harsh conditions can conceivably constitute mental torture and will affect many conglomerates from industrialized countries and the host countries that allow them to operate. Expansion of the mental aspects of
torture may also have the same salutary effect that expansive definitions of sexual harassment and civil rights violations have had on the workforce of the United States.

Strategy three: promote the notion of tolerance
The United Nations General Assembly in 1993, acting on the advice of UNESCO, declared 1995 as the year of Tolerance. Tolerance is simply respecting other people's rights, freedoms, and differences. The increase in ethnic and nationalist conflicts such as the Bosnian and Rwandan genocides call for an appropriate focus on tolerance. The accelerating discriminations against minority groups, acts of xenophobia around the world, increasing incidence of religious and cultural intolerance, all with potential torture implications, show the need for a more tolerant world. Systematic and random acts of violence, rigid political ideologies, banishing of individuals and organizations with opposing views and ideologies represent important challenges for people around the world.

The UN General Assembly described intolerance as having ethical and political implications that, if it becomes collective, can quickly erode democratic principles, institutionalize fascist tendencies, and quickly threaten world peace and stability. Anti-torture advocates should focus on the promotion of tolerance among critical agencies such as security forces, policy makers, political ideologues, and party propaganda machinery, and foot soldiers of various "revolutions" springing up in many parts of the world. Students from the elementary schools through universities, as future leaders, represent a major target group for tolerance programmes and training. According to the famous UNESCO preamble that states that "since wars begin in the mind of men, it is in the minds of men that the defence of men must be constructed," anti-torture advocates must promote tolerance of opposing views and different persons as a powerful primary prevention tool against torture. Every individual in any society must consistently ask themselves whether they are tolerant of their neighbour, community members, political opponents, other ethnic groups, other social classes, and others that look and act differently.

Strategy four: continue the present focus on physical aspects of torture
Torture practices will not be eliminated soon. As long as rogue elements get away with atrocities, the practice of SSTT will continue. The need to continue identification of torture practices and victims is still relevant. Developing rehabilitation programmes and services for torture victims and their families is also important. Showcasing the ugly effects of physical torture will continue to represent a powerful visual image for moving the society to act. The work of organizations such as RCT, IRCT, and Amnesty International is critical and will remain relevant.

Strategy five: use free trade to promote anti-torture activities
Current trends in global trade and market economy suggest that free trading arrangement will become increasingly important, and may render obsolete geographical boundaries of nation states. For instance, the next scramble for Africa may focus on carving out trading spheres of influence rather than areas of political and cultural influence. Since the private sector depends on law and order to move their products and make profits, developing linkages between emerging worldwide trading relationships and prevention of torture activities will be useful. A basic strategic framework for linking trade and anti-torture activities could be the fact that SSTT thrives under anarchy and uncertainty, two major adversaries for the private sector, which thrives on long-term planning and stability. The private sector, including bilateral institutions and the anti-torture movement may have major areas of agreement regarding the promotion of democracy and elimination of practices that promote SSTT.

Anti-torture advocates should work with the private sector, bilateral institutions, and supporters of free trade by:

a. Using languages that explicitly forbid the use of torture in bilateral agreements with institutions such as the World Bank, International Monetary Fund, and other bilateral institutions.

b. Getting conglomerates to obtain verifiable assurances that torture practices, in any form, are prohibited in host countries of operations.

c. Receiving assurances from host countries on zero torture practices and policies in country-to-country bilateral treaties and relationships.

d. Signing bilateral treaties that deny political or economic asylum to torture perpetrators and their supporters in all countries of the world.

e. Signing treaties that prevent operation of bank accounts by torture perpetrators and their families.

Strategy six: use the NGOs as major promoters of anti-torture activities
The NGOs are becoming more critical in the provision of health and humanitarian services in developing countries. Religious organizations, private independent foundations, and non-profit organizations are critical NGOs that have traditional concerns for the socially disadvantaged and oppressed. Anti-torture advocates should expand the natural alliance that exists with NGOs regarding torture policies. The NGOs can insist on explicit verifiable language and policy that exclude torture in all forms in their areas of operation. If all NGOs secure this commitment from their host countries, preventing torture practices is possible. The NGOs, because they provide basic health and humanitarian services that keep many governments in power in developing countries, can exert considerable pressure on host governments to maintain their anti-torture pledges.

