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MEDICAL ASPECTS OF TORTURE

Torture types and their relation to symptoms and lesions in 200 victims, followed by a description of the medical profession in relation to torture

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CHAPTER I. INTRODUCTION & AIMS

INTRODUCTION

SUMMARISED HISTORICAL ASPECTS OF TORTURE

Torture has been known throughout the history of man (*Amnesty International = AI* 1975 (Report on torture), *Ruthven* 1978, *Ternisien & Bacry* 1980, *Ackroyd et al* 1980, *Rasmussen & Marcussen* 1982, *Aalund* 1983, *Wagner & Rasmussen* 1983a, *Peters* 1985, *Genefke* 1986a,b). One of the first accounts of torture describes how *Rameses II*, who reigned in Egypt 1304-1237 BC, tortured captured enemy soldiers in order to get information about their military positions before an ensuing battle was going to take place. In ancient Greece accounts are given of the torture of slaves, because otherwise their testimonies in court were not considered valid. The use of torture on citizens was forbidden. The same double standard was found in the Roman Empire, which introduced the torture of citizens in about 50 BC. The cruelty of *Caligula* (37-41 AD) included torturing prisoners to death as an entertainment while feasting.

The Roman Catholic Church was responsible for the widespread institutionalized use of torture during the Inquisition from the 12th century. In the 18th century, torture was almost eliminated in Europe, and in 1789 the first human rights declaration forbidding torture was approved ("Déclaration De Droits de L'Homme: Assemblée Nationale, France"). The French Revolution was to a large extent responsible for this since the Declaration abolished torture in France "forever". From the legal point of view, torture was considered to be on a par with murder, and the punishment for torture was the same: execution by guillotine.

In Denmark torture was abolished in principle in 1683 (Christian V's Danske Lov), and entirely eliminated in 1837.

In 1889 the ninth edition of the Encyclopaedia Britannica commented: "The whole subject of torture is now only of historical interest as far as Europe is concerned".

Torture was again introduced into Europe from about 1920, when the three great political movements – Fascism, Nazism, and Communism – cast Europe again into barbarism, which included torture, culminating in World War II.

Ancient torture was different in 3 major aspects compared with today's: 1) it was accepted, today it is not, 2) it was carried out in public, today it is secret, 3) it was carried out after "legal" proceedings, today it is arbitrary. For example the Inquisition was something used by an accepted "legal" institution, the person was condemned to torture, the torture took place in public, and there was no secrecy. Today torture is forbidden, and no government would probably admit that torture was widespread in their country as a part of their governing and repressive policy. When a government is confronted with evidence of cases of torture, the usual response is that this was a single case, a military or police employee had gone mad, and the authorities did not approve of it.

DEFINITION OF TORTURE

United Nations (UN)

Article 5 of the United Nations Universal Declaration of Human Rights (1948) states that: "No one shall be subjected to torture or cruel, inhuman or degrading treatment or punishment". The declaration was adopted in the aftermath of the horrifying experience of World War II with the desire that from then, there should be a stop to disregard of and contempt for human rights, which had in the past led to barbaric actions which had revolted and shocked the conscience of the world. The hope was to create a world in which people could enjoy freedom of speech, religion, and belief, a world without fear, distress, and suffering. The Declaration, however, offered no guidance on what was to be understood by the term "torture". Its definitions were to some extent elastic, capable of changed interpretation with time (*Rodley* 1987).

The United Nations Declaration on the Protection of all persons from being subjected to torture and other cruel, inhuman or degrading treatment or punishment (1975) offers the following definition (article 1):

"1. For the purpose of this Declaration, torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted by or at the instigation of a public official on a person for such purposes as obtaining from him or a third person information or confession, punishing him for an act he has committed or is suspected of having committed, or intimidating him or other persons. It does not include pain or suffering arising only from – inherent in or incidental to – lawful sanctions to the extent consistent with the Standard Minimum Rules for the Treatment of Prisoners.
2. Torture constitutes an aggravated and deliberate form of cruel, inhuman or degrading treatment or punishment."

The United Nations (UN) Code of Conduct for Law Enforcement Officials (1979) uses the same definition, as does the UN Principle of Medical Ethics (1982). The definition was, however, amended by the UN Convention against Torture and other Cruel, Inhuman or Degrading treatment or Punishment (1984), article 1:

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

2. This article is without prejudice to any international instrument or national legislation which does or may contain provisions of wider application."

