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CONSPIRACY OF SILENCE

Not the torturer

Not the torturer will scare me,
or the body’s final fall
nor the barrels of death’s rifles
or the shadows on the wall,
not the night when to the ground
the last, dim star of pain is hurled,
but the blind indifference
of a merciless, unfeeling world.

Halfdan Rasmussen*

“Torture remains a global problem of great magnitude”, is
the first sentence in IRCT’s Plan of Action. One can also
read that “a series of obstacles must be overcome in order
to raise attention to and awareness of the torture problem” – a
statement that naturally raises the principal question: Which
obstacles?

One obstacle of the utmost importance, particularly for
the work against torture, is indifference. This may be
explained by man’s aversion to torture, with all its unbear­
able details, perhaps combined with shame at belonging to a
race that is performing detailed and well planned bestialities,
which, by the way, are not even known among animals. This
explanation is valid to some extent, particularly where tor­
ture is practised, and where fear is necessarily an essential
element.

Furthermore, this manifestation of the conspiracy of
silence is very common in societies where the Convention
against Torture is enforced. Here also is the argument of
loathing and suppression of something unpleasant, though not
to quite the same extent. Especially in these highly developed
and technically well equipped societies, the free media, partic­
ularly TV and the film industry, excel in showing violence,
murder, sadism in every form, and insight into criminal syndi­
cates. This may be part of the entertainment industry, but
it certainly shows some very real elements of the world of
torture. Are we therefore not playing the same role as the
French Revolution’s knitting women (les tricoteuses), who
could not get enough rolling heads? Or can we brush aside
the real torture of the world around us just because the
entertainment industry saturates us sufficiently to keep us up
to date with the world’s profusion of loathsomeness?

However, the problem can be turned around into the
question whether these are good enough arguments for not
involving ourselves in this problematic field, thus making us
partners in this conspiracy of silence.

Anthony Reeler’s review in this issue of Torture of Yael
Daniell’s epoch-making book on violations against various
population groups, such as the Indians, on the Nazi holo­
caust, the South-American repressive regimes, and the former
Yugoslavia, (see page 29) focuses on the conspiracy of
silence in the context of a torture victim being unable to share
his unbearable experiences with others who cannot possibly
grasp the indescribable horrors. In Daniell’s words, the tor­
ture becomes “profoundly destructive as it attests to the per­
son’s, family’s, society’s, community’s and nation’s inability
to integrate the trauma.”

The conspiracy of silence thus gives security to the people
in power on two fronts: the torture survivors who have to
survive in silence with their traumas, and the world around,
which should come forward to stop the horrors in the name
of human rights and common decency. However, the impor­
tance of some kind of action to cast light on the systematized
torture, which is often practised with government approval,
often reaches far beyond the justice that may benefit the
individual. Apart from the concern for the torture survivor,
there is also the question of the dignity of a society that is
violated in its rights – a society that for instance has to exist
with impunity – and thus has to tolerate injustice as a con­
tinuous threat and a hindrance to even the most sincere
efforts to start a new order of society with respect for human
rights. In such an unjustified system, neither the society itself
nor its violated individuals can benefit from compassion,
understanding, and help with integration into a new existence,
not to mention even a symbolic economic compensation –
and thus none of the involved partners will be able to obtain
moral redress.

It is therefore important to break the conspiracy of silence
– both by those having good reasons for retaining their un­
bearable knowledge, and by those without good arguments
for not seeing, hearing, and speaking, and thus neglecting to
take part in what might be a clash with those in power. They
who are the only ones to benefit from the conspiracy of
silence.

H.M.

*Translated from Danish by the late Elsa Gress, author
Turkey is now paying for its torture practice

Illustrated by four judgements at the European Court of Human Rights in Strasbourg

Henrik Docker

The deep hostility between the Turkish state and the Kurds has roots that go back to the 1920s. Again and again both parties have taken up arms, and behind a State of Emergency the population has been oppressed. The PKK (Kurdish Labour Party) was, however, often the aggressor. Of about 28,000 killed during the last 13 years, at least some 10,000 were presumed victims of PKK raids against police stations or barracks.

On 30 November 1998, the latest State of Emergency was extended for four months by the Grand National Assembly of Turkey. This resolution was passed on the recommendation of the National Security Council, whose members include military officers and government officials in equal numbers. The provinces affected are Diyarbakir, Tunceli, Hakkari, Sirnak, Siirt, and Van. Five more neighbouring Kurdish provinces (Batman, Bingöl, Bitlis, Mardin, and Mus) were placed under the jurisdiction of the Diyarbakir-based “Super-Prefect” under the same conditions as the State of Emergency. This situation puts a stranglehold on basic human rights and worsens the living conditions of the Kurds in these provinces.

Most of the blatant and systematic violations of human rights in Turkey take place in these provinces. The legal situation enables the administrative authorities there to act arbitrarily. Torture, arbitrary arrest, extrajudicial execution, enforced disappearance, and other violations of human rights take place in this region because the security forces, the police, and the army are equipped with extensive powers (Law no. 2935, especially Articles 4 and 7).

During the State of Emergency, the Council of Ministers has the power to pass decrees with the force of law without the Parliament being required to endorse them with this jurisdiction. During this period the powers of the executive authorities in these provinces are also extended considerably. It should be noted that Article 15 in the European Convention on Human Rights allows the countries bound by it to be relieved from their obligations towards the Convention in times of war or public emergency. However, it does not accept any derogation from some of the rules, including Article 2 on the right to life, and Article 3 which prohibits the use of torture.

During the period between the foundation of the Republic of Turkey on 29 October 1923 and the conversion of martial law into the State of Emergency Regional Governorate on 19 July 1987, most of the Kurdish provinces had already been under martial law for 25 years, 9 months, and 8 days. The declaration of the State of Emergency in the eleven Kurdish provinces and four neighbouring provinces in 1987 merely confirmed a situation in which legal safeguards of human rights are permanently suspended.

During 1998 a stream of Turkish plaintiffs reached the human rights protection institutions in Strasbourg, France. In about ten instances the European Court of Human Rights, situated in that city, established that Turkey had violated the European Convention on Human Rights on vital points, including Article 3, which prohibits the use of torture. In every case Turkey paid the damages it was ordered to by the Court.

This attempt to censure the widespread use of torture in a country that belongs to Europe, and which is thereby obliged to respect the European Convention on Human Rights, has however attracted far less attention than the political crisis after the fall of the Yıldız Government and the arrest of the Kurdish guerrilla leader Mohammed Ocalan, aged 49, the most wanted head of the PKK, in Italy in November 1998 and his subsequent capture in Kenya in February 1999. Since then two things have happened:

• Ocalan, through his foreign lawyers, has lodged an application against Turkey with the European Court of Human Rights. In his application he alleges a violation of the European Convention on Human Rights under Article 5 (the right to liberty and security). He also refers to Article 2 (the right to life), Article 3 (prohibition of torture) and Article 6 §1 (the right to a fair trial).

• The special Committee for the Prevention of Torture under the Council of Europe has visited Turkey. In the course of four days, three members of a delegation plus three advisers saw 13 police stations, detention centres and offices as well as the prison on the island of Imrali where Ocalan is currently the sole inmate. No details on this is available as the consultations of the Committee are confidential.

Human rights protagonists engaged themselves furthermore in alarming news about centrally placed Turks within the fight for human rights in general: The Association of Human Rights in Turkey (IHD) had its branches in the towns Bursa, Mardin, and Balıkesir closed in November and December 1998. As in previous cases, the reason given was that the centres subscribe to publications on human rights.

Case one

In December 1998, the Security Court of Adana sentenced Akin Birdal, Chairman of IHD, to one year in prison for ‘separatist propaganda’ (based on Article 312 of the Turkish Penal Code, which represses incitement to hatred and discrimination on the basis of race, religion or origin). Mr Birdal made a speech on 10 December 1998 (Human Rights Day) urging peace in south-east Turkey (where most of the Kurds in the country live). At the present moment Birdal is accused in more than ten cases.

But let us focus on the inter-European endeavours to teach Turkey that the continuous mishandling of its own citizens...
contravenes modern international law, which, incidentally, also includes the protection of individuals through what is called international human rights law. The case of Kurt vs. Turkey, delivered on 25 May 1998, is characteristic.

Case two
Government campaign against an applicant
The European Court of Human Rights found violations of Article 3 ("no one shall be subjected to torture or inhuman and degrading treatment..."), Article 13 (unacknowledged detention of applicant's son), and Article 25 (the right to make a complaint to the Strasbourg institutions, protecting human rights).

The Court ordered Turkey to pay 10,000 GBP (British pound sterling) to the applicant, and 15,000 to her son, to be held by the applicant for him and his heirs. The son Üzeyir Kurt disappeared in November 1993, and was last seen by his mother (the applicant) in the custody of the Turkish security forces.

These forces had clashed with suspected terrorists in the Turkish village of Agili on 23 and 25 November 1993. The Government holds that the son left the village and joined the PKK, or possibly that he was kidnapped by the PKK. The State Security Court has denied any knowledge of the whereabouts of the son.

Since she lodged a complaint with the European Commission of Human Rights in Strasbourg (the body receiving complaints in the first place), she and her lawyer have been the target of a concerted campaign by the authorities to withdraw her complaint. Unfortunately, she is by no means the only Turkish applicant thus harassed by the authorities in that country.

However, the applicant made statements after her application to the Commission in Strasbourg repudiating all petitions made in her name. But the Court of Human Rights was not persuaded that these statements were made on the initiative of the applicant. She was in fact brought twice to the office of a notary by a uniformed soldier and was not required to pay the notary for drawing up the statements.

The Court in Strasbourg found that the Turkish authorities failed to do anything to register the disappearance of her son; they conducted no investigation, and the public prosecutor gave no real consideration to the mother's complaint that her son was possibly detained in the village. The prosecutor accepted without putting any questions the assertion by the gendarmerie that her son could not have been detained, because he did not appear in the custody records.

The Human Rights Commission, which interviewed the applicant in Ankara in February 1996, found her credible and consistent under cross-examination on the essential points of her allegation. The value of her testimony outweighed the Government's attempts to explain away the serious question of the disappearance of her son. The authorities meted out inhuman and degrading treatment, thereby violating Article 3. It is interesting that the Court accepted as inconsistent with Article 3 the way in which the mother (the applicant) was treated in general. Thus, inhuman and degrading treatment does not necessarily have to refer to one or more concrete situations or interrogations of the applicant.

Case three
Wide scope for interpretation of Article 3
In the case of Tekin vs. Turkey the Court found violation of Articles 3 and 13 (not sufficient domestic investigation into Mr Salih Tekins allegation of ill-treatment) and awarded the applicant 25,000 GBP in non-pecuniary damages. He was arrested by Turkish gendarmerie in February 1993 on suspicion of having threatened village guards.

According to Mr Tekin, a Turkish national of Kurdish origin born in 1964 and living in Diyarbakir, he was detained in freezing conditions. He was blindfolded, threatened with death, and beaten by police officers. Four days later he was transferred to the gendarmerie headquarters at Derik, where he claims to have been tortured. The same day, on being released, he was brought before a public prosecutor, to whom he complained of ill-treatment.

The prosecutor took no action. On the contrary, proceedings were later brought against Mr Tekin. After various negotiations in September 1995, the Mardin Provincial Administrative Board decided that the two officers who allegedly participated in the ill-treatment were exempt from public prosecution due to insufficient evidence.

As the Turkish Government later failed to furnish all necessary facilities to the Human Rights Commission (as it is a duty according to Article 28 of the Convention), and since key witnesses did not attend before the Commission, the respondent state (Turkey) was not justified in complaining of insufficient evidence.

Having itself examined the case in toto, the Court found it proved beyond reasonable doubt that Mr Tekin had been treated in such a way as to leave bruises and wounds on his body in the cold and dark cell in Derik. And that was a violation of Article 3 in the Convention.

In the case of Selcuk & Asker, the Court of Human Rights found violations of four Articles, viz. 3 (inhuman treatment because their homes were destroyed by Turkish soldiers), 8 (respect for private life), and 1 of Protocol No. 1 (to the Convention) and 13 (right to effective remedy if one's rights and freedoms set forth in the Convention are violated).

The applicants, Mrs Keje Selcuk and Mr Ismet Asker, in 1993 aged 54 and 60 respectively, were living in the village Islamköy in the mountainous Kulp district of the province of Diyarbakir, when soldiers came and burnt down the homes of Mr and Mrs Asker and later that of Mrs Selcuk. A mill owned by the latter was also destroyed by fire.

The Court accepted the applicants' testimony despite denial by the Turkish Government. The destruction of the houses was carried out contemptuously. The lack of proper investigation, though Mr Asker had presented a complaint to the District Governor, was a violation of Article 13 of the Convention. The Court awarded Mrs Selcuk 17,760 GBP and Mr Asker 22,408 GBP plus compensation for non-pecuniary damage of GBP 10,000 each.