Strategy seven: promote population-based democracy around the world
Population-based democracy refers to the direct and indirect participation of every individual in the political process of their countries. This participation transcends cultural, ethnic, social, and economic differences. Population-based democracy assures the broad participation of individuals and communities in the decision-making process of their country. Since nobody, no matter what his good intentions, has the monopoly to representation and service for their "beloved" constituents, it is critical that anti-torture advocates should focus on the promotion of population-based democracies that regularly allow the entire population to review the performance of their leaders and return or dismiss them from office. This is a very fundamental issue that I have found that many human rights organizations and activists do not adequately pursue.

Population-based democracy is the foundation for a free
and just society. It is not the panacea for all societal problems. However, it represents a potentially powerful avenue to change policies, programmes, personalities and practices, including torture practices. Countries that practice population-based democracy also have strong judiciaries that safeguard individual freedom. Torture is rare or easily amenable to sanctions in countries that have population-based democracies and free, independent judiciaries. In the United States, they vigorously persecute injustice against Blacks and other minorities at every opportunity through criminal and civil courts. Promoting population-based democracy could represent one of the most important torture prevention strategies.

Conclusion

RCT, IRCT, and Amnesty International and other organizations have done a tremendous job in calling attention to human rights abuses and torture practices across the world. Dictatorships have fallen and torture perpetrators have either been punished or gone into hiding. They have rehabilitated many torture victims. However, torture practices continue in many countries. A major threat to the documentation and dissemination of torture practices is the emerging trend in global trade and profits. As businesses expand and the decline in public dollars continues around the world, the role of private enterprise will become more important. For in­

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Selected list of publications

received in the IRCT International Documentation Centre


Another pain ... humiliation

To recognize a pain in the back, to associate a muscular cramp or a pain in the jaw with the fact that the patient you have in front of you is a victim of repression, mistreatment, indeed even of torture, requires time, and makes it necessary for you to listen patiently, attentively, and with understanding. This patient needs something other than a simple clinical examination, which may be far from reassuring because of unbearable memories of undressing, of interrogations, or of hands terribly laid on his body, reminders of other "care" of evil memory. And "health" care in which other doctors have participated!

In order to ensure confidence, it is necessary that the one who is facing you perceives not only that you are prepared to listen to him, but also that you can understand. Understand that his pain is not only physical, but that it is sometimes this very same pain that sends him back to the moral pain that is always present. Why haven't most of the Shoah victims talked earlier? Why do some of them talk only 50 years later? Why do some martyred human beings need years to be able to talk? Maybe because, for most of them, they have simply not found anyone able to listen, to understand. Too often, during conversations, they let us know that some medical consultation was more or less limited to referring them to some traumatizing examinations (submit cheerfully to a sigmoidoscopy when a few months ago you endured a rectal injection of chilli), with prescription of a few tranquillizers and antidepressants, and the advice to "go to sleep and forget all about it".

But this "all about it" reappears in front of one's eyes as on a TV screen very often, sometimes far too often.

Not to be heard; not to be understood often leads the man facing you to adopt an attitude of rejection, to refuse to communicate. How many of those who are considered afflicted with "psycho behavioural troubles" may in fact only be victims who try to express, in their own way, an inner turmoil in reaction to the mad situation they experienced, associated with a rejection created by the other's lack of understanding?

Cultural difference or barrier
To listen and truly understand, it is necessary to accept the person seeking help with his cultural differences, his particularities. It is necessary to keep in mind that our model of society is not that of other people. To consider Africa as an undifferentiated entity and to believe that an Algerian reacts like a man living in Zaire or Angola, is as absurd as to think that an Englishman will react like a Russian, or that a Lapp has the same way of living, the same sensibility as an inhabitant of a Greek island! Africa is obviously a continent, but if an example were necessary to prove its disparity, one might ask why the Maghreb is regarded as being separate from it, and is associated with the Middle East? The answer is that Africa is one, but it is not homogeneous.

To understand this is to agree to make sure that cultural differences do not become cultural barriers.

To digest the unspeakable
In AVRE (1), my meeting with Mauritanians, and more particularly with Haal Pulaar, made me face the bestial horror of torturers from this country, made me face the inhumanity of their practices. But this was, for me, mainly the opportunity to face courage, the resistance of those who were subjected to their treatment, and who survived. But, over and above that, and perhaps principally, it was an opportunity to discover another culture. While in our European civilization, the sight of a naked body, often seen in commercial situations, becomes banal, for these Mauritanians the unspeakable was more in the humiliation of being naked or of just wearing underwear (which is about the same for them) than in the physical pain.