This definition differs from the earlier definition in the Declaration against torture (1975) primarily in being wider. In the most recent version the term "lawful sanctions" is without reference to the Standard Minimum Rules for the treatment of prisoners. This was done because it was considered incorrect to refer to a non-legally binding document. However, it also allows for sanctions by the National law which could very well constitute what is clearly prohibited by the Standard Minimum Rules. For example, the use of such extreme forms of corporal punishment as flagellation and punitive amputation is sanctioned by the national law of several countries.

The Convention includes the activities of so-called paramilitary groups or "death squads" by the wording: "or with the consent or acquiescence of a public official or other person acting in an official capacity."

The Council of Europe

The European Convention on the Protection of detainees from torture and from cruel, inhuman or degrading treatment or punishment (1950) includes no definition of torture or cruel, inhuman or degrading treatment or punishment. The Commission of Human Rights has, however, examined several cases of alleged torture and declared whether torture or ill-treatment contrary to the declaration had been inflicted. The best known cases are examinations of torture allegations in Greece in 1968 and in Northern Ireland in 1976 (*AI* 1984 (Torture in the eighties), *Rodley* 1987). The Northern Ireland case illustrates the difficulties in distinguishing between torture versus inhuman and degrading treatment. The European Human Rights Commission found that the interrogation technique (hooding, wall-standing, subjection to continuous noise, deprivation of sleep, and deprivation of food and drink) could be classified as torture, while the European Court of Human Rights judged (January 1978) that cruel, inhuman and degrading treatment had been committed, and thus reversed the ruling by the Commission (*Mikaelsen & Pedersen* 1979).

World Medical Association

The World Medical Association (WMA) adopted the Tokyo Declaration of 10 October 1975. The Declaration serves as a guideline for the medical profession concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment. It includes the following definiton of torture:

"Torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason."

This definition differs from the UN definiton adopted 2 months later (9 December 1975) mainly in that there are no exclusions (UN definition includes: "It does not include pain or suffering arising from, inherent in or accidental to, lawful sanctions to the extent consistent with the Standard Minimum Rules for the Treatment of Prisoners") and there is no attempt to clarify cruel, inhuman or degrading treatment (UN: "Torture constitutes an aggravated and deliberate form of cruel, inhuman or degrading treatment or punishment"). The Tokyo Declaration of 1975 is very clear, and the present author therefore adopts its definition of torture in the following study.

It is not possible to include the suffering of a torture victim in a definition of torture. However, it is important to realize that a torture victim is a defenceless person, on whom one or more persons, who have power, inflict physical or psychological damage (*Wagner & Rasmussen* 1983a). Torture is an extreme manifestation of absolute power, perverted to show malice. It is an instrument of power which can be employed to maintain the power system.

For practical purposes a definition of torture leaves open the question of the treatment being no longer torture, but cruel, inhuman or degrading treatment. Grey areas exist which need an investigation on a case by case basis in order to develop a common understanding of what constitutes cruel, inhuman or degrading treatment. The UN Standard Minimum Rules for the treatment of prisoners serve as important international guidelines.

In order to concentrate the different efforts in the fight against *torture,* a rather strict definition is essential. Several human rights groups have suggested the inclusion in the definition of torture of forced exile, police brutality, harsh prison conditions, etc. All these might be contained in human rights' work, but should not be included in the definition of torture. By broadening the definition, the effectivenes of the work for torture victims will be weakened.

THE MEDICAL WORK OF AMNESTY INTERNATIONAL AND TORTURE

An international AI Conference for the Abolition of Torture was held in Paris in December 1973 (*AI* 1973 (Conference for the abolition of torture)), at which the work of AI itself in this field was discussed. Among the recommendations were the following:

" Medical and associated personnel should refuse to allow their professional or research skills to be exploited in any way for the purpose of torture, interrogation or punishment, nor should they participate in the training of others for such purposes.

Medical personnel working in prisons or other security camps should insist that they be employed by, and responsible to, an independent authority. Medical personnel who know of instances or plans of torture must report them to the responsible national and international bodies.

Prisoners and others held against their will shall have the right of free access to physicians of their own choosing."

The first medical group within Amnesty International was formed in Denmark by Dr. *Inge Kemp Genefke* in 1974 (*Genefke* 1974, 1978, *Moltke* 1974). The initial team comprised 9 doctors from different specialities. One of the objectives of the group was to examine persons who were alleged to have been tortured, with the aim of collecting information about torture in order to unveil and relieve torture sequelae. There was a pressing need to document torture allegations, since these were not believed, even among our own colleagues (*Boberg-Ans* 1975). The methods of medical examination and system of reporting are described in detail in chapter III: Method.