In several other Turkish cases the Court of Human Rights (hereafter: the Court) established serious violations outside the scope of Article 3, but frequently connected with the political and military clashes between the Turkish state (security forces and army against the Kurds, village inhabitants, and active supporters of the PKK).

Case four
No effective investigation
In a judgement of September 1998, the Court awarded three applicants the following damages: Hüseyin Demir 20,000 FRF (French francs), Mr Süheïr Sissin & Mr Fatih Kaplan 25,000 FRF each after being arrested as members of the PKK and held for 23 days in custody without being brought before a judge. It was considered a violation of Article 5 (the obligation to put a detained person promptly before a judge).
Case five
Mr Esref Yasa was awarded 6,000 GBP in non-pecuniary damages after being shot at, allegedly by policemen, when he was cycling to his kiosk in Diyarbakir; he was hit by eight bullets and still suffers after-effects. No effective investigation was carried through into the circumstances of the shooting. Six months later, his uncle, Mr Hasim Yasa, who had been looking after the applicant's kiosk, was shot dead. The investigation is still pending. The applicant suggested that the sale of the Kurdish newspaper Özgür Gundem and other Kurdish papers may have been the reason behind the shooting. The Court could not establish that the shooting and the murder were carried out by the security forces, but that Article 2 was violated because of the inadequate investigation, with no result five years after the incidents.

Case six
Ms Havva Ergi, living in the village of Kesentas, south-east Turkey, was hit in the head by a rifle bullet while standing in the doorway of her house in September 1993; she died instantly. Her brother, the applicant, claimed that the village was attacked by security forces, apparently in retaliation for the killing by members of the PKK of a villager who had "collaborated" with the Government. Again the Court could not establish that his sister was killed by the security forces, but the failure to perform an adequate investigation was a violation of Article 2. The Court awarded the applicant and his niece 1,000 and 5,000 GBP, respectively, as non-pecuniary damages.

Case seven
Mr Hüseyin Gülec lodged a complaint against the commanding officer of the security forces in his home town Idil in the Sırnak Province, because his son was killed during demonstrations in March 1991. The Court reiterated that Article 2 of the Convention required by implication that the authorities in a given country should perform some form of effective official investigation when individuals have been killed as a result of force by agents of the state.

The Court in this case rejected the Government's argument that the PKK was responsible for the death of Ahmed Gülec. The investigating officers did not seem to have doubted the version of events supplied by the gendarmerie. They had not bothered to interview two key witnesses who stood at the applicant's side when his son was hit by the bullet fragment which caused his death. The Court awarded the applicant 50,000 FRF non-pecuniary damages.

Conclusions
The above mentioned cases have been described in some detail in order to illustrate the seriousness of the many complaints against Turkey in its continuous confrontation with the large Kurdish population group. Apparently, the Turkish Government is unable to find a balance between the legitimate wish to maintain the Turkish Republic and the distribution of a just part of the power to the Kurds. The main problem seems to be that hitherto the Government in Ankara has been unwilling to accept any kind of Kurdish authority. Seen from the outside an indispensable precondition for a settlement is the renunciation of violence and torture by both parts.

References
Socio-psychological and medical aspects of violence and torture – the situation in the Ukraine

Alexander Hodlevsky, MD, PhD*

An NGO called Youth and Family Social and Psychological Support Agency (new name: Youth & Family Community Mental Health Agency) has been in operation in Odessa, the Ukraine, since 1992. It is an NGO that unites the voluntary activities of psychiatrists and psychologists who are interested in the development of community mental health services and crisis intervention services. Psychological and psychotherapeutic help is given anonymously and confidentially.

The social and economic situation of the Ukraine has been deteriorating noticeably during the last decades. A state of chronic crisis has changed both the citizen’s private life and the society as a whole. Unfortunately, violations of human rights, violence, theft, and murder of well-known businessmen and bankers have become everyday events. The general social tension and the aggressiveness of different social groups have increased, and the necessity for creating and developing the basis for a civil society is far down the planning agenda.

At present, the government is unable to provide personal safety and protection from the powers of corruption and criminal groups to anybody – politicians, journalists, businessmen, citizens in general – despite the activity of militia and public prosecutors’ offices in the Ukraine.

Different kinds of violence have become widespread and everyday experiences. Most people do not consider the cases of abuse as violence against the personality. Rather, they consider it a necessary element of survival in the society’s situation of chronic crisis.

It is necessary to note that people who have experienced violence, including torture, are in general, and for different reasons, afraid of, or they avoid applying for, official medical or legal help; they fear for their own lives and for the lives of their relations because of the threats from criminal elements. Only special circumstances (e.g. legal persecution) force these people to apply to forensic medical services and to general practitioners, who give them expert help. In the Ukraine, unfortunately, there is no state system of psychological and medical help for victims of different types of violence, including torture.

The importance and necessity of such help is understandable. During the last years, non-government services and programmes of psychotherapeutic, psychiatric, and psychosocial help for people who had experienced violence began to develop in the Ukraine. However, NGOs are acting in a situation of economic crisis, insufficient development of the “Third sector”, and absence of financial support from the government.

Since 1994, the Youth & Family Community Mental Health Agency has managed 22 persons (14 male, 8 female; aged 9 to 34 years) who had suffered abuse, including torture. Taking into account the case histories, the clinical state, and the clinical and psychopathological analysis, we have categorized them into the following groups:

**Group 1**
Seven businessmen (28 to 34 years) who refused to pay a contribution to the criminal organizations; they were kidnapped and held by the Mafia for two or more days. The following kinds of torture were used:
- burning with a hot iron
- beating with a wet towel and rubber truncheons on the genital organs and other parts of the body
- prolonged periods in dark, wet cellars without food, but with constant threats of execution
- giving dependence-producing drugs
- sexual abuse of wives in the presence of their husbands.

After release, the victims had emotional instability, aggressiveness, sleep disorders, social and family problems (including sexual), a tendency to alcohol abuse, and pain in the injured parts of the body. These patients later developed post-traumatic stress disorder, together with obsessive-compulsive disorders (ODC), addictive disorders, and aggressive behaviour.

**Group 2**
Four young men (18 to 20 years), doing military service in the Ukrainian army. They were victims of constant taunting and mockery by fellow-soldiers; they finally deserted their units. They had suffered the following kinds of torture:
- burning of the skin with matches and cigarettes
- deprivation of sleep
- physical beating and verbal threats
- prolonged standing in an uncomfortable position
- use of various mechanical ways to irritate the anus.

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After deserting they showed fear, anxiety, depression, anger, feelings of guilt, suicidal thoughts, and OCD.

Group 3
Eleven homeless youngsters (3 boys, 8 girls; 9 to 16 years) who had left home because of family conflict or domestic violence. They were picked up by adult men and subjected to torture, mainly associated with paedophile behaviour:
• burning the skin and genitals with cigarettes
• traumatization of genitals
• beating
• sexual abuse
• confinement in dark premises without food for several hours or several days.

After their escape, examination by the NGO Child Shelter of Odessa showed fear, depression, phobias, anger, eating and sleep disorders, irritability, aggressiveness, and pain syndrome.

Conclusions
1. It is not only wars and dictatorships that promote the growth of violence and torture in a society; social crisis events and growth of criminal activities in the developing countries can bring about the same results.
2. The NGOs can be very useful in demonstrating and investigating the problem of torture and violence in the developing countries of eastern Europe.
3. International collaboration, support for NGOs by international organizations, and funds are necessary to prevent violence and torture during peacetime.

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Torture methods prevalent in Bhutan

Khem Kumar Adhikari, MD*

The state-sponsored terrorism of the Royal Bhutan Police and Army, and the depopulation policy of the Royal Government were initiated after the peaceful protests in September/October 1990; they led to the mass fleeing of the people from the country to avoid persecution and torture. At present, more than 100,000 Bhutanese people are living in asylum in the UNHCR monitored refugee camps in eastern Nepal. Almost half of these people have experienced some of the torture methods used in Bhutan. They have their own stories and pain. Most of them are still suffering from the traumatic experiences. Some have lost their memory, some hands, some legs, etc. Many of them have lost their nearest and dearest in prison. Death in prison is very common in Bhutan. Since the International Committee of the Red Cross was allowed to visit the Bhutanese prison (the government allowed visits only to the prison in Thimphu), the prisoners who were released after the visit report some improvement, but normally done to show to the delegation at the time of their visit.

Torture methods in use by the government of Bhutan

The most common forms of torture are severe beating and kicking. Severe beating inflicted at the time of arrest, or to extract information or force the signing of a confession. Daily beatings by prison guards, and being forced to beat each other. Beatings were frequently done with bamboo canes or wooden sticks, iron rods, electric wire, belts, whips, rifle butts, bayonets, roots of trees, and thorn branches. The most common forms of torture are:
- Severe beating and kicking.
- Kept in handcuffs or hands tied.
- Kept in leg shackles — leg shackles that are worn continuously while the person is forced to do hard labour.
- Detention in isolation cells — for years in some cases.
- No light — kept in the dark with windows and doors closed.
- Exposure to extremes of cold — victims forced into the river with the temperature below five degrees for hours in the name of bathing.
- Cramped confinement — victims unable to lie flat to sleep.
- Leg cramps (called Cheputua) — thick plank or wood placed above and below thighs, tightened with rope, the guards stand on the planks to increase the pressure.
- Made to behave like animals — victims forced to walk on all fours, made to climb on each other's backs and bullfight.
- Sexual abuse — victims forced to perform oral and anal sex.
- Suspended by hands — victims handcuffed and hang from a hook.
- Paraded naked in front of other prisoners.
- Made to stand upside down on hands for long periods.
- Blindfolded.
- Cut or slashed.
- Strangulation.
- Clean the toilets with hands.
- Needle/pin forced under the fingernails.
- Submersion in water.
- Beaten on genitals.
- Forced to eat beef (Hindus do not take beef).
- "Tuppi" pulled out by roots.
- Put in pit.
- Taking of blood.
- Forced labour — victims made to work from 8 am to 4 pm, frequently in freezing weather with leg shackles; beaten if they are slow.
- Forced signing of confessions. After interrogation and torture, most prisoners are forced to sign statements without seeing or reading them.
- Fingerprints and photos taken routinely.

Other forms of torture are:
- Insufficient and contaminated food — mixed with small glass pieces, sand, nails, etc., and not cooked properly; use of dirty water.
- Insufficient access to toilet and washing facilities. Prisoners are only allowed to go the toilet at a fixed time once or twice a day; if they want to go at other times they are supposed to urinate/defecate in a small tin provided and kept near them, to be thrown out the next day.
- Starvation methods — not given anything to eat for three to ten days.
- Forced statements — beatings to extract the truth. To avoid this intense torture, the prisoners must say whatever the government wants.
- No water to drink, and sometimes prisoners are made to drink urine or salted water.
- Whoever begs for water during beating and interrogation has salt poured in their mouth.
- Guards urinate on their faces.
- Crowded cells — as many as 20 people are kept in a small room that is normally fit for five people, so there is no question of sleeping; many must sit upright the whole night.

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• Defecate in their clothes or in front of others in the room.
• Washing facilities denied completely. Due to filthy living conditions, lice are common.
• Beating, hunger, detention in isolation, no communication with outside world, etc.

Those who died in custody: Mr. Dharma Raj Gurung, Mr. Gambit Rai, Mr. Man Bahadur Chhetri, Mr. Punya Prasad Dhakal, and many others.

Those who were raped: from a sample of 38, 30 women have been registered as having been raped by the Royal Bhutan Army; includes rape under custody and others.

Situation in eastern Bhutan
The situation in the eastern part of the country has deteriorated since October 1997, when the people came out in the streets to denounce the government's human rights violations. Mass arrests, torture, rape, etc. have become rampant, and the people have been forced to flee the country to save their lives. The report on Bhutan by Amnesty International, published at the beginning of 1998, amply proves the horrible situation prevailing in the country.

For further information about Bhutan, please turn to p. 24.

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**Practical information for use especially by medical doctors in charge of NGO-directed missions**

**Fact-finding missions**

**Hans Petter Hougen, MD, DMSc, Chief Deputy Forensic Pathologist**

**Introduction**

The purpose of medical fact-finding missions is to document human rights abuses based on observations and medical examinations in the country where the violations have taken place, or in neighbouring countries to which the examinees have fled.

Fact-finding missions are carried out by doctors who have a special knowledge within their field and within the field of human rights. If possible, at least two doctors should go on a mission because professional discussions and interchanges of experience are of utmost importance to obtain a high quality product. Another reason for sending more than one doctor on fact-finding missions concerns training. It is a good idea for a team to consist of doctors with experience and young doctors who can get “on the spot” training.