To describe torture is difficult, to talk about sexual torture is certainly not easy, even impossible in some cases - or at such a long distance in time - but to talk about the way they undressed you, of the humiliation of feeling a torturer pull down your underpants when you were blindfolded, to see yourself dragged along inside the prison wearing only these pants, facing the gaze of all the others. "It was as if I was being dragged along naked"; this is a nearly insurmountable barrier! Here is the "not to be talked about". How difficult it is to survive with shame, with humiliation, with the impossibility of facing one's own naked image in the bathroom mirror. How painful to have to accept one's own tears just at the memory of one's father, totally undressed, having to cross the river Senegal to be deported and to know that he had to get out of the water in the same state of nakedness. When reaching the foreign shore. To understand these martyred black men you have to understand this. You have to accept these differences, and make them understand that you have understood.

What is an act of torture?
Is there a definition of torture? In my opinion there is not. To speak about torture is, I think, impossible. Torture that we would end up considering as "standards" practised by the Mauritanian police: burning, rape, tying up penises to prevent urinating, beating, sodomising with sticks, by men, or even by trained dogs (humiliation, insult, much more degrading when the place given to dogs by Muslims is known), tobacco under the eyelids, etc. are unfortunately part of a state horror. But if you survive, you may recover from this type of pain. You keep the physical scars, sometimes sizeable, and even the pain, which comes back to your mind with your screams and your tears; you can live with all this. But to have to face culpability, shame, is something totally different.

You have to understand the culpability of these men who cannot digest the idea of having been so much martyred just because they made the mistake of having black skin - and are proud of it! But you must also realize that they have to assume the culpability of having survived, sometimes having been the only one to survive out of a group of 6 persons arrested together. The anguish of having no news from their wives and children for years, of knowing that they have left them over there, of having to face the dishonour of not being able to be a real father, a family head, a husband, of not being able to provide for the needs of all the family, the culpability of remembering their nudity in front of others; the nightmare of not having been able to wash their bodies for weeks (and so to pray), of having to wear the same underpants for
months, the shame of knowing that others have seen them in this shameful and dirty state.

As time goes on
Sometimes physical pain dies down in the memory, scars heal, close, sometimes don't even leave any mark. But the mental pain, shame, humiliation always come back, always cling to you like an endless pain. The difficulties of life in France for a foreigner, the quite often excessively long wait for the OFPRA's (2) decision, which is also a recognition of your status as a victim, the fact that your family, or what is left of it, tries to survive in one of those refugee camps, forgotten by nearly everyone, in Senegal or Mali, the fact that you have to accept jobs so different from the work that you used to do in your own country when you were a doctor, an engineer (your diploma having no equivalent in France), or even a minister – these are all hardships. Together they represent a sum of misfortunes, but can also be a reason to fight, to carry on resisting, to show to others and to yourself that you have remained human.

But when, to justify your application for political refugee status, you have to face the additional humiliation of having to pour it all out again, the humiliation of explaining to a stranger, a foreigner, your own humiliation. When this shame is added to all the rest of the shame, there is often only one solution ... to remain silent. Even if this has the consequence of ruining this administrative formality, which is nevertheless so important.

That is why, to find yourself again, to recover the taste of this new life, it is often necessary to have the support of someone who is willing to try to understand how this destructive machine called torture, through which you have gone, works. But someone who also agrees to respect your legitimate secrets.

Pierre Duterte

Notes
(1) Association pour les Victimes de la Répression en Exil - 125 rue d'Avron 75020 Paris - 01 43 07 77.
(2) French Office for the Protection of Refugees and Stateless Persons.

Pierre Duterte is a doctor working in general practise and is a member of the treatment team at Association pour les Victimes de la Répression en Exil (AVRE). AVRE is associated with IRCT and is a centre for treatment of torture victims, many of whom are refugees from French speaking areas of Africa. Pierre Duterte is also president of an association created to provide help to Mauritanian refugees in camps and Senegal. The organisation sends them monthly medical supplies.

In this article Pierre Duterte describes his experiences from several years of talking with refugees and torture victims from Africa.

CENTRE PRESENTATIONS

The Human Rights Clinic in the Bronx

For a description of the centre, please turn to the section DOCUMENTATION AND BACKGROUND, page 79: A good example of a documentation and treatment service for survivors of torture: The Human Rights Clinic in the Bronx.
New centre project in Rome

Medical and psychological assistance provided to torture victims by the group
"Medici e Psicologi contro la Tortura" (Doctors and Psychologists against Torture)
in Rome from March 1996 to March 1997

Ettore Zerbino, MD*, Antee Di Napoli, MD*, Anna Sabatini, Psychologist*,
Andrea Taviani, MD* & Gian Luigi Spadoni, MD*

Since the project started to operate on 1 March 1996, 26 victims of torture have contacted us; 15 asked for medical evaluation and assistance (12 males, 3 females, aged 18-36 years). They came from four continents: Africa, America, Asia, and Europe (Ethiopia, 4; Tunisia, 4; one each from Zaire, Egypt, Ghana, Nigeria, Iran, Montenegro, El Salvador).