From April 1975 to May 1982, 219 persons were examined by the Danish medical group. First results from the group were published in 1977 (*AI* 1977 (Evidence of torture), *Rasmussen et al* 1977). 67 persons, 32 Chileans and 35 Greek persons, were included in this study.

During the following years, the group's results have mostly focused on a specific country (*AI* 1978 (Northern Ireland), *Cohn et al* 1978, *Severin et al* 1978, *Kjærsgaard & Genefke* 1977, *Jess et al* 1980, *Petersen & Rasmussen* 1980, *AI* 1980 (Spain), *Wallach et al* 1980, *AI* 1980 (Argentina), *Rasmussen & Lunde* 1980, *AI* 1981 (Iraq), *Wallach & Rasmussen* 1983, *AI* 1983 (Chile)) or on special areas of torture (*Bro-Rasmussen & Rasmussen* 1978, *Lunde et al* 1980, *Lunde et al* 1981, *Lunde* 1981, *Rasmussen & Marcussen* 1982, *Bro-Rasmussen et al* 1982, *Lunde* 1982, etc.). In the list of references, studies which include torture victims who are also included in the present study are marked with (*).

Some of the torture victims have been re-examined (*Daugaard et al* 1983, *Abildgaard et al* 1984, *Petersen et al* 1985, etc.) These studies have also been marked with (*).

Several publications include general descriptions of the medical work against torture in Amnesty International (*AI* 1979 (Manual), *AI* 1980 (Medical struggle), *AI* 1981 (Tortur – en internasjonal forbrytelse)).

THE AIMS OF THE PRESENT STUDY

In October 1974 the author was privileged to participate in the creation of the first medical group in Amnesty International. During the following years the medical work against torture has included examination of torture victims in many countries, including Denmark, in order to add evidence to torture allegations, to give descriptions of torture methods, and to carry out research into torture sequelae. As the first medical advisor in Amnesty International from May 1980 to June 1981, I participated in an effort to coordinate internationally the medical work against torture. During the last three years, as a board member of the International Foundation for the Rehabilitation of Torture Victims (IRCT) and consultant for the Rehabilitation and Research Centre for Torture Victims (RCT), I have had the opportunity of direct participation in the International work against torture. This book was written in order to fulfil an increasing desire to gather the accumulated knowledge and recommendations on the subject in one book. The views expressed, however, are mine, and not necessarily those of the organisations I have worked for. The study is based on the medical records of 200 torture victims who were examined during the 7-year period from April 1975 to May 1982. Its aims were:

1) to describe different types of torture with resulting symptoms and signs, to evaluate their consequences, with respect to diagnostic significance and the person's health, and to relate the results to the accumulated knowledge on the subject.
2) to evaluate the influence of exile on health complaints by torture victims.
3) to describe the type and frequency of medical involvement in torture.
4) to describe the relationship between the medical profession and torture, and to propose a better and more expedient use of the medical profession in the prevention of torture.

CHAPTER II. METHODS

DESCRIPTION OF EXAMINATION PROCEDURES

BACKGROUND

None of the nine participating doctors of the first medical team had any previous experience in examining torture victims. Searching medical libraries revealed only very few studies in this field. The group, therefore, realized that it was necessary to gain its own experience and develop its own methods.

The primary aim was to develop a technique that would enable the doctors to participate in fact-finding missions for Amnesty International. It was hoped that examinations of the persons alleged to have been tortured would result in conclusive evidence as to whether such allegations were true or false. Necessary equipment for the medical examinations was provided. From the literature many rumours of a so-called truth drug were found. We were therefore provided with equipment for sampling of urine, blood and saliva to perform pharmacological analyses. Photographic equipment for the documentation of objective findings, especially skin lesions, was also provided. The relevant anamnestic information was discussed, a draft for the outline of the report was written (reproduced in the appendix), and a check-list for the physical medical examination was established (also reproduced in the appendix).

QUESTIONING TECHNIQUE

As a part of the examination procedure, the team agreed to avoid all leading questions during the examination.

Questions like "Have you been tortured by electricity?" were not used. The history of the person who allegedly had been tortured was to be as far as possible the person's own words. Questions like "What happened then?" or "Could you tell about the prison conditions", etc. were used. When it came to torture methods, it was emphasized that all details be presented. Eventually the person was asked to place him- or herself in the position and actually "play" the torture sessions like a pantomime.

It was a general principle that two doctors from the group participated in the examinations together, one asking the questions, the other taking notes. The doctor who took notes however was allowed to put additional questions during the interview. With a few exceptions, the examination was conducted with the use of an interpreter. Whenever possible, interpreters with medical knowledge and a knowledge of torture were preferred. The examinations lasted 4-8 hours.