**Before the mission**

The preparation time varies. Some missions deal with specific cases, e.g. participation in or supervision of an autopsy, and in these cases the preparatory phase is short, usually not more than a day or two. The information is often scarce, but it is important to obtain as much knowledge as possible about the case. If it is an Amnesty International mission, be sure to get all the necessary information. Usually you are contacted by the researcher or somebody else from the centre who knows the case. If not, phone the centre to get as much information as you can. Air tickets and other practical arrangements are usually taken care of by the organization. Make sure that there is someone to receive you at the arrival airport. It is a good idea to have a name, address and/or phone number of a contact person. Usually there is no time for vaccination, but contact your health authorities if possible. It is usually not a good idea to inform the press before you leave, unless otherwise agreed upon with the organization for which you work. Your embassy in the country of arrival should be informed about your stay. If you bring medical equipment/instruments, make a careful choice because it is usually easier to get in to a country as a regular tourist (the local authorities are often not particularly cooperative). An official statement with your name, title, nationality, and the reason for your trip to the country is a must. Remember to have a valid passport; some countries demand a passport that is valid from three to six months after the date of arrival. Do not forget a camera.

Long flights are usually boring. Make the best of it by reading all the gathered information and prepare yourself for the coming work.

Most fact-finding missions are planned several months ahead. You then have time to divide the tasks with the researcher (if it is an Amnesty International mission) to minimize the risk of misunderstandings during the mission. Discuss as soon as possible with the researcher the possibility of later publication in medical journals. If the organization approves this, or if it is a mission with a clear scientific aim, it is important to elaborate a detailed project, including relevant literature. Questionnaires and checklists, drawings, etc. have to be prepared in detail before the mission. It is important for each member of the team to have his or her area of responsibility, and it is a good idea to have a coordinator.

Contact the health authorities at an early stage regarding vaccinations.

Teaching local human rights activists is a frequent request. Contact the researcher or the local people, so that you know what topics they are interested in and the professional background of the participants. The teaching responsibilities should be divided between the doctors; prepare yourself for teaching also in related subjects. Make sure that a slide projector and/or overhead projector is available.

**The mission**

On arrival you will normally be received by the researcher or representatives of the local organization. A meeting with the relevant people as soon as possible is important so that you can be updated. Things change quickly, and often the circumstances are different from the scenario one would expect. This could mean some adjustment or change in the original planning. If this is necessary, it is my opinion that all changes should be approved by the doctors. The doctors have the professional know-how and should therefore take part in the decision so that the original project is not changed to such an extent that it ends up in nothing. It is my personal experience that a lot can be achieved by insisting a little: “We have come a long way and are experts in the field; it would therefore be most unfortunate if we should go home without having achieved anything because all possible ways to overcome small final obstacles were not tried.” If everything fails with respect to the project, the possibility of teaching will still remain.

Correct behaviour is obviously necessary, also when the delegates meet local or national authorities. If it is an Amnesty International mission, meetings with authorities will be
arranged by the researcher, and there will be no doubt about
the affiliation. If you represent other organizations, you will
normally also state the affiliation, and be prepared to docu-
ment it (letter of introduction and ID-card proving you are
a physician). Be suitably dressed for formal meetings.

On the mission you will meet people who confront you
with cases of more or less human rights relevance. It is tempt­
ing to deal with these cases, but you should always focus on
the main purpose of the mission, which has first priority.

Do not forget to keep a diary and write down the names
of the persons you have meetings with. This will facilitate
writing of the report and future correspondence.

Press contact should be agreed upon with the researcher if it
is an Amnesty International mission. The local contact persons
will often put pressure on you to get press statements, and press
conferences will often be arranged. If you make press statements
or give interviews, it is a good idea to do so immediately
before departure, so that you are out of the country at the
time of release. Even if your embassy is aware of your presence
in the country, it cannot guarantee your security. I once gave
interviews at such an early stage that articles appeared in
major newspapers the day before I left the country, even though
I knew that another foreign colleague a few years earlier had
been detained under similar circumstances. Luckily nothing
happened to me, but I was very nervous until my plane was
in the air with me on board. If you are interviewed, be very
cautious with names; the main rule is no names or recogniz­
able descriptions of contact persons, just organizations.

Remember to bring a camera, and remember to use it. Do
not take any pictures of contact persons or torture victims
without consent. Do not photograph faces if it is not strictly
necessary.

After the mission
Write the report as soon as possible. Report writing is time
consuming, because the reports often contain not only text,
but also tables, figures, and illustrations. Divide the work
between the participants and be sure that there is one
responsible coordinator. It is a good idea to give a quick
summarized version to your local NGO or other relevant
groups. The report is usually written in English.

Press coverage of the outcome of the mission is normally
taken care of by the organization, as is usual with Amnesty
International. If this is not the case, then coordinate the
press coverage with them. It is a good idea to have a press
conference when you launch the report. Make sure the press
is invited through the usual channels, and try to avoid hav­
ning the press conference on the same day as other important
planned events. Invite well-known people to the conference,
and make sure the press is aware of this.

Bibliography
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Examination technique and reporting of the
examination of torture victims

Allan Dorfælt, MD*

In many countries torture is used as an instrument against
individuals or groups of people, it is carried out by the au­
thorities as well as by other groups, but with the accept of the
authorities. Torture will always leave some kind of life-long
after-effects, weak or strong, in the victim, and it can have a
major impact on his state of health. Many refugees, who have
been arrested or imprisoned in their country of origin, have
been tortured, and therefore doctors in the country of exile
may well have to treat torture victims although torture is not
practised in that country. Knowledge of the torture experi­
enced by the particular victim is a necessary condition for
being able to handle health problems in people with direct or
indirect after-effects of torture. The following is a description
of how to carry out a medical examination of suspected tor­
ture victims with a view to substantiating that torture has
taken place.

Medical examinations of suspected torture victims may be
carried out for different purposes. Examples could be exami­
nation of an individual in order to initiate treatment of after­
effects of torture, or it could be examination of a whole
group of people in order to demonstrate the use of system­
atic torture. Therefore the examination may take place
under highly different conditions, which means that both the
examination method and the report may vary greatly. In this

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way the conditions depend on whether the examination is performed in the doctor's home country, where there is the time and framework for a longer and more thorough examination than during a mission to the victim's home country or to a third country, where several victims often have to be examined every day, and this under very primitive conditions. The doctors involved will have to evaluate the situation and adapt to the available conditions and possibilities.

In principle the examination of torture victims is not different from other medical examinations, i.e. history taking, examination, evaluation, and conclusion. What is special, however, is the combination of physical and psychological elements; these are normally met separately, rarely in this combination. So the examination must be able to show assaults on the examinee, assaults which the examinee often tries to suppress, but which may suddenly come to the surface and cause very unpleasant feelings and thus influence the examination situation. Furthermore, the interval between the trauma and the examination varies from days to years, and thus the examinee's memory of events may be very poor. Evaluation is often difficult because the examinee may be living under stressful conditions as a refugee, something which may itself cause various symptoms. The doctor must therefore be prepared for considerable variation in the victims' reactions, and be ready to vary his examination technique accordingly. The examiner must prepare the interview beforehand to make sure that all the necessary facets of a conclusion are included. This may be in the form of an outline or a questionnaire possibly designed specially for the examination.

The examining doctors
Torture victims should preferably be examined by two doctors together: one as examiner, the other as observer. The former can concentrate on the interview, the latter can take notes and ask additional questions. Afterwards, based on his notes, the observer can write the report. The examining doctors are often not specialists in the examination of torture victims, so it is a great advantage to be two for the evaluation. This is also the best way of training new doctors, using them as observers a few times before they are put in charge of an examination. It is an advantage for at least one of the examiners to be of the same sex as the examinee.

Interpretation
Examination of torture victims usually requires an interpreter, whose work requires considerable skill. The interpreter should be professional, familiar with torture and the examination of torture victims, so that he knows the terminology and is not unduly influenced by the situation. Furthermore, the interpreter must be impartial and observe professional secrecy, something which the examinee must know and trust.

Good interpretation also demands special skills from the examiner, who must involve the interpreter and control the interpretation so that the questions asked and the answers given are in harmony with each other. It is important that each word is translated, all nuances included, preferably in short passages, and without the interpreter giving his own evaluation of the answers. Only the examiner should evaluate the examinee's statements. It is an advantage for the examiner and the interpreter to know each other, or for there to have been a briefing beforehand. Furthermore, the interpreter and examinee should preferably understand each other completely, i.e. speak the same dialect, and the interpreter should understand the examinee's social and cultural background so that nuances are not missed. It is important for the interpreter to be impartial and to observe professional secrecy. Preferably, the interpreter should be of the same sex as the examinee. Family members, friends, or other non-professionals should be used as interpreters only exceptionally, partly because they are not sufficiently impartial, partly because it may be uncomfortable for the examinee.

The ideal examination situation thus comprises the examinee, two doctors, and an interpreter. In some cases, a fifth person may be present, e.g. an assessor for the examinee or a representative from a non-governmental organization. However, this should only be an exception, as this is a medical examination, and it is important that no stress is put on any of the participants.

Seating arrangements
The examiner should sit opposite the examinee, face to face and with good eye contact. It may be an advantage to have a desk in between, to create a distance so that the examinee can keep his dignity and own space, and to make it easier for the doctor to write notes, etc. The interpreter should sit at the side of the desk for close contact with both, and to be able to take an active role without being physically between the doctor and the examinee. The observer ideally sits opposite the interpreter, possibly slightly further back, but sufficiently close to take an active part if needed. Any fifth person/assessor should sit behind the examinee or the observer, situated so as not to take an active part.

Surroundings
The physical surroundings should be pleasant, preferably light rooms with comfortable chairs and access to fresh air. Many torture survivors are anxious and do not feel safe in small dark rooms, which remind them of their imprisonment and torture. Furthermore, an examination may last from half an hour to several hours, depending on the circumstances, and can be very tiring, both physically and mentally, for all involved. It should therefore be possible to take a break and to move around, possibly also to eat and/or drink.

Interview
It is crucial for the examination to be performed with respect and mutual confidence. It must be pointed out to the examinee that the examination can be stopped at any time should it be too stressful. All relevant details are sometimes not revealed because of poor memory, suppression, and/or because the examinee feels uncomfortable. It may be necessary to ask questions about the same subject several times in different ways, which may give the impression of a cross-examination, and it is therefore important for examiners and interpreters to be open and forthcoming with respect to body language, to be patient, to create confidence.

It is best to start with neutral subjects such as identification of the person to be examined and a presentation of the participants, at the same time stressing their professional secrecy and the purpose of the examination. Then questions about family situation and family members, education, and possibly about politics, religion, membership of organizations, and the examinee's health status before the arrest/torture. These subjects are often easy for the examinee to answer and they form a good basis for the following interview.
A cup of coffee, tea, sweet biscuits or the like all help to create a good atmosphere.

Next follow questions about arrests, imprisonments, including the conditions of the cell, sanitation, and nutrition, the possibilities for out-door exercises, the interrogations, torture, and the conditions under which the examinee was set free, as well as his state of health throughout. This part of the examination may be extremely stressful for a torture victim, who is reminded of his experiences, and perhaps even re-lives some of them. He may therefore react strongly, and it may be necessary to interrupt the examination for a period to give everyone time to simmer down and find themselves again. Then follow questions about the state of health after the imprisonment and torture, and about present health, especially after a long interval. It is often less stressful to talk about these subjects, but if the examinee lives in a foreign country as a refugee, this situation in itself may be traumatic and cause mental stress, poor memory, and suppression.

Ideally it should be possible to give the examinee a referral to relevant treatment if the examination reveals the need for it.

**Objective examination**

When carrying out the objective examination of the suspected torture victim it is very important to explain the purpose of the examination and to carry it out with suitable respect for the victim's background; exactly as is the case when taking the history. Many see the objective examination as the "real" medical examination, but for some the examination may remind them of their interrogations and torture, so the doctor must be conscious of his use of instruments, etc.

All objective findings must be registered, also if they are unspecific or may have been caused by other things than torture. The significance of the individual findings and their relation to possible torture should appear in the conclusion.

**Report**

The report, like the examination, depends on the purpose and the circumstances. If it is a question of documenting torture in a larger population, the individual cases can be relatively short, whereas an examination of a single individual to be used in connection with an application for asylum must be more thorough. However, all reports should ideally contain the elements listed below.
Documenting and interpreting injuries

Derrick J. Pounder, MD, Professor*

Torture is a trauma that produces physical, functional, and psychological effects. These sequelae may be seen in the acute, sub-acute, and chronic stages. The physical injuries may be external and observable on simple clinical examination. Internal injuries are not directly observable but may be inferred from a functional effect or demonstrated by clinical investigations such as imaging techniques and blood chemistry.

Acute and external signs
The externally visible physical effects are most apparent in the acute stage when the victim is seen immediately after torture. However, this physical evidence commonly resolves completely, leaving no observable evidence in the sub-acute and chronic stages. As a result, 80% or more of torture victims who present for physical examination many months after the event do not have physical evidence of injury but do have the psychological sequelae.