The torture methods reported were for the most part similar, regardless of continent of origin. This may be indirect confirmation of the suspected existence of training centres for torturers. Beating was reported by nearly all, especially on the back, feet, and hands. The instruments used included sticks and clubs, and other blunt instruments (in one case an electric stick). Some victims, including the four from Tunisia, were beaten on the head, leading to later severe headache and in some cases loss of hearing.

Victims from Africa were forced into abnormal body positions for many hours, including the "parrot's perch" and its variant called the "roast chicken". In the former the person is suspended by a stick passing behind the knees, with the hands blocked on it; in the latter, rotation around the stick is added. All the victims reported being beaten while suspended — on the back, the soles of the feet, and the head. The positions, which in themselves are extremely painful, make breathing difficult. If long-lasting, severe changes in the joints can result from the hanging of the entire body weight in such an unnatural position.

One-third of the cases reported torture with cutting weapons; confirmatory scars were present in some cases. A similar proportion presented with lesions of the nails following their being torn off. Some reported being burnt on several parts of the body. Others said they had been forced to crawl on hands and knees for hours, to such an extent that they could not maintain the standing position for several days. Other isolated forms of torture included:

- electro shock
- immersion of the head in ice-cold water to the point of near suffocation
- exposure to sunshine uninterruptedly for many days
- anal insufflation of compressed air
- whipping
- forced to move unceasingly to the point of faintness.

More than half the victims reported total isolation from their families, so that they could not give or receive any news from their relatives for several months; many were told that their "disappeared" relatives were dead, when in fact they were not.

About three-quarters also reported severe violations of human rights outside the torture sessions, e.g. continuous insults, mockery, being spat at and slapped by the prison guards. Conditions in the prisons were very bad. Food and water were scarce. One victim from Africa, kept in an extremely overcrowded cell during the dry season, had access to water only once daily; he quenched his thirst from the sweat obtained by wringing out his T-shirt. Cells were so overcrowded that it was impossible to lie down to sleep. If sleep was possible, half reported being woken by noise. One-third were deprived of light, and almost all of them said they were allowed into the open air for only one hour per month.

Three female victims, one under age at the time, reported particularly harrowing experiences. Two from Africa witnessed the massacre of their families and were then raped. The third, from Iran, was the victim of an attack by Pasdaran. Her house was bombed, resulting in the loss of one eye (the other is poor-sighted) and a hand; she is horribly disfigured.

On the whole, our cases had symptoms and signs that were compatible with the reported violence. Nearly all presented with anxiety, insomnia, and headache. Many suffered severe depression. Some had mental confusion, nightmares, anorexia, and vertigo. Less frequent symptoms included nausea, photophobia, intolerance of noise, and extreme anxiety. Pain in the joints, stomachache, and loss of hearing were quite frequent.

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"Medici e Psicologi contro la Tortura" are based in Rome in Italy.
TORTURE WORLDWIDE

From the Rehabilitation Centre for Victims of Violence (RCVV) in Kenya we bring the following case story about Wariyo Galgalo, Ethiopian born male, 28 years old, married with one child

Wariyo Galgalo – an Ethiopian torture victim

Background of Ethiopian civil war
Ethiopia has had one of the longest civil wars in Africa, with devastating effects. The wars here have lasted for over 25 years. After President Mengistu Haile Mariam was deposed in 1992, different liberation movements continued to fight each other. Several factions emerged, some fighting the government in power, others fighting each other. Our client, Wariyo Galgalo, was a member of one of the factions, the Oromo Liberation Movement.

Arrest and torture of Wariyo Galgalo
Wariyo Galgalo was arrested by the government in power in November 1992, released in May 1993, and later re-arrested. He was finally released in May 1994 during an amnesty for political prisoners. He is still suspected of belonging to a movement considered hostile to the government.

Galgalo was tortured in prison, almost to the point of death. When he came out he was unable to walk, and was confined to bed. It is said that he was paralysed in both lower limbs.

His sister helped him to come to Sololo Hospital on the eastern Kenya-Ethiopian border. They later escaped to Kenya, where he is now a registered UNHCR refugee.

Galgalo was then admitted to the Kenyatta National Hospital in Nairobi for treatment of incontinence of urine and faeces.

Torture methods
Wariyo Galgalo was tortured to make him admit to the charges against him. Among several torture methods:

1. He was stripped naked and suspended upside down, hands and feet tied together, legs and knees flexed ("la barra"). In this position he was beaten on his back with gun butts, and whipped.