DATA COLLECTION

In order to evaluate possible consequences of alleged torture, the following data were collected as part of a medical examination:

1. Demographic data, including social background.
2. State of health and diseases before arrest.
3. Circumstances about arrest and detention.
4. Details about the alleged torture, both physical and psychological. Information was also sought on the duration of each torture method.
5. Prison conditions.
6. Physical and mental symptoms as reported by the victim. The symptoms were generally divided into symptoms present immediately after the alleged torture, symptoms during the subsequent period, and symptoms at the time of examination.
7. Objective medical examination, including both physical and mental observations.

SELECTION OF PERSONS TO BE EXAMINED

After the coup in Chile, September 11, 1973, the military forces under the leadership of Augusto Pinochet were responsible for massive repression against suspected political opponents. Torture was used on a large scale.

Many Chileans were expelled from their country, and Denmark subsequently received several refugees who alleged having been tortured. The medical group contacted these torture victims in order to gain information about possible torture forms and their immediate consequences.

Further, the purpose was to gain experience for future medical fact-finding missions. The victims who presented themselves for a medical examination and for an interview were not offered any privileges, and their participation was of course voluntary. It has been the strategy of the medical group to offer the examined persons total anonymity if they so wished.

Greece was ruled by a junta from 1967 to 1974. Through Amnesty contacts, three missions to Greece were carried out during 1975/1976, each with two doctors. By examining citizens who alleged torture by the junta, evidence was collected on torture during that period, and experience was gained on arranging missions.

In 1977 the first survey on the findings was presented (*AI* 1977 (Evidence of torture), *Rasmussen et al* 1977). The survey comprised 67 persons, 32 from Chile and 35 from Greece.

During the following years, the experience accumulated by medical teams was applied in medical fact-finding missions to Northern Ireland, Spain, and Chile (*AI* 1978 (Northern Ireland), *Jess et al* 1980, *Petersen & Rasmussen* 1980, *AI* 1980 (Spain), *Wallach & Rasmussen* 1983, *AI* (Chile) 1983). All these missions were arranged by the international secretariat, Amnesty International in London. The secretariat also referred persons who alleged torture to the Danish medical team for examination (*Cohn et al* 1978, *Severin et al* 1978).

Missions were also arranged to France to examine exiled Uruguayans (*Kjærsgaard & Genefke* 1977), to Italy to examine exiled Argentinians (*Wallach et al* 1980, *AI* 1980 (Argentina)), and to the Middle East to examine exiled Iraqis (*AI* 1981 (Iraq)).

THE EXAMINING DOCTORS

The examinations have been carried out by a total of 25 different Danish doctors. When new doctors were enrolled in the medi-

cal examination team, they had to go through a training period, examining a number of persons together with an experienced investigator from the team. The names of the examining doctors are listed in the appendix. The names of the dentists who have performed examinations on a number of occasions are also listed.

As already indicated above, small studies of a group of torture victims included in this survey have been published. They mostly concern studies in which the sample comprises torture victims from the same country.

In order to standardize the examination and reporting system, the examination team met every month, and later every second month to discuss relevant problems. Small working groups were also held that focused on aspects of the examination, e.g. a psychiatrist in the group presented the problems of a psychiatric evaluation, a neurologist the neurological examination and evaluation, an experienced mission delegate problems arising in that connection, etc.

The Danish medical team was contacted by other Amnesty International medical groups who wanted to take up similar activities, and collaboration has resulted particularly with medical groups from Canada (*Allodi & Cowgill* 1982), The Netherlands (*Smeulers* 1975, *Warmenhoven et al* 1981), USA (*Randall et al* 1985), and Norway (*Fossum et al* 1982).

DATA COLLECTING FORM

The author realized in 1980 that a more standardized way of evaluating the examinations of torture victims was needed. An international form for the collection of data from torture victims was prepared, based partly on comments from Canadian and American groups. The form comprised all data relevant to the examination of torture victims, and it was intended that examining doctors, in addition to their written report, should fill in the form simply by ticking the relevant squares. In this way, examinations by different doctors and also by different medical groups could be collected and compared. It was hoped that the form would serve multi-centre research, but so far this idea has not proved feasible.

From the beginning of 1981, the Danish medical group has used the data collecting form for most of its examinations. It has also been used succesfully in one medical fact-finding mission to Chile where Dr *Wallach,* together with the author, examined 18 victims in April/May 1982 (*AI* 1983 (Chile), *Wallach & Rasmussen* 1983). When the author decided to evaluate the results of the Danish medical group's examination of torture victims, the data collecting form was used as the basis for making an EDP recording system for all the individual reports. The EDP recording system includes 460 data entries for each of the 200 persons, i.e. 92,000 data.