The expectation of finding physical evidence of torture decreases as the survival time after the torture increases. In these late examinations the absence of physical evidence of torture, i.e. a negative physical examination result, is a neutral finding and should not be taken as evidence that weighs against the possibility or probability of torture. On the other hand, the minority of individuals who have some residual physical evidence, i.e. a positive physical examination result, can be said to have corroborating evidence that they had been tortured. Clearly, in the acute stage such corroborating evidence is found in the majority of victims. The most frequent physical findings in torture victims have been well described in the forensic medicine literature, and in numerous publications dealing with torture.

The type of torture used will influence not only the type of physical injury produced but also the likelihood of there being an observable injury. Epidemiological studies of torture show that both technology and political sophistication influence the type of torture used and the likelihood of physical evidence. The most primitive form of torture involves crude violence using whatever comes easily to hand. Beating, kicking, burning with kerosene, suspension, beating of the soles of the feet (falanga) all come into this category. The disregard of the resultant physical evidence reflects the sense of immunity that the torturers feel, itself a reflection of the social and political situation in the country. The next stage in the development of torture is technical, with the use of improvised instruments and devices. Examples include apparatus for electrical torture, special devices for suspending victims, or for controlled drowning of victims. The use of such equipment reflects the institutionalization of torture. There remains the indifference to the resulting physical evidence, reflecting a continuing sense of immunity from legal sanctions or redress.

No physical evidence
The next stage of evolution of the torture methods is driven by factors that are essentially social and political in nature. This occurs when the state pays lip service to the principle of the prohibition of torture, while at the same time acquiescing in its practice. The torturers now continue to torture but need to do so in a more sophisticated way, leaving less physical evidence. Rather than using electrodes to produce electric shocks, currents are passed through wet cloths over a large area, leaving no physical marks. Instead of being struck, the victim may be violently shaken. A motorcycle crash helmet may be placed on the head and the helmet struck. All these methods have in common the infliction of physical violence in a manner that is designed to reduce physical evidence. As this social/political sophistication of the torturer develops, there is, paradoxically, a reduction in the use of dedicated torture equipment. In the democracies and aspiring democracies, there is a tendency to use torture methods that leave no physical evidence and can be presented to the public as relatively benign. A typical example would be the techniques used by the British in Northern Ireland, comprising positional abuse, hooding, sleep deprivation, and loud noise. Israel uses similar techniques but with a cold rather than a noisy environment. Other countries, e.g. Spain and South Africa, which are less concerned with public perception and more concerned with torturing without physical evidence, use various forms of asphyxiation. These involve pinioning the victim and asphyxiating with a plastic bag, gas mask, or piece of rubber (such as the inner tube of a tyre); it can render a person repeatedly unconscious, bringing them to the point of death, and leave no physical evidence whatever.

The importance of background information
An appreciation of the technical level and social/political sophistication of torture in a specific country clearly assists in evaluating a torture victim from that country. When the torturers' sophistication is low, physical evidence can be expected in victims examined in the acute stage, but in only a small minority in the chronic stage. By contrast, there is no expectation of physical findings in victims subjected to the more sophisticated forms of torture.

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Thus, the finding of physical evidence corroborating torture is the exception rather than the rule. This is because most physical effects heal, leaving no long-term evidence, and the sophisticated forms of torture are specifically selected because they leave no physical evidence. For these reasons it is of fundamental importance that the results of the physical examination of the victim are viewed in the light of the history given and of the known epidemiology of torture in the place alleged. The pattern of torture in a country may vary over time consequent on political and social changes, may vary between cities, between different agencies of the state (such as different police forces), and even between different groups of torturers. Evaluation of the consistency between the known epidemiology of torture in the place alleged, the history given by the victim, and the results of the physical examination should form the basis of the ultimate opinion.

In taking the history it is of importance to obtain information that goes beyond directing the physical examination, psychological examination, and treatment. The history provides a means of documenting and evaluating the credibility of the witness, and in this respect minor details may be of great importance. For example, persons subjected to plastic bag asphyxiation may be able to describe very accurately how they were pinioned so as to leave no marks, the type and colour of plastic bag used, how it was applied, and the physical sensation of the asphyxiation process, including the presence or absence of incontinence. Part of the history should be a description of the appearances of any injuries immediately following the torture. Individuals who dismiss certain scars on their body as being the result of previous accidents and not the torture episode tend to enhance their credibility, and such statements should be documented. The history should be taken in the light of the known epidemiology of torture in that place to establish consistency or inconsistency. Results of the physical examination can then be expressed as expected or unexpected in the light of the history and epidemiology. As a result, a negative physical examination may be entirely consistent with the history provided and with the known pattern of torture in the place alleged.

Description and evaluation
When there are physical findings, the individual lesion should be well described and then the overall pattern of injuries assessed. Generally it is the pattern of injuries on the body that is more informative than the individual lesions. The fresher the injury, the easier the interpretation. Scars are generally non-specific, and here evaluating the overall pattern is most productive. For example, multiple small white scars on the insides of both thighs would be a typical result of electrical torture using electrodes, and it is difficult to conceive of another cause for this localized pattern of scarring.

As well as stating whether the physical findings are consistent with the history, an attempt should be made to offer an opinion on the injury itself, if possible. This opinion should be in two parts, namely the suggested cause of the injury and the degree of certainty that this is the case. For example, an injury might be said to be diagnostic of a blow from an object such as a baton, meaning that the diagnosis can be made with reasonable medical certainty. Alternatively, the injury might be described as suggestive of some cause, meaning that this is the most likely cause of such an appearance, although there are other possible causes (and here it is wise to enumerate some of the alternatives for the sake of balance in the report). Lastly, an injury may be described as consistent with something or other, meaning that an injury of this appearance could have many possible causes, one of which is the allegation made.

Conclusions
In summary, most torture victims who are examined by a doctor have no residual physical evidence of torture either because the evidence has healed completely or because the torture methods used leave no evidence. Even so, the careful taking of a history concerning the methods of torture and their effects may provide important evidence. Psychological assessment will invariably disclose sequel of torture. When the victim has observable injuries these should be documented according to standard clinical practice and evaluated against the history provided and the known epidemiology of torture in the place alleged. Opinions on the cause of injuries based purely on their appearance should take into account the overall pattern of injury and give an indication of the certainty of the diagnosis. In documenting injuries from torture, a doctor serves the best interest of the campaign against torture by maintaining objectivity and balance.

Further reading
Abstract

Introduction: The legacy of post-communist Bulgaria has many aspects with respect to torture. On the one hand, the communist regime conducted political repression and torture; on the other, speaking publicly about torture and other human rights violations was taboo. As a result, the law enforcement agencies inherited to some extent an attitude of unlawful application of force, and the society remained less sensitive to certain human rights violations and/or more inclined to react with denial. This article represents part of the assessment studies carried out by members of the Assistance Center for Torture Survivors (ACET) before its opening for the reception of torture victims.

Methods: We studied two groups; 105 prison inmates and 49 asylum seekers. For the purposes of the study we adapted the Self Reporting Questionnaire of Dr Federico Allodi, Canada, including mainly parts A, B, and G of the original questionnaire.

Results: Torture during their contact with some of the law enforcement agencies was reported by 72% of the prison inmates. More than half of them declared that they needed medical care, legal advice, or counselling on the consequences of traumatic experiences. Among the asylum seekers 90% reported having suffered torture or other forms of inhuman and degrading treatment. Their declared needs for rehabilitation appeared to be similar to those of the previous group.

Conclusions: We did not intend to compare the two groups. The study showed the need of both groups for rehabilitation of some torture-related conditions. Preventive efforts by the staff of the law enforcement agencies should also be considered.

Introduction

In ACET, torture is understood as it is defined in the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, 1984. We share the opinion that “in earlier times the main purpose of torture was to get information or confession, to punish or to terrorise. Today the purpose is solely to destroy the individual and then use the broken person to spread terror throughout the rest of the community ... Torture is the worst possible kind of suppression one can inflict on the human being.”

A wide variety of torture techniques have been employed all over the world during the long history of human rights violations. They may be divided into three categories: physical, psychological, and combined. The consequences of torture are very complex, but can be divided broadly into physical, psychological, and social.

The legacy of post-communist Bulgaria has many aspects with respect to torture. On the one hand, the communist regime conducted political repression and torture; on the other, speaking publicly about torture and other human rights violations was taboo. As a result, the law enforcement agencies inherited to some extent an attitude to unlawful application of force, and society became less sensitive to certain human rights violations or more inclined to react with denial. Before 1997, the issue of torture in Bulgaria was obscure, e.g. with respect to public opinion and awareness, number of survivors, primary and secondary victims, need for rehabilitation, etc. We know that the political authorities today do not practice political suppression in Bulgaria. But we do not know to what extent they have succeeded in eradicating the above-mentioned attitude to unlawful application of force.

We started our research assuming that three separate groups of torture victims possibly existed in Bulgaria: victims of the previous regime; torture victims among the asylum seekers; and victims of contemporary police brutality and other forms of inhuman and degrading treatment. Accordingly, we planned and carried out studies among these groups. In addition, we studied the media coverage of the issue and analysed publications in the two most popular Bulgarian newspapers within a two-year period. The present article represents some of the findings concerning prison inmates and asylum seekers.

Methods

Two groups were studied. First, 105 male prison inmates. Ideally, the study should have been done in a group of people who had been released from detention or imprisonment. This was not possible because we did not succeed in contacting any organization of former prisoners. We distributed questionnaires among prisoners, realizing the prospects for misinformation. After processing the questionnaires, 90 seemed valid. Second, 49 asylum seekers (41 male, 8 female), studied in the waiting rooms of the National Bureau on Territorial Asylum and Refugees, and in the Refugee Office of the Bulgarian Red Cross. Asylum seekers with enormously different durations of stay in Bulgaria completed the questionnaires.

For the purposes of the study we adapted the Self Reporting Questionnaire of Dr Federico Allodi, Canada, including mainly parts A, B, and G of the original questionnaire. Some additional questions were included, concerning identification of the perpetrator and the assessment of respondents about their rehabilitation needs. The results were processed using descriptive analysis.

Results

The group of prison inmates

Their ages ranged from 20 to 55 years, 31.5 average. Torture during contacts with some of the law enforcement agencies was reported by 72%, distributed as follows: police authorities – 42.2%; investigation and prosecution authorities – 36.7%; pri
son authorities – 14.4%. With respect to the perpetrator: public official – 75.4%; someone acting at the instigation of a public official – 15.4%; someone acting with the consent of a public official – 9.2%; someone acting secretly from the public official – 9.2%. Except for the last, all the answers are included in the definition of torture.

Table 1. The commonest types of torture according to our findings. (n=90).

<table>
<thead>
<tr>
<th>Types of ill-treatment or torture</th>
<th>n</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>Physical assaults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slapping, kicking, or punching</td>
<td>51</td>
<td>56.7</td>
</tr>
<tr>
<td>Blows with clubs</td>
<td>38</td>
<td>42.2</td>
</tr>
<tr>
<td>Blows with other objects</td>
<td>15</td>
<td>16.7</td>
</tr>
<tr>
<td>Deprivation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- of food, comfort or communication</td>
<td>34</td>
<td>37.8</td>
</tr>
<tr>
<td>- of needed medication or medical care</td>
<td>35</td>
<td>38.9</td>
</tr>
<tr>
<td>Detention in overcrowded cells</td>
<td>30</td>
<td>33.3</td>
</tr>
<tr>
<td>Sensory over-stimulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constant noise</td>
<td>12</td>
<td>13.3</td>
</tr>
<tr>
<td>Powerful lights</td>
<td>13</td>
<td>14.4</td>
</tr>
<tr>
<td>Psychological torture and ill-treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Threats against person</td>
<td>36</td>
<td>40.0</td>
</tr>
<tr>
<td>False accusations</td>
<td>28</td>
<td>31.1</td>
</tr>
<tr>
<td>Verbal abuse</td>
<td>24</td>
<td>26.7</td>
</tr>
<tr>
<td>Threats against own life or family</td>
<td>13</td>
<td>14.4</td>
</tr>
</tbody>
</table>

No prisoner reported more sophisticated methods of torture, e.g. falanga, submarino, electric torture, etc. or existence of special torture chambers. We interpreted this as a good sign, indicating absence of an orderly system for repression and torture in Bulgaria. The deprivations listed above may reflect the economic crisis in the country.

Table 2. The influence of the torture on different aspects of the prisoners’ lives. (n=90).