2. On several occasions he was left tied as above, lying on a wet floor for long periods.

3. He was forcibly submerged in deep water almost to the point of suffocation (wet submarino).

4. He also underwent electric torture with shocks of high voltage. Electric terminals were placed on various parts of the body. This ugly torture method was very agonizing for him.

Complications arising from the torture
As a result of the torture, Wariyo Galgalo developed serious physical, neurological, and psychological complications, as follows:

- Physical
  - Soreness of the soles of the feet
  - Painful scars on the back
  - Stiffness of the trunk
  - Stiff muscles of the lower limbs
  - Disuse atrophy of the muscles of the lower limbs

- Neurological
  - Paralysis/weakness of muscles of the lower limbs
  - Acute paraesthesiae on the lower limbs, particularly along the legs and soles of the feet

- Psychological
  - Hostility and feeling of hopelessness
  - Persistent headache
  - Persistent feeling of dizziness
  - Anxiety
  - Sleep disturbances
  - Loss of appetite
  - Hallucinating behaviour
  - Despair

Treatment regime
By the time Wariyo Galgalo managed to reach RCVV in February 1996 he had undergone various examination procedures.

The diagnosis of paraparesis was confirmed, the muscles of the lower limbs being reduced to a power 2 according to the Oxford rating. He showed signs of recovery, but could barely walk with the aid of crutches.

A treatment regime that started at the beginning of February 1996 included:

1. Intensive physical therapy
2. Medical treatment
3. Intensive psychiatric and psychological treatment

By the end of March 1996 he was up and about.

He is now walking without crutches. Most of his ailments were treated. He was discharged in early May 1996 and attends monthly for check-up.

Tom John Onyuka Okoth
Land of double standards

Breach of the Hippocratic Oath
During the last year, Dr. Tufan Köse, a physician, and Mr. Mustafa Cinkılıç, a lawyer, both from the rehabilitation centre for torture victims in Adana, Turkey, have been through a trial that was principally about ethical principles. They refused to let the authorities look into the 167 medical records on clients who had been treated at the centre. The authorities demanded to see the records, assuming that they would constitute proof that torture had been committed.

It is a case of principles and the necessary right to defend international medical standards and - getting to the core of the matter - to defend the honour of the medical profession. As Sepp Graessner and Salah Ahmad point out in the following article, too many physicians in Turkey collaborate with torturers. They are forced to do it, or maybe even see a convenience and a career opportunity in doing so. Considering this, it demands even more respect to see physicians fight to protect victims of torture and stand up for ethical standards, as in the case of Adana.

The principal nature of the trial has therefore attracted great international attention. International observers have been present in Adana: representatives from medical organizations, human rights organizations, politicians, and representatives from rehabilitation centres from around the world. The Medical Director of the Berlin centre “Behandlungszentrum für Folteropfer”, Sepp Graessner, has attended seven out of eight trial hearings. His colleague Salah Ahmad has also been present as an observer at several of the hearings. I am convinced that the international presence in Adana has been interpreted by the Turkish authorities as a manifestation of international concern for the outcome of the case and the obligation to respect international ethical standards. This was how it was intended.

Inge Genefke, MD, DMSc. h.c.
Secretary-General, IRCT
Copenhagen
Denmark

In May 1997 in Adana, Turkey, the physician Tufan Köse was sentenced to pay a fine because he had supposedly broken law 530 of the Turkish Penal Code. He had apparently refused to release files of torture victims, who were seeking rehabilitation in the Adana Treatment Center, to government officials. The Turkish court argued that Köse had thwarted officials in launching their investigations of presumed torturers. Torture is considered a crime under Turkish criminal law.

Investigations of torturers frequently peter out so that, as a last resort, officials obviously have to turn to doctors who treat victims. Yet physicians are guardians of the doctor/patient confidentiality, because therapy and diagnosis involve sensitive and personal testimony. Victims of torture need a safe haven to cope with their experiences and to avoid long-term damage. Maybe such insight is asking too much of police officers, because their identification with perpetrators is common and less painful. As a direct result, preventative efforts to eliminate torture in Turkey have been frozen in an uncivilized stage. No other term comes to mind to describe a system in which the police prefer to “torture out” confessions rather than collect and interpret evidence.