MISSING VALUES

In this retrospective study, some data were inevitably missing. When any data in an individual report were missing, they were registered on the form as not-indicated. In this way, "not-indicated" implies either that the person examined did not give the examining doctor the information, or that the examining doctor received the information but did not mention it in the report.

TORTURE TYPES

When a torture type is registered as "not-indicated", the likely implication is that the person has not been subjected to this form of torture, because often the person usually, either spontaneously or by request, tells about the experienced torture.

Some subjects, however, are not spontaneously revealed: rape and sexual humiliation. They are are known to be very sensitive and both sexes are reluctant to tell about their experiences. For a woman, for instance, it is felt embarrassing and humiliating if she has been raped. She does not want to disclose it to anyone, not even to her husband. In some cases, on the other hand, the examining doctors are the first to be told about such sexual humiliations, and the telling itself can cause much relief.

SYMPTOMS

To obtain all the details of symptoms after alleged torture, a more structured interview technique is required. For instance, ex-victims rarely report sexual symptoms spontaneously, and the examining doctors sometimes do not find the situation suitable for questions about such sensitive subjects, either because the contact is not sufficiently established, or for cultural reasons, or the surroundings, or the interpreter. When sexual symptoms are not recorded, it is usually because they have not been asked for. Dr Lunde and the author visited Greece in 1976 and 1977 to re-examine Greek men. The examination included blood analysis of follicle stimulating hormone (FSH), luteinizing hormone (LH), testosterone, and the filling in of questionnaires about sexual function before and after alleged torture (*Lunde et al* 1980, *Lunde et al* 1981). It was found that sexual problems at re-examination were indicated at a higher rate than at the first examination, probably due to the use of the questionnaire.

It has been recommended that data about symptoms be obtained at the time of the alleged torture, in the subsequent period, and at the time of the medical examination. For practical reasons, symptoms in this survey have been referred to two periods: the periods at and around the alleged torture, and the time of examination. The time at and around the time of torture may last up to month after the torture, depending on the lesions. In the present survey this period will simply be called: "the time of torture". The medical examination was carried out at varying intervals after the reported torture, and these intervals were recorded.

There was a difference between symptoms recorded at the time of torture and at the time of examination. First, many of the symptoms listed in the registration form were not recorded, the usual reason for this being that symptoms had disappeared and therefore the person did not find it important to mention them. The examining doctors might also concentrate more on symptoms directly related to the alleged torture than on symptoms which might seem "irrelevant" to the reported torture. Second, there was a higher frequency of recorded symptoms at the time of examination.

In Table II,1, the reply frequency of reported symptoms from the two periods is indicated. When the reported symptoms fulfil the criterion of a reply rate equal to or exceeding 0.75, these will be referred to as A-variables in the present study, and reply rates below this level will be categorized as B-variables. B-variables will not be the subject of more extensive analysis.

A finer grading of frequency and severity of different symptoms has seldom been possible.

Symptoms known to have been present before torture, and symptoms known to be related to factors other than torture have been excluded.

MEDICAL EXAMINATION

The physical findings have been recorded on a check-list throughout the whole seven-year period of examinations, and therefore it is rare

Table II,1. *Reply frequency in 200 examined persons (italicized numbers indicates frequency ≥0.75).*

Organ systems	At the time of torture	At the time of examination
Locomotor symptoms	*0.88*	*0.93*
Skin changes	*0.78*	*0.79*
Dental symptoms	0.59	*0.79*
Eye symptoms	0.42	*0.82*
Ear-nose-throat symptoms	0.58	*0.86*
Heart and lung symptoms	0.64	*0.85*
Digestive tract symptoms	*0.77*	*0.85*
Kidney and bladder symptoms	0.61	*0.82*
Female genital tract symptoms	*0.90*	*0.97*
Breast symptoms (female)	0.54	0.72
Sexual problems	0.32	0.48
Central nervous symptoms	*0.84*	*0.86*
Peripheral nerve symptoms	0.52	0.68
Mental symptoms	*0.75*	*0.87*

to find physical findings not being recorded. When these signs were suggestive of the alleged torture, they were registered in the present study.

REGISTRATION

The registration of all data has been filed on an electronic data base and analysed using the Statistical Analysis System (SAS) library available on NEUCC. Names and birthdays have not been registered, so that identification of a particular individual is impossible without the code, which has been kept in a safe.

STATISTICAL EVALUATION

To determine whether an association existed between a torture type and a specific symptom, a simple Chi-square test with 1 D.F. (degree of freedom) was applied. When the subsequent p