<table>
<thead>
<tr>
<th>Sequelae reported</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illnesses</td>
<td>25</td>
<td>38.5</td>
</tr>
<tr>
<td>Mental disorders</td>
<td>15</td>
<td>23.0</td>
</tr>
<tr>
<td>Alcohol/drug abuse</td>
<td>6</td>
<td>9.2</td>
</tr>
<tr>
<td>Family life harmed</td>
<td>28</td>
<td>43.0</td>
</tr>
<tr>
<td>Relations with friends disturbed</td>
<td>21</td>
<td>32.3</td>
</tr>
<tr>
<td>Work efficiency jeopardized</td>
<td>13</td>
<td>20.0</td>
</tr>
</tbody>
</table>

The scores were slightly higher in the group that allegedly suffered torture, and anxiety symptoms were commoner than depressive and psychosomatic symptoms. The heightened suspiciousness and paranoid tendencies (someone trying to harm the prisoner) were perhaps not psychotic symptoms, but represented rather a defence mechanism related to being in prison.

Answers about need for rehabilitation: medical care – 42.2%; legal advice – 38.9%; counselling – 35.6%.

Table 3. The commonest mental symptoms among prisoners. (n=90).

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>among all (n=90)</th>
<th>allegedly tortured (n=65)</th>
<th>non tortured (n=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nervous, tense or worried</td>
<td>57 63.3</td>
<td>43 66.1</td>
<td>17 68</td>
</tr>
<tr>
<td>Sleep problems</td>
<td>44 48.9</td>
<td>35 53.8</td>
<td>11 44</td>
</tr>
<tr>
<td>Someone trying to harm him</td>
<td>37 41.1</td>
<td>33 50.8</td>
<td>10 40</td>
</tr>
<tr>
<td>Feels unhappy</td>
<td>38 42.2</td>
<td>32 49.2</td>
<td>5 20</td>
</tr>
<tr>
<td>Headache</td>
<td>40 44.4</td>
<td>31 47.7</td>
<td>9 36</td>
</tr>
<tr>
<td>Lost interest in the surrounding world</td>
<td>31 44.4</td>
<td>26 40.0</td>
<td>2 8</td>
</tr>
<tr>
<td>Always tired</td>
<td>28 31.1</td>
<td>24 36.9</td>
<td>7 28</td>
</tr>
<tr>
<td>Stomach discomfort</td>
<td>29 32.2</td>
<td>22 33.8</td>
<td>5 20</td>
</tr>
</tbody>
</table>

The group of asylum seekers

Bulgaria ratified the 1951 Geneva Convention, and its 1967 Protocol, on 12 May 1993 without reservations. Since the creation of the National Bureau for Territorial Asylum and Refugees in 1993, more than 2000 people have applied for asylum, most from countries in the Middle East and North Africa with poor human rights records.

The study included 49 asylum seekers, ages ranging from 21 to 49 years, 31.4 average. They had suffered the following: political persecution or harassment – 46.9%; arrest or detention – 32.6%; political imprisonment or concentration camp – 6.1%; temporary disappearance – 18.4%.

Forty-four persons (90%) reported torture or other forms of inhuman and degrading treatment. Answers with respect to the perpetrator: public official – 68.2%; someone acting in an official capacity – 54.5%; someone acting with the consent of a public official – 34.0%; someone acting at the instigation of a public official – 25.0%.

Table 4. The commonest types of torture experienced by the asylum seekers. (n=49).

<table>
<thead>
<tr>
<th>Types of ill treatment or torture</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical assaults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slapping, kicking, or punching</td>
<td>30</td>
<td>61.2</td>
</tr>
<tr>
<td>Blows with other objects</td>
<td>17</td>
<td>34.7</td>
</tr>
<tr>
<td>Exposure to cold or heat, prolonged standing up</td>
<td>11</td>
<td>22.4</td>
</tr>
<tr>
<td>Deprivation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- of food, comfort or communication</td>
<td>21</td>
<td>42.8</td>
</tr>
<tr>
<td>- of needed medication or medical care</td>
<td>14</td>
<td>28.6</td>
</tr>
<tr>
<td>Detention in overcrowded cells</td>
<td>20</td>
<td>40.8</td>
</tr>
<tr>
<td>Sensory over-stimulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constant noise</td>
<td>10</td>
<td>20.4</td>
</tr>
<tr>
<td>Powerful lights</td>
<td>8</td>
<td>16.3</td>
</tr>
<tr>
<td>Psychological torture and ill-treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal abuse</td>
<td>32</td>
<td>65.3</td>
</tr>
<tr>
<td>Threats against person</td>
<td>25</td>
<td>51.0</td>
</tr>
<tr>
<td>False accusations</td>
<td>23</td>
<td>46.9</td>
</tr>
<tr>
<td>Threats against own life or family</td>
<td>11</td>
<td>22.4</td>
</tr>
</tbody>
</table>

Again, no-one reported “sophisticated” methods of torture. One possible explanation, applicable also to the prisoners, is that personal contact and a trustful atmosphere are needed before most traumatic experiences are revealed.

Table 5. The influence of the torture on the asylum seekers’ lives. (n=49).

<table>
<thead>
<tr>
<th>Sequel reported</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illnesses and/or mental disorders</td>
<td>14</td>
<td>32.6</td>
</tr>
<tr>
<td>Alcohol/drug abuse</td>
<td>6</td>
<td>14.3</td>
</tr>
<tr>
<td>Family life disturbed</td>
<td>17</td>
<td>38.8</td>
</tr>
<tr>
<td>Relations with friends disturbed</td>
<td>19</td>
<td>42.8</td>
</tr>
<tr>
<td>Work efficiency jeopardized</td>
<td>17</td>
<td>38.8</td>
</tr>
</tbody>
</table>
Table 6. The commonest mental symptoms among asylum seekers. (n=49).

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Among all (n=49)</th>
<th>Allegedly tortured (n=44)</th>
<th>Non tortured (n=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nervous, tense or worried</td>
<td>27 (55.1)</td>
<td>23 (52.2)</td>
<td>1 (20)</td>
</tr>
<tr>
<td>Someone trying to harm him</td>
<td>24 (49.0)</td>
<td>23 (52.2)</td>
<td>-</td>
</tr>
<tr>
<td>Sleep problems</td>
<td>23 (46.9)</td>
<td>21 (47.7)</td>
<td>3 (60)</td>
</tr>
<tr>
<td>Feels unhappy</td>
<td>22 (44.9)</td>
<td>19 (43.1)</td>
<td>1 (20)</td>
</tr>
<tr>
<td>Easily tired</td>
<td>22 (44.9)</td>
<td>19 (43.1)</td>
<td>2 (40)</td>
</tr>
<tr>
<td>Headaches</td>
<td>21 (42.8)</td>
<td>19 (43.1)</td>
<td>2 (40)</td>
</tr>
<tr>
<td>Difficulty making decisions</td>
<td>21 (42.8)</td>
<td>19 (43.1)</td>
<td>1 (20)</td>
</tr>
</tbody>
</table>

The distribution of the mental symptoms is similar to that of the first group. Suspiciousness and paranoid tendencies here are even higher, probably amplified by the social displacement syndrome described by Tyhurst.6

Answers about need for rehabilitation: medical care - 51.0%; legal advice - 67.3%; counselling - 42.8%.

Conclusions
In drawing conclusions it should be kept in mind that we did not aim to compare the two groups. An additional limitation was the lack of opportunity for personal contact between the research team and the respondents. The design of the study had some features of epidemiological studies, but we were not able to investigate a large enough sample. Although the respondents took part voluntarily, most were in a rather unfavourable position, in prison or desperately in need of asylum. We should assume that some of them, intentionally or not, exaggerated reported experiences of torture and its consequences. This is not to underestimate the humiliation of human dignity that these people possibly experienced.

Our first group included only currently imprisoned people. This probably influenced their answers in two ways: 1) allegations against the prison administration were very few; 2) the well-known attitude of prisoners, i.e. to complain about everybody and everything, probably increased torture allegations.

Nevertheless, the results of our study directed our attention towards the needs of 1) rehabilitation opportunities for former prisoners who suffered torture; and 2) proactive preventive efforts among the staff of law enforcement agencies in Bulgaria.

Turning to the asylum seekers, again a significant proportion of the respondents allegedly suffered torture and/or other forms of cruel, inhuman or degrading treatment. Most of them reported physical, psychological, and social consequences of this experience, and requested medical, psychological, and legal help. Accordingly, the activities of ACET related to asylum seekers should be directed 1) to providing rehabilitation services to torture victims, 2) to organizing training seminars for the staff members of the National Bureau on Territorial Asylum and Refugees and other organizations working with refugees, seminars on psychological reactions of refugees and challenges related to the care of torture victims, and 3) to increasing public awareness of the issue.

References
The late ear, nose, and throat region sequelae of torture

Ruth Sinding, MD, Otorhinolaryngologist* & Knud Smidt-Nielsen, MD**

Abstract
The purpose of the present study was to examine the late sequelae of torture to the ear, nose and throat region, because they were considered to occur more frequently than previously assumed.

The material consisted of 63 torture survivors who had been referred to the Rehabilitation and Research Centre for Torture Victims (RCT), mainly coming from the Middle East. Following routine medical examination by a general practitioner at RCT, consecutive clients were referred to an ear, nose and throat specialist for registration of their symptoms and signs.

The results showed that 95% of the survivors indicated that they had been beaten on the head and neck, while the telefono form of torture was described by 17%.

Sixty had torture-related symptoms, an average of 2.7 symptoms per survivor. The commonest were tinnitus (75%), decreased hearing (46%), impaired air passage through the nose (41%), and dizziness (40%).

There was a significant relationship between telefono and tinnitus.

The conclusion was that late sequelae of torture of the ear, nose and throat region are much more common and more serious than previously considered. We recommend examination by an ear, nose and throat specialist of all torture survivors who have gone through trauma to the head and neck.

There are only few descriptions of the ear, nose, and throat region sequelae following torture, and almost none about late sequelae. Rasmussen found that 21% of torture victims complained of late ear, nose and throat symptoms. Considering the serious chronic sequelae that torture survivors risk, and the quite good chances of treating them, it seems strange that so little has been published about the subject. The present authors thought that the sequelae from the ear, nose and throat were much more frequent than previously considered, and they therefore decided to carry out a prospective study aiming to
1. register late symptoms from ear, nose, and throat in torture survivors
2. note the objective findings from a specialist’s examination
3. compare symptoms and signs, and
4. find out whether there was any connection between these findings and specific forms of torture.

Methods
All consecutive clients referred to the Rehabilitation and Research Centre for Torture Victims (RCT) from 13 January 1995 to 15 August 1996 were asked about symptoms from the ear, nose and throat at their general medical examination. This information was transferred to a questionnaire, and the clients were referred to the same specialist otolaryngologist for examination and registration of objective findings according to the IC 10-system (International WHO classification).

After history taking by the specialist, the outer ear, auditory meatus, ear drums, nose, mouth, fauces, rhinopharynx, and pharynx were examined routinely, and the vestibular apparatus when indicated by the history. Audiograms were taken from all the clients, and tympanometry was performed when indicated. Patients who complained of vertigo had a caloric test using Hallpike’s method. An interpreter was present at all the examinations. The interpreters became very familiar with the various procedures, and were thus a valuable support for both patients and specialist. The examination took place in a friendly atmosphere and there was good patient cooperation. All the procedures were explained carefully, and nobody refused to take part in the examinations.

Material
A total of 63 clients, referred to RCT because of torture sequelae, took part in the study: 51 men and 12 women, average age 37 years, range 11 to 54 (table 1).

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>F</th>
<th>M</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>11-20</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>21-30</td>
<td>1</td>
<td>7</td>
<td>8</td>
<td>13%</td>
</tr>
<tr>
<td>31-40</td>
<td>8</td>
<td>28</td>
<td>36</td>
<td>57%</td>
</tr>
<tr>
<td>41-50</td>
<td>3</td>
<td>13</td>
<td>16</td>
<td>25%</td>
</tr>
<tr>
<td>51-54</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>51</td>
<td>63</td>
<td>100%</td>
</tr>
</tbody>
</table>

The clients’ nationalities are shown in table 2; 60 from the Middle East (Iran, Iraq, Turkey, and stateless Palestinians), one each from Chile, Afghanistan, and the former Yugoslavia. The average period since the first exposure to torture was 14.9 years. All had been granted asylum in Denmark.

* Consultant to RCT

** RCT
Borgergade 13
1014 Copenhagen K
Denmark
Vertigo, probably otogenic

Table 4. Throat problems. n=11

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iran</td>
<td>4</td>
<td>6%</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Yemen</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Jordan</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Syria</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Kuwait</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Lebanon</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Iraq</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>16%</td>
</tr>
</tbody>
</table>

Table 2. Nationality and sex. n=63.