How many police stations in Turkey have equipment for electro-torture? Some? Many? - All!
The ruling in Adana punishes a physician whose medical ethics distinguish him from a mass of colleagues in a land of double standards. This mass might best be characterized in the tone of a satire, yet this tone would be inappropriate owing to the serious nature of torture. We are faced with conspiracy in a national regime of torture. This regime in Turkey can only survive because the police are assured of collaboration with physicians and judges. Those physicians who refuse to join in this conspiracy against human rights live as a threatened minority in Turkey.

Physicians who collaborate with torturers place themselves in an exposed position. Some become perpetrators, convinced of their political motivations, while others may feel themselves pressured to defy medical ethics out of fear, intimidation, and/or peer pressure.

What can one say about physicians from the Erzurum University Clinic who supposedly did not realize that a seriously wounded gunshot patient was missing for three days and three nights? He had come to the hospital initially because members of a death squad had shot him in the chest at home. The patient was picked up from the ward by white-clad agents. He was taken away to an interrogation centre, where he was tortured severely. On returning in an obviously wretched state, the patient complained to the doctors that he had not been adequately protected. The patient was told that his file did not record an absence, and therefore he must have been suffering from fever dreams.

And what can one think about court physicians who determine after a five minute examination that fifteen people were not subjected to violence during interrogation (the word torture is avoided). The fifteen statements presented to the court were dated on the same day. They recorded the examination times for all fifteen patients from 7 am to 7:05 am. It would seem difficult for a judge to overlook this important detail. Maybe the court physician chose this cunning presentation for his information; therefore, we allow mitigating circumstances.

Sabri Ergül, a social-democratic member of the Turkish Parliament, confirms that he witnessed how a female doctor maintained five meters of distance while examining adolescent torture victims from Manisa so as not to damage her medical ethos. She concluded that traces of torture could not be confirmed, merely that multiple haematoma could be identified. We could ponder over this physicians dilemma. Instead, we prefer to consider the consequences of her actions.

Approximately 20% of people under detention pending trial in Turkish jails are examined by court physicians. These physicians examine individuals for physical traces of abuse. In anticipation of the defendants claim that he or she was abused, physicians include statements denying traces of torture in the defendants file.
An additional 20% of those in detention are brought to rooms blindfolded. During the interrogation, they concluded from the delivered statements that a physician was present. Many of our patients were forced to undergo surgical procedures (often suture of lacerations) while blindfolded. In some cases, patients experienced lumbar puncture due to neurological failure of extremities. Every physician in Turkey knows what it means for a patient to be examined blindfolded. Shunning the light is not a patient's symptom.

In Turkish-Kurdistan, victims who were interrogated and tortured are warned on release not to consult a physician. Torture survivors seek other help than that of a doctor because a visit to a physician may have grave consequences for the doctor. Physicians regret not to be able to offer treatment, and thus a medical certificate cannot be issued. This practice is confirmed by physicians in Turkish-Kurdistan, who express understanding for the actions of their colleagues. In the light of the unresolved deaths of doctors in Turkish-Kurdistan, we do not wish to comment further.

Dr. Kizilkan, the President of the Medical Association in Diyarbakir, is currently confronted with an accusation that he possessed explosives and stored them on his balcony. At the beginning of the year, "the lords of the twilight" rang his doorbell. Who knows what might have happened had he opened ...? It is generally known that our colleague Kizilkan had repeatedly expressed his opposition to the deplorable state of affairs in his region.

The proceedings against Köse in Adana commenced in the Turkish National Security Council, which expressed outrage about the publication of human rights abuses by our colleagues from the Turkish Human Rights Foundation. Obviously, in the light of the proceedings against Dr. Köse, leaders in the land of double standards are not outraged by the reality of omnipresent torture.

Sepp Graessner, MD
Salah Ahmad, Diplom Pedagogue
Centre for the Treatment of Torture Victims
Berlin
Germany

BOOK REVIEWS

A resource kit about the integration of refugees


This resource kit is for therapists who work with groups. It describes all the problems encountered during an integration process in which the traumatized refugees/families are themselves involved. Workshops are suggested for all the modules; there are many good suggestions for discussions and overheads for use at meetings/conversations.

The background for the collection of the material is first given, and a description of methods used in the work with the book and with the clients. The problems that may arise during an integration process are then described, starting with the difficulties of finding one's way around in the new country. A couple of games are suggested to start a discussion - a fine and amusing way of learning how to get around in a new town, of learning from one's own experiences and those of others.

The next step is economy, not only to learn about the value of the money, but also about the laws that influence the life of the individual. The economic situation of the participants is dealt with - how to make a budget, to save, to cope with daily shopping.

Then the life in exile as a traumatized person. What does it mean to have suffered losses, to have to live with the traumas - how to survive?