<table>
<thead>
<tr>
<th>Nationality</th>
<th>F</th>
<th>M</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iraq</td>
<td>5</td>
<td>23</td>
<td>28</td>
</tr>
<tr>
<td>Lebanon</td>
<td>7</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Turkey</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Kuwait</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Kurdistan</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Stateless Palestians</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Chile</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Yugoslavia</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Syria</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Bahrain</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Gaza</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Iran</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>51</td>
<td>63</td>
</tr>
</tbody>
</table>

Results

Types of torture that were registered included blows to the head and neck, 60 persons (95%), and blows with both hands to the ears at the same time, called teléfono, 11 persons (17%). Blows to the head and neck often led to unconsciousness, several times in some victims. Apart from these blows, electrical torture to the ears was common, and submersion in dirty water (submarino). Furthermore, the prisonners were often exposed to continuous loud noise or beating on a metal bucket that had been placed over their heads. Poor hygiene can also have added to their ear, nose and throat symptoms. Other conditions that can be mentioned include the length of imprisonment, extreme climatic conditions and low body temperature, exhaustion, poor nutrition, and lack of adequate medical attention.

Sixty persons (95%) complained of sequelae from torture related to the ear, nose and throat (table 3), an average of 2.37 complaints per patient. The otorhinolaryngological findings are shown in table 4. The patients were youngish, without otological symptoms before the torture, apart from a few whose adenoids had been removed, and one who had otitis as a child.

Table 3. Ear, nose and throat symptoms. n=63.

<table>
<thead>
<tr>
<th>The commonest symptoms</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tinnitus</td>
<td>47</td>
<td>75%</td>
</tr>
<tr>
<td>Impaired hearing</td>
<td>29</td>
<td>46%</td>
</tr>
<tr>
<td>Dizziness</td>
<td>25</td>
<td>40%</td>
</tr>
<tr>
<td>Reduced air passage through the nose</td>
<td>26</td>
<td>41%</td>
</tr>
<tr>
<td>Throat problems</td>
<td>11</td>
<td>16%</td>
</tr>
<tr>
<td>Pain in the ear</td>
<td>7</td>
<td>11%</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>16%</td>
</tr>
</tbody>
</table>

Table 4. Abnormal signs at the otological examination. n=63.

<table>
<thead>
<tr>
<th>Signs</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired hearing</td>
<td>22</td>
<td>35%</td>
</tr>
<tr>
<td>Vertigo, probably otogenic</td>
<td>3</td>
<td>4%</td>
</tr>
<tr>
<td>Deviated nasal septum</td>
<td>23</td>
<td>37%</td>
</tr>
<tr>
<td>Previous nasal fracture</td>
<td>11</td>
<td>17%</td>
</tr>
<tr>
<td>Otitis externa</td>
<td>23</td>
<td>37%</td>
</tr>
</tbody>
</table>

Tinnitus, the commonest symptom, was present in 47 patients (75%), often so serious as to disturb sleep at night and to reduce the quality of life during the day. There was a significant correlation between teléfono and tinnitus (p=0.052, Fisher’s exact test).

Twenty-nine (46%) complained of reduced hearing; the diagnosis was confirmed by audiometry in 22 of them (76%). There was no significant relation between teléfono and reduced hearing.

Twenty-five persons (40%) complained of different forms of dizziness. Oto-neurological examination showed discrete neurological changes such as swaying at the Romberg test, deviation when walking blindfolded, poor finger to finger test, but good finger to nose test. Four persons had initial nystagmus when looking to the side. Only three cases had a pathological caloric test. They were referred for further examination, at which one was found to have a small loose os­scle in the posterior semicircular canal. The other two clients did not want further examination. The remaining 23 clients were registered with the diagnosis: vertigo without otogenic cause.

A very common problem, 26 patients (41%), was decreased air passage through the nose. Twenty-three of them had a deviated nasal septum, in 11 the result of a fractured nose. Dryness of the pharynx was a complaint in 11 cases (16%), and some complained of snoring.

Seven clients (11%) complained of pain in the ear, and there were 23 cases of external otitis in the whole study group, i.e. 37%. The ear pain was caused by the external otitis in almost all these cases.

The term other included various symptoms that were not directly related to the torture, e.g. nosebleed, common cold, hay fever. As expected, the otological examination also showed signs not related to the torture, e.g. ear wax and intercurrent conditions such as acute tonsillitis, sinusitis, and pharyngitis. These have not been included in this study. One case with a toxic goitre was found by chance; it had probably developed in connection with the imprisonment and torture since the patient had not previously had symptoms of thyroid disease.

Discussion

The present study found that sequelae from torture in relation to the ear, nose and throat were much commoner than has previously been reported: 60/63 (95%) of the torture survivors had symptoms that could be related to their torture. The commonest were tinnitus, impaired hearing, dizziness, and decreased air passage through the nose. All the survivors had more than one symptom. None had previous serious complaints from the ear, nose, and throat. As already mentioned, this prospective study was carried out because of the extraordinarily high number of complaints from the above mentioned areas that were registered from the clients at RCT. The numbers were indeed surprisingly high. One reason might be that the clients at RCT are serious cases with many traumas and symptoms. In addition, the specialist examination revealed every symptom and sign, probably including symptoms that may have been present for a long time, but had not been given the same attention by the patient as, for example, more serious mental problems and chronic pain.

Tinnitus was by far the commonest and most serious symptom (75%). Graessner mentions two paramount conditions: the loss of silence, and the constant reminder of the trauma that caused the noise in the ears, both with a negative influence on the quality of life. Tinnitus is serious, not
least because it is very difficult to treat, even for specialist clinics, when available. Treatment usually has to be supplemented by psychotherapy, and possibly surgery. Tinnitus was significantly related to the form of torture called telefonio, as previously demonstrated.

Ninety-six percent of the clients said that they had been beaten on the neck and head. In cases where there were no otological explanations of tinnitus, whiplash injury could be suspected to be the cause of the complaint. Patients have described how, while blindfolded, they were often pushed forward, violently and unexpectedly, without being able to take precautions. Furthermore, victims who were suspended by one or both legs in a fan were often beaten, unexpectedly, on the back with a sandbag, again without being able to take any precautions. Palestinians have also spoken of systematic beatings on the neck.

Forty-six clients complained of decreased hearing, confirmed by audiometry in the majority. This was yet another handicap for the survivors to live with, and may be one of several reasons for their problems in learning foreign languages and in adapting to society. Several patients were referred for hearing aids, and other measures included changing the sound of the doorbell or the telephone.

Forty percent complained of dizziness, but only three cases had otogenic signs of relevant damage. There were, however, many diffuse neurological findings in connection with the examination, and one might talk about a post-traumatic vertigo syndrome, just like a post-commotional syndrome.

The decreased air passage through the nose, present in 41%, also led to impaired breathing, dryness of the throat, and snoring. Recurrent pharyngitis was common, perhaps due to the deviation of the nasal septum and previous fracture of the nasal bone. Severe cases of impaired passage were referred to the University Hospital in Copenhagen (Righospitalet) for operation.

Otalgia was almost always related to the presence of external otitis, diagnosed in 37% of the clients. This condition may have been caused by submarino, submerging the head in dirty water, like the many cases that follow swimming in less than clean water in swimming pools, etc.

References

Acknowledgement
We wish to thank Dr. Ole Vedel Rasmussen for his help in finalizing this article.

Selected list of publications received in the IRCT International Documentation Centre

Presentation of recent torture survivors to a family practice center / Gavagan, Thomas ; Martines, Antonio. – In: Journal of family practice; vol. 44, no. 2. – 19970200. – p. 209-212.


Horror e impunidad / Red de Apoyo por la Justicia y la Paz. – Caracas : Red de Apoyo por la Justicia y la Paz, 19960800. – 241 p.


Rapport : Turquie no. 3 : torture et prisons : nouveaux tours de vis / Özden, Malik. – Geneva : APT ; Association pour la Prevention de la Torture, 19960700. – 36 p. – Sous la direction de Carol Mottet, Responsable de programmes en Europe, APT.

Report : Turkey file no. 3 : torture and prisons: from bad to worse / Özden, Malik. – Geneva : APT ; Association for the Prevention of Torture, 19960700. – 26 p. – Under the direction of Carol Mottet, Programme Officer for Europe. APT.

Turkey authorizes publication of report by Council of Europe Anti-Torture Committee

STRASBOURG, 23.02.99 – The Turkish Government has authorized publication of the report drawn up by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) after its visit to Turkey in October 1997. The visit report is published together with the interim response of the Turkish authorities.

Under Article 11 of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, the information gathered by the Committee in relation to a visit, its report and its consultations with the State concerned are confidential. However, the State may decide to lift the rule of confidentiality provided for in the Convention.

The CPT has to date carried out seven visits to Turkey – in 1990, 1991, 1992, 1994, 1996 (two visits) and 1997. Public statements making known the Committee’s concerns about the treatment of persons in police custody were issued in December 1992 and December 1996.

In the report on its visit from 5 to 17 October 1997, the CPT analyses whether recently-adopted measures to combat torture and other forms of ill-treatment by law enforcement officials are being properly implemented. The CPT also sets out its findings regarding prisons and reformatories visited in Izmir, Mersin and Ünye, as well as psychiatric establishments in Istanbul and Samsun.

In their interim response, the Turkish authorities emphasize the progress made in their country in the field of human rights during recent years, but also recognize the need to introduce and effectively implement additional improvements. The response addresses many of the issues raised by the CPT in its visit report and indicates that further information will be provided in a follow-up report to be presented later this year. The Turkish authorities also reaffirm their readiness to maintain close cooperation with the CPT.

The CPT was set under the 1987 European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. All 40 member States of the Council of Europe are bound by the Convention: Albania, Andorra, Austria, Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania (as from 1 March 1999), Luxembourg, Malta, Moldova, the Netherlands, Norway, Poland, Portugal, Romania, the Russian Federation, San Marino, Slovakia, Slovenia, Spain, Sweden, Switzerland, “The Former Yugoslav Republic of Macedonia”, Turkey, Ukraine, and the United Kingdom.

The CPT is composed of persons from a variety of backgrounds: lawyers, doctors, prison experts, persons with parliamentary experience, etc.

The Committee’s task is to examine the treatment of persons deprived of their liberty. For this purpose, it is entitled to visit any place where such persons are held by a public authority. It may formulate recommendations to strengthen, if necessary, their protection against torture and inhuman or degrading treatment or punishment.

The CPT organizes periodic visits as well as other visits which appear to it to be required in the circumstances.

The CPT’s report on its visit to Turkey in October 1997 (110 pages) and the interim response of the Turkish authorities (103 pages) can be obtained from:

• The Council of Europe Press Department
tel. +33(0)3 88 41 25 97
fax (0)3 88 4127 90
e-mail pressunit@coe.fr

• The CPT’s Secretariat
tel. +33(0)3 88 41 23 88
fax (0)3 88 41 27 72
e-mail cptdoc@coe.fr

• The CPT’s Internet site: www.cpt.coe.fr

(Source: CPT Press Release, 2 March 1999)
Bhutan does not have a written constitution or a bill of rights. The institution of absolute monarchy, with inherent feudal characteristics, has ruled the country since 1907. The ruling elite constitutes a very small proportion of the country’s population. To hold on to power, the government has been violating the fundamental rights of the Bhutanese people against international norms. The judiciary is not independent, and there is no lawyer with a law degree in the country. There is no system of defence counsel. There is no freedom of speech, expression, assembly, etc. Political parties and human rights groups are banned. The study of law and political sciences is not allowed. Anyone who speaks for the general public and in the interests of the country, which may not suit the ruling elite, is labelled anti-national, and may face the death sentence.

The Human Rights Movement of 1952 led to the packing of Mahasur Chhetri of Chirang district in a sack; while he was still alive it was thrown into the Sankosh river. Similarly, Mr. Garja Man Gurung of Samchi District disappeared inside a Dzong (fort) in Paro where he had gone to submit the land taxes of the district. The spiritual head of the drukpa kargyupa sect of Buddhism, Shabdrung Rinpoche, the present incarnation, lives in exile in Manali in India after the previous two incarnations had been brutally murdered by the Government of Bhutan for the sake of power. Hundreds of people from eastern Bhutan have taken asylum in Arunachal Pradesh in India since 1962. Hundreds have disappeared through no fault of their own.

Arbitrary arrest, detention, torture, burning and flogging, starvation, overcrowding, absence of toilet and bathing facilities, inadequate food, food unfit for human consumption served once a day, confinement incomunicado for long periods, no communication with the outside world, relatives not allowed to visit even once, detention without charge and trial, are prevalent in today’s Bhutan. The prisoners are continuously handcuffed or shackled, while they are made to carry out heavy manual work. Medical facilities are not made available until the prisoner reaches the last stages. He is released on the verge of death so that the government cannot be blamed for his death in custody.

Every aspect of life, social, political, economic, religious, is controlled by the government. No social groups or NGOs exist in Bhutan to help and counsel torture victims because they are totally banned. The only options left are to live as such, or die, or flee the country. In 1990, when the people of southern Bhutan protested peacefully and petitioned the king for their basic rights, such as the right to nationality and citizenship and other fundamental human rights, they had to face the same consequences and ultimately flee the country, to lead the life of refugees for the past seven years.