The next four modules concern the family, working through all the daily problems: to be a child, a young person, a male, a female, part of a family, to have other values than those predominant in the surrounding society. The kinds of worry that will crop up, depending on the age and the position in society and the family.

The last module covers health and what it means to be in good health and how we find things to enjoy together during the daily routine. Here there is an example of another game about the various activities in Sydney, and how to find them. I tried this game with a colleague and, without having been there, we both think we can find our way around with public transport.

Following this last module, there are handouts and overheads for use at the meetings, as well as suggestions for an evaluation.

The overall impression of the material is that it is so well prepared that it may well be used all over the world. Nothing is forgotten, and as a Danish social worker I shall have no problems in using the material for group work. The material reads easily, and the overheads are very practical.

The problems are the same all over, and the material is similar to that used by the Danish Refugee Council for the integration of refugees in Denmark. The games that help to learn something relatively complex in an amusing way were new to me. A slight adaptation would make the material suitable for refugees who cannot read or write.

All in all, I can recommend Families in cultural transition to all who work with refugees in the developed countries.

Winnie Atkinson
Social worker, RCT
Copenhagen
Denmark

TORTURE Volume 7, Number 3 1997

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A new approach in the treatment of torture survivors


"Who has been tortured, will not become at home again in this world ..." The German psychoanalyst A. Drees introduces a chapter in his new book, titled Folter: Opfer, Täter, Therapeuten with this well known quote from the work of Jean Paul Amery, who had himself been tortured in Nazi Germany. In spite of this pessimistic evaluation, new books on the treatment of sequels of violence continue to be published. The recent focus on symptom-oriented behavioural approaches, and on the DSM concept of one "posttraumatic stress disorder", has frequently been criticized as being too narrow a concept for the understanding of the complexity of the effects of intentional atrocities (Summerfield and Hume, 1993).

The book, which unfortunately has not yet been published in languages other than German, is interesting because it presents a very concrete, though idiosyncratic model of therapy that is based on psychodynamic approaches, but integrates strategies from different forms of therapy.

Drees questions the frequently used simplified model of an all-powerful therapist helping and counselling "victims" in a history-free healing environment. (This openness and other therapeutic strategies used derive probably at least in part from the earlier work of the author with dying patients, which had been based on the Balint group approach.)

The treatment model had been developed in an in-patient setting, which is not a common situation for therapy, since most specialized centres are based on experiences in an outpatient approach. (Stigmatization as a "Psychiatric patient" and regression, as well the repetition of imprisonment by hospitalization are the most important factors held against hospitalization.) In the special setting described by Drees, torture survivors are also treated together with patients suffering from mainly psychosomatic disorders, which might be an acceptable way to integrate extreme trauma and its sequels of shame, fear, and mistrust in a general setting of a community healing its members.

The "prismatic" de-focusing proposed as therapeutic strategy by the author uses fantasies and imagery experienced by the three persons involved in therapy (therapist, survivor, interpreter) that are triggered by the reported traumatic memories and the general non-verbal presentation of the patient. De-focusing is seen as a way to support a therapeutic process of fantasies, helping to move away from the "frozen" memory of trauma, which keeps the survivor in a restricted framework of experience. Another model suggested by the author is that of an out-patient short form of psychotherapy, based on a small group of basic principles, stressing the need for openness, empathy, fantasy, a change of roles, pre-traumatic "anchoring", and good contact with reality.

Though the strategies presented in the book lack research to give scientific credibility to therapy outcome, this holds true for most approaches that intend to support a comprehensive understanding of the spectrum of human experience and personal trauma histories.

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Who works best for human rights?


The increasing efforts to protect individuals against human rights violations by international rules have inspired the author of this book. He is introduced as a researcher born in 1966 and working at the Max-Planck Institute.

The following organs/institutions are described and compared: "The Human Rights Committee" (HRC), the "Special Rapporteur on Torture" (SRT), the "Committee Against Torture" (CAT) based on the "Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment", and the "Committee for the Prevention of Torture" (CPT) based on the "European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment".

The book is systematic in its approach, describing the mandate, working conditions, achievements, modus operandi, etc.

In the third part of the book the activities in Germany, Austria, the United Kingdom (with special emphasis on Northern Ireland), France, and Turkey are described. Turkey is the only country that has had visits from SRT, CAT, and CPT. On the basis of three visits to Turkey, the CPT decided, with the necessary two thirds majority among its members,
BOOK REVIEWS

that they would publish their findings of torture in Turkish police stations. The findings were also based on medical examinations. This is one of the few examples in the book of the mention of medical documentation. As a forensic scientist I find it difficult to understand that a book on the judicial aspects of torture does not find more space to stress the need for documentation. Forensic examinations are only mentioned once (p. 209). CPT finds such examinations important, and an examination based on photos alone does not seem to be sufficient. I can only agree with that.