At present, over 100,000 Bhutanese refugees are living in seven camps in eastern Nepal, monitored by UNHCR and the government of Nepal. Hundreds of refugees who were tortured by the Royal Bhutan Police and Military forces were treated by the Centre for Victims of Torture (CVICT) in Nepal in the initial days, and are now being treated by Save the Children Fund (UK). Since 1997, the eastern Bhutanese have been tortured in the same way because of their peaceful protest, and hundreds of them have fled the country to nearby north-east India and Nepal. The Bhutanese people have been living in a state of terror since 1990, with no certainty or security in their lives.

Pressures from the international community
Since 1992, following pressure from the international community and Amnesty International, the government of Bhutan has allowed the International Committee of the Red Cross (ICRC) to visit the country, but access was given to only one prison, located in the capital, Thimphu. They are not allowed to visit the southern and eastern parts of the country. The same with Amnesty International. Consequently, hundreds of Bhutanese people are still languishing in pris-
on in inhuman conditions with no access to the outside world, without charge or trial.

Therefore it is only the international community, international NGOs, and the donor countries to Bhutan that can bring considerable pressure to the government of Bhutan, to allow them to visit the country in order to monitor the situation and ask the government drastically to improve the human rights conditions in Bhutan. Bhutan depends heavily on donor countries for its economy, being one of the least developed countries in the world.

India is the major donor and the closest ally of Bhutan. Almost all the European countries, including the Scandinavian countries, Japan, and USA contribute to the development of Bhutan. From Denmark, the Danish International Development Agency (DANIDA) contributes with a major share in the development projects in Bhutan. Rehabilitation can only be initiated under international pressure.

“Bhutanization”
The ruling coterie constitutes a minor proportion of the country’s population. To safeguard their interests, the practices adopted in the system are against the international human rights norms. The judiciary is not independent of the executive, and functions according to the wishes of the king. The lawyers are appointed without any legal background and are even without qualifications in law degrees. There is no freedom of speech, expression, or formation of associations/organizations. Opposition is not tolerated and political parties and human rights groups are banned. People have to obey the rules framed in the interest of the ruling elite, though the rules violate basic human rights.

Atrocities and human rights violations are the government’s daily routine. They cannot come in to the open because of the system and the ignorance of the common people. Anyone trying to protest would face the same consequences as befell their friends. In the late 1980s, the government went a step further and imposed “Bhutanization” under the rhetoric of “One Nation, One People”, whereby all Bhutanese, irrespective of their ethnic background, were forced to wear the dress of the northern Bhutanese, follow the tradition and culture of the ruling class, read and write their language, and practice their religion.

The government enacted a new Citizenship Act in 1995 with a view to depriving the citizenship rights to as many southern Bhutanese as possible. Mr. T.N. Rizal, a Royal Advisory councillor, appealed to the king to reconsider the implementation of the new Citizenship Act. However, he was arrested, tortured, and stripped of his public office on the grounds of opposing government policies. He was later abducted from Nepal, and still languishes in prison in Bhutan as a prisoner of conscience of Amnesty International, together with hundreds of other prisoners from southern and eastern Bhutan without any charges or trial.

There was a peaceful protest in September/October 1990 against these discriminatory policies of the government in all the southern districts of the country. This was taken as an act of treason by the government, which deployed heavy military and para-military forces in each of the five districts, leading to mass indiscriminate arrests of innocent villagers and clergymen, arbitrary detention, looting, plunder, rape and gang rape, torture and hunting down of human rights activists even outside the country with the help of anti-social elements or by unlawful means. All basic social facilities were abruptly ended, school health facilities were turned into detention centres, and army barracks, hospitals, and infirmaries were closed to the public. Many people lost their lives during detention in prison due to inhuman and degrading treatment and torture.

For further information about Bhutan, please turn to p. 9.
European conference on psychotrauma, asylum seekers, refugees: pitfalls in treatment, the political and judicial context

December 3 and 4, 1998, 's-Hertogenbosch/Vught, the Netherlands

Boris Drozdek, Psychiatrist*

Which pitfalls do therapists encounter when they help asylum seekers and refugees who have had psycho-traumatic experiences, and to what extent does the political and judicial context in which this help occurs influence it? The conference programme consisted of two parts. On both mornings plenary sessions were held, at which qualified speakers, with an international reputation in the field of psychotraumatology, presented the framework of the debate, the state-of-the-art with respect to helping refugees and asylum seekers, and the results of their most recent research.

Stuart Turner (Traumatic Stress Clinic, UK) addressed the congress. The focus of his presentation was the complexity of the term PTSD (Post Traumatic Stress Disorder), and its effect on the treatment of PTSD. Hans Hovens (Centrum '45, the Netherlands) discussed the possibilities for treating traumatized asylum seekers, considering the restrictive influence of their as yet undefined judicial and existential status. The question is not whether to offer help to traumatized asylum seekers, but what kind of help will be of the most use to them. Boris Drozdek (Day-hospital for traumatized asylum seekers and refugees) presented the dilemmas surrounding the subject of treating traumatized asylum seekers. He called for a more hands-on and caring approach to mental health treatment, and for the treatment to fit the patient. He also defended the opinion that asylum seekers should not have to wait for the outcome of the judicial process before being treated for their psychological problems. Eleanor Major (Psychosocial Center for Refugees, Norway) presented the results of her most recent study into the transgenerational transmission of trauma, and the influence of traumatized refugee parents on their children. She emphasized that, despite the traumatic experiences and consequent psychological damage they had suffered, refugee parents were still able to bring up their children in a proper and responsible manner.

The second morning was opened by Marianne Kastrup (Rehabilitation and Research Centre for Torture Victims, Denmark). Her paper covered the international obligations, which most countries have and which few meet, with respect to educational programmes and courses concerning the problems of torture victims. In most European countries these problems receive little attention in the training programmes for therapists at various levels. Guus van der Veer (Pharos Foundation, the Netherlands) spoke about his own experiences and the dilemmas surrounding the psychotherapeutic approach to traumatized asylum seekers and refugees. He also dealt in great detail with the themes of tailor-made therapy, individual treatment and the questions of working through traumatic experiences, and helping clients to cope with loneliness. It appears that it is often not the trauma that is the greatest problem for traumatized asylum seekers, but loneliness, the lack of social contact, and the feeling of being unwelcome. Christina Pourgourides (Medical Foundation, UK) warned about the clear social and political dimensions of violence and war traumas. Simply focusing on the PTSD symptoms and treating them is a simplification of the problem and does not lead to effective treatment. According to her, it is a typically Western approach to define the suffering of clients in this way.

In both parallel sessions, international experts in the various fields of therapeutic methods used for treating traumatized asylum seekers and refugees presented and discussed their techniques with the public. Also during these sessions, the emphasis was on pitfalls in treatment, or in other words: what must the treatment take into account when working with this group, which is different from working with other groups? A wide range of verbal and experiential methods were presented - from psychotherapy, cognitive behavioural therapy, hypnotherapy, systemic therapy, “rebalancing”, and empowerment to psychomotor therapy, music therapy, body dialogue, physiotherapy, creative art therapy, and sociotherapy.

Attention was also paid to the secondary traumatization of therapists, aftercare and employment rehabilitation of asylum seekers and refugees, working with the help of interpreters, treating traumatized children and the children of traumatized refugees, and somatic aspects of traumatized asylum seekers and refugees. Gorana Simunkovic from Croatia discussed the pitfalls in the training of professional and non-professional therapists, and the treatment of torture victims. Andreas Maercker (Germany) presented the results of his epidemiological research, and a report was presented which was prepared for the French government on the situation of refugees in France.

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CONFERENCE REPORTS

This congress was a success and certainly achieved its goals: to create a context in which therapists can exchange their visions, opinions and methods of treatment, and to create a European platform of professionals and experts in order not only to improve treatment, but also to send a clear signal to politicians and governments. The various schools of thought in the treatment of trauma did actually come closer together in an attempt to combine the best of each one, to create a more effective and humane reception of the victims of political violence and war, asylum seekers, and refugees in Europe.

BOOK REVIEWS

Important contribution to the literature about psychotherapy with torture survivors


An increasing number of health professionals and other formal and informal helpers all over the world are faced with the challenge of assisting victims of torture and other forms of organized violence in their efforts to restore their outer and inner worlds. The publishers of “Treating victims of Torture and Violence” claim that this is “the definitive manual for therapists treating victims of torture, prisoners of war, and casualties of forced migration”. If so, the book should be assured an extensive worldwide readership.

Peter Elsass is Professor of Clinical Psychology at the University of Copenhagen, Denmark. He has been affiliated to the Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen for ten years, and this book is to some extent based on his experiences as a psychotherapy supervisor and researcher at the centre. He should thus be in an excellent position to address the topic of the book.

The book starts with a chapter about torture, violence, and aggression, followed by a discussion of diagnostic descriptions and the psychodynamic understanding of trauma-provoked conditions.

In the chapter on psychotherapeutic treatment, supportive interventions and a combination of cognitive and psychodynamic viewpoints are emphasized. The author then provides an extensive discussion of the cultural psychological aspects of torture and its consequences, and of psychotherapy in a transcultural context. He has also included a chapter presenting his follow-up study of patients who had been treated at the RCT as a postscript, and the quantitative aspects of this study as an appendix.

The author has reviewed an impressive amount of relevant literature. He has wisely chosen to include views from different professional traditions, particularly from the field of psychology, psychiatry, and anthropology. The summaries and clinical applications at the end of each chapter increase the value of the book. They contain a lot of clinically useful advice based on the author’s own and his colleagues’ experiences, and his reading of the literature. The author does not promote any particular “partisan” therapeutic approach, which makes it relevant for psychotherapists of different persuasions.

Some minor critical remarks. With coverage of such an extensive list of topics, it would have been useful had the book been more extensively indexed. Further, the author refers several times to “Western” culture, “Western” psychiatry, etc., as opposed to “non-Western”. Such dichotomies are quite frequently used in mental health literature. Although didactically useful, these concepts may be too general considering the great variation and complexities of societies and cultures. I would also have welcomed an even greater integration of clinical experiences and research findings from RCT in the main text, including illustrative clinical vignettes.

In spite of all the material covered in this book, there is a great need for further qualitative and quantitative studies of psychotherapy and other forms of treatment with survivors of organized violence, both in scientific and popularized forms, in order to improve the quality and the evidence base of our clinical practice.

In conclusion, this book is thus not a “definitive therapeutic manual” – in fact one of the assets of the book is that it does not come across as an “Americanstyle” manual. But it is well researched and well written, and it deserves to be widely read. In particular this is an important book for therapists treating patients who have experienced torture and
other forms of organized violence. They are likely to find it informative, at times also challenging their own opinions. Other mental health professionals should also find it stimulating, providing new and varied perspectives on a complex therapeutic field. It will also be a valuable book for other educated readers who are trying to understand evil in general and torture in particular - as well as the healing forces that may counteract it. It should be available in all the medical, psychosocial, and psychotherapeutic centres serving the survivors, and also in good academic libraries.

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Bridge between science and alternative healing:
 victims of organized violence


At the end of the 20th century, it is more recognized that culture has an essential role in the prevention, treatment, and rehabilitation of torture survivors and their families. However, the social and anthropological values, and the ancestral wisdom of the people of the Third World countries, are still underestimated. This knowledge has been neglected by the Western approach because it is considered magic and non-scientific.

During the last four years, we have been trying in Honduras to build a bridge between Western and non-Western views and practices in working with torture survivors and their families. Our experience has been based on cultural values, combining holistic, alternative medicine with academic medicine, and transforming the nature of our institution in a process of collaboration with the community.

One of the few systematic sources that deal with this issue is Karl Peltzer's book "Counselling and Psychotherapy of Victims of Organised Violence in Sociocultural Context", published in 1996 by the IKO-Verlag für Interkulturelle Kommunikation.

Dr Inge Genefke, IRCT, states in the foreword: "This is a most valuable book, in which the author shares with us useful ethnocultural knowledge with the humility and generosity which characterize the competent health professional."

One of the main purposes of the book is to consider "culture, community and society in the process of developing psychosocial problems due to organized violence and presenting ways of ameliorating and healing problems at those levels".

In 325 pages, eight chapters, several tables, documented cases, and excellent literature review, Dr Peltzer has achieved the principal objectives of his book.

Three models of counselling and therapy services, i.e. Malawi-IRCT, Uganda-IPSER, and Germany-DW, are compared and analysed with respect to target groups, team structure, national staff, therapeutic focus, therapeutic approach, research, ideology, and project centres.

According to the author, the Uganda-IPSER service is community-based, the therapeutic approach is developed by lay counsellors working with community resources, and the ideological frameworks are ecological, systemic, experiential, anthropological, public health, and relativistic. The German-DW is based on medical consultancy, the therapeutic approach, professional services, the activating resources depend on the exile community, and the conception is Christian, biblical-theological, and psychosocial multicultural.

With respect to ethnocultural assessment, Dr Peltzer estimated that most psychological tests have been developed and standardized in Europe and America, and none or only few in non-Western countries. Most of the tests reflect the norms and values of Western culture. Lack of consideration of these factors will lead to wrong diagnosis and treatment of the individual cases and groups.

The ethnocultural construction of organized violence, torture, rape, trauma, and war also differ with respect to Western and non-Western approaches.

The author agrees with other investigators that the diagnostic category PTSD does not appear fully applicable to the African victims, because in the African context mind/affect and the body are more conceptualized as a unity. In Malawi the thoughts are believed to be in the heart, not in the head.

According to Dr Peltzer, ethnocultural intervention is relevant during treatment of victims of organized violence. Among these traditional and spiritual techniques are divination, rituals to bring the spirit of the dead home, symbolic burial in the absence of a corpse, rituals (cleansing), family counselling, and herbal treatment.

An integrative model for ethnocultural counselling and psychotherapy is suggested by the author, on the basis of qualitative analysis of patient and therapist interactions, case discussions, supervision, evaluation of treatment, and literature review. The most innovative aspects of this suggestion are the gender considerations, sociopolitical counselling, psychotherapy as liberation, cultural specialists such as traditional healers, and sociopolitical integration.
This excellent book is based on research of the sociocultural context of the victims of organized violence from different perspectives; it describes the author's experiences as therapist, consultant, and researcher.

Finally, I highly recommend Dr Peltzer's book for developing reflection, research, and new thoughts about the necessity of changing the traditional model or conception of the centres that provide services and treatment for the victims of torture and organized violence.

Juan Almendares, MD. Executive Director Centre for the Prevention, Treatment and Rehabilitation of Torture Victims and Their Relatives (CPTRT) Apartado Postal 5377 Tegucigalpa MDC Honduras

A brilliant focus on genocide and the conspiracy of silence


This is an important book which will be a reference text for many years to come. Its importance does not stem from it being the definitive text on the field - no text can yet claim this - but from being the first text to bring the issue of the long-term effects of trauma to the fore. It is not easy to do justice to such a large text in a short review, but some key comments can be made.

Firstly, the scope is enormous: the Holocaust, World War II, the genocide in Armenia and Cambodia, the Vietnam War, repression in the former Communist states and the Third World, the genocide of indigenous peoples, crime and domestic violence, and the latest findings in psychobiology. Thirty-nine chapters covering some of the more horrible aspects of human nature, but all focusing on the question about the extent to which what might be termed epidemic violence has long-term, inter-generational effects. Although in fairness little of the evidence reaches the kind of scientific rigour that is required to answer this question, the inferential picture - from psychodynamic case studies, epidemiology, social anthropological investigations, and brain chemistry studies - indicates considerable cause for concern. The picture that emerges from all the research, notwithstanding its flaws, must make all aware that the long-term implications of epidemic violence may be having a demonstrable effect upon the ways in which many societies currently function.

Secondly, the book makes it clear that it is not a simple issue to study this problem. A longitudinal problem is not easily studied by cross-sectional studies, nor is a complex systemic problem amenable to studies of simple linear relationships. For this reason, Danieli herself proposes a systemic perspective - the TCMI Framework. Whilst the TCMI Framework may be a useful organizing device, it is not apparent that a more established such as General Systems Theory might not have been used. However, whether this is an issue of semantics or not, the point about the range of factors to be considered in understanding the multi-generational effects of trauma is well taken. The strength of the systemic view here is the ability to integrate findings from many different contexts and theoretical perspectives.

Thirdly, the conspiracy of silence is shown once again to be an important mechanism in retarding our understanding. It is interesting to see how little work has been done in reality. Few people will have any knowledge about the genocide in Armenia or have seen that one of the major consequences of colonialism was genocide and the subsequent collapse of cultures. To start looking at the multi-generational legacy of trauma means to start re-interpretting history. History becomes the study of victims of mass violence and the subsequent collapse of cultures, which was a point Franz Fanon was making not so long ago.

Fourthly, throughout the book, studies implicate the role of culture as an important factor in understanding trauma. Not merely as a protective feature, which is how we frequently view it today, but also as a feature transmitting further trauma. However, the most dramatic evidence on the role of culture comes from the studies where culture is destroyed massively - in Armenia, North America, Australia, to mention a few - and we still have no clear idea of the effects on the many indigenous cultures now under threat and attack, such as in South and Central America.

Finally, it is noteworthy that much of the work implicates justice as an important aspect of work in trauma, which may not sit easily with those who see themselves as healers only. As Richard Goldstone comments "...I don't think that justice depends on peace, but I think that peace depends on justice" [p.684]. A concern with justice emerges out of a broad framework such as that posed by Danieli, and few will not be convinced that the violence in the Balkans came out of multi-generational legacies of trauma, a conspiracy of silence, and a lack of real substantial justice. Impunity here becomes the tool by which silence is ensured, and also the mechanism by which trauma is attenuated over the generations.

On a personal note, this was a very disturbing book to read. Behind the dry academic text lie the histories of some of mankind's more shameful stories, and it was rather horri-
BOOK REVIEWS

fying to see the 20th century laid out as a story of genocide and cruelty. I wondered about our wonderful modern world and also whether the price we have paid for it is worth it all. Danieli says it best in closing:

"This book is a record of humanity's unremitting shame. As the twentieth century draws to a close, the contributors trace some of the elemental threads of this century's tragic tapestry. Nevertheless, the reader may find hope in the courage and dignity chronicled in these chapters and in the genuine commitment of so many serious scholars to accumulate and apply knowledge to make the world a better place for our generation, and for generations to come."

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FROM THE MEDICAL LITERATURE

Booklet on health and human rights in Kosova


The International Federation of Health and Human Rights Organisations (IFHHRO) has published the "Kosova File on health and human rights" which includes the reports of two fact-finding missions by the Johannes Wier Foundation for health and human rights (the Netherlands) and Physicians for Human Rights (USA), both conducted in the summer of 1998 in Kosova and Albania.

These reports were part of the reason for the World Medical Association to adopt a Resolution on Reported Violations of Health and Human Rights in Kosova.

Both this WMA resolution and the two mission reports draw attention to the rapidly deteriorating health and health care situation in Kosova as a result of the political and armed conflict, and in particular to the vulnerable position of ethnic-Albanian health professionals in Kosova, especially when these colleagues fulfill their professional duty to draw attention to the gross human rights violations they witness in their daily contact with patients.

The Kosova File makes clear that the social, economic and cultural rights of the ethnic-Albanian population in Kosova are violated on a large scale.

The Kosova File has been submitted to the United Nations Committe on Social, Economic and Cultural Rights on 16 November 1998 during its meeting in Geneva, Switzerland.

NEW PUBLICATIONS FROM IRCT

New edition of Update on Centres and Programmes Worldwide

The IRCT Network Coordination Division has published the report "Rehabilitation of Torture Victims: 1998 Update on Centres and Programmes Worldwide" which outlines the activities of 126 centres and programmes working for victims of torture in 54 countries. These centres and programmes address the physical and psychological sequelae of torture and help generate awareness among and contribute to appropriate action not only by health professionals, but also other professional groups, the general public, governments, non-governmental organizations and intergovernmental organizations.

This publication has developed into an increasingly comprehensive overview of services available for victims of torture worldwide and may be obtained from the Publications Division at IRCT.

NEW PUBLICATIONS FROM IRCT

FROM THE MEDICAL LITERATURE

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NEWS IN BRIEF

New Chairperson

The Johannes Wier Foundation in Amersfoort, the Netherlands has elected a new chairperson, Dr Frank Garnier, who is a General Practitioner in Amsterdam and an experienced director and organizer.

IMA is concerned about reported custodial deaths

At the 60th Annual Central Council of the Indian Medical Association (IMA), 27-28 December 1998, the Central Council adopted certain very important resolutions. We reproduce one of the resolutions:

"IMA is concerned about the reported custodial deaths, torture and over increasing domestic violence and appalling conditions of prisons. IMA requests the Government to bring in necessary constitutional changes in Indian Penal Code Act suitably to make it most effective and also appoint committees including IMA to visit prisons periodically to observe the conditions and recommend accordingly."

(Source: IMA News, January 1999)
Instructions to authors

General remarks
The editorial board of Torture is grateful for small news items as well as articles dealing with aspects connected to torture, rehabilitation of torture victims, and the fight against torture.

Summary of requirements
We prefer articles, reviews, and other material to be word processed in a PC DOS/Windows format, for example Word Perfect or Word, and the text should be forwarded on a disc or by e-mail (only file attachments in Mime/Base64 format are acceptable) as well as in a printed copy.

Your manuscript should be prepared in correspondence with the uniform requirements for manuscripts submitted to biochemical journals. These requirements – the Vancouver system – are described in detail in Br Med J 1991; 302:-338-41 or N Engl J Med 1991; 334: 424-8.

A good illustration (photo, drawing or table) is always very welcome.

Details of address of the author/authors, qualifications such as MD or PhD, and full professorship are published as a footnote to papers, and this information should be provided on the title page of the manuscript.

The editorial board assumes that the material submitted for publication in Torture has not been presented anywhere else for consideration with a view to publication at the same time as an evaluation is being made by the board of Torture.

If the material has been published on a previous occasion, please state where and when.

The editors retain the customary right to style and, if necessary, shorten material accepted for publication.

If you want to make a review of a book dealing with aspects concerning torture, please remember to give details about the publisher, number of pages and the price, preferably in USD. The review should in the shortest possible way give a personal evaluation of the book – a mere description of the contents and some quotations are not sufficient.

The review, which must be max 1/2 a Torture page long, equal to approx. 60 lines of 50 taps, should be given an appropriate title.

References
Should be numbered in the order in which they appear in the text.

ARTICLES IN JOURNALS

Standard journal article
(List all authors, but if the number exceeds six give six followed by et al).


Organization as author

No author given

BOOKS AND OTHER MONOGRAPHS

Personal author(s)

Editor(s), compiler as author

Organization as author and publisher

Chapter in a book

Conference proceedings

Conference paper

OTHER PUBLISHED MATERIAL

Newspaper article

Audiovisual

Legal material

UNPUBLISHED MATERIAL

FORTHCOMING CONFERENCES AND SEMINARS

Oxford, United Kingdom
Refugee Studies Programme
Short Courses Programme for 1999

The Law of Refugee Status
15-16 May 1999

Asylum in a Frontier-Free Europe
25-26 September 1999

Short courses cost GBP 120 (excluding accommodation)
Venue: Queen Elizabeth House, 21 St Giles, Oxford

Further information:
Short Courses Secretary
Refugee Studies Programme
Queen Elizabeth House
21 St Giles, Oxford
OX1 3LA Oxfordshire
United Kingdom
Phone: +44 1865 270722
Fax: +44 1865 270721
E-mail: rsp@qeh.ox.ac.uk
http://www.qeh.ox.ac.uk/rsp/

Paris, France
2-3 July 1999

Saving Human Lives in the Midst of Conflict: from Humanitarian Action towards Humanizing Governmental Action
Early announcement

Further information:
Médecins du Monde
62, rue Marcadet
75018 Paris
France
Phone: +33 (0) 1 44 92 15 15
Fax: +33 (0) 1 44 92 14 40
E-mail: medmonde@medecinsdumonde.org

New Delhi, India
22-25 September 1999

VIII International Symposium on Torture: Torture as a Challenge to the Health, Legal and Other Professions

Organized by the International Rehabilitation Council for Torture Victims and the National Human Rights Commission of India - in collaboration with the Indian Law Institute and the Indian Medical Association

Main themes:
Torture as a challenge to the medical and other health professions.
Torture as a challenge to civil society.
Torture as a challenge to the administration of justice.
Torture as a challenge to the educational system.

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The IRCT is a private non-profit foundation, which was created in 1985 by The Rehabilitation and Research Centre for Torture Victims (RCT), Copenhagen.

The objectives of the foundation is on an international basis to promote the provision of specialized treatment and rehabilitation services for victims of torture and to contribute to the prevention of torture globally.

To further these goals the IRCT seeks on an international basis

- to develop and maintain an advocacy programme which accumulates, processes and disseminates information about torture as well as the consequences and the rehabilitation of torture
- to operate a documentation centre about torture and related topics
- to establish international funding for rehabilitation services as well as programmes for the prevention of torture
- to promote education and training of relevant professions in the medical as well as social, legal, and ethical aspects of torture
- to encourage the establishment and maintenance of rehabilitation services
- to establish and expand institutional relations in the international effort to abolish the practice of torture and
- to support all other activities which may contribute to the prevention of torture.