It is said more than once in the book that CPT is the more efficient of the described organs. They make far more visits, their recommendations are more specific, and they often describe individual cases. Names are only rarely mentioned – among the few, Bent Sørensen, member of both CAT and CPT.

The importance of NGOs, as a source of information, is often emphasized.

The tone of the book is conversational, non-emotional. Having read through it, I find it difficult to remember even the major points, because they tend to drown in the many words.

The language is German, and that may deter some from reading it.

Who is the book written for? It is obviously too large for physicians, even those with their daily work in the human rights sphere. Lawyers may find it useful, though I don’t see it as convenient for quick look-ups. It may have a use for pre or postgraduate students who are looking for an overview of the field and an inspiration for PhD theses. There is an obvious opportunity and a need for research with the aim of estimating the effects of various measures for the protection of human rights. 

Professor Jørgen Lange Thomsen, Post-mortem Examiner Forensic Institute University of Odense Denmark

NEWS IN BRIEF

Mary Robinson, President of Ireland, appointed as new UN High Commissioner for Human Rights

Mr. Jose Ayala-Lasso is to become Minister of Foreign Affairs of Ecuador and has therefore resigned as UN High Commissioner for Human Rights.

Mary Robinson, President of Ireland, is appointed as the new United Nations High Commissioner for Human Rights. In that capacity, she will assume principal responsibility for the human rights activities of the organization, including the tasks of streamlining the human rights machinery throughout the United Nations system and supervising the Centre for Human Rights in Geneva.

Ms. Robinson, President of Ireland since 1990, has outstanding legal qualifications and has worked in the area of human rights with special expertise in constitutional and European human rights law.

Among the numerous international activities relating to human rights in which she participated, Ms. Robinson served as Special Rapporteur to the Interregional Meeting organized in 1993 by the Council of Europe on the theme “Human rights at the Dawn of the 21st Century”, as part of its preparation for the 1993 Vienna World Conference on Human Rights.

Ms. Robinson was the first Head of State to visit Rwanda in the aftermath of the genocide there and made two further visits, the most recent to address the Pan-African Conference on “Peace, Gender and Development”. She was also the first Head of State to visit the International Criminal Tribunal for the Former Yugoslavia, as well as the first Head of State to visit Somalia following the crisis there in 1992.

(Source: UN Information Centre for the Nordic Countries)

FROM THE MEDICAL LITERATURE

Spanish introduction to physiotherapy for torture survivors


The pamphlet is an introduction in Spanish to the work of physiotherapists at the Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen.

Several torture methods and their sequelae are described, and physiotherapy working processes are described and illustrated, e.g. examination of a client, and the multi-disciplinary therapy at RCT.

A detailed description is given of some physiotherapy treatment methods, e.g. relaxation, massage, respiration exercises, and the correction of posture.

The publication is particularly for physiotherapists, but it is also aimed at para-professionals who wish to involve themselves in physiotherapeutic treatment of torture survivors at places where physiotherapists are not available.
Johannesburg, South Africa
15-19 October 1997

Sixth International Conference on Safe Communities “Consolidating Communities Against Violence”

The international scientific committee is co-chaired by Prof. Victor Nell of University of South Africa’s Health Psychology Unit and Prof. Leif Svanstrom of Karolinska Institute in Stockholm, Sweden.

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Cape Town, South Africa
8-13 March 1998

Fifth International Conference for Health and Human Rights Conflict, Health and Social reconstruction

Announcement – Call for Papers

Further information:
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Copenhagen, Denmark
3-7 November 1997

Supervision Seminar for Advanced Therapists
5-day Seminar on Clinical Supervision and Therapeutical Network Building

Preliminary Announcement

Teachers: Anders Groth, Consultant, Psychiatrist
Nini Leick, Consultant, Psychologist
Jørgen Nystrup, Chief Psychiatrist

Place: RCT, Copenhagen

Objective:
- To teach the participants how to give, receive and profit from clinical supervision of the therapeutical relations.
- To manage the set-up of a peer group (intercollegiate network).

Participants: Approx. fifteen participants with considerable experience from counselling and psychotherapy with traumatized clients (preferably torture survivors) will be admitted. We recommend that two persons working in the same area participate together in order to get the maximum benefit from the seminar.

The course will be in English only. There will be the opportunity to exchange ideas before and after the seminar.

RCT has limited possibilities for funding of participants from developing countries.

Deadline for application: 15 September.

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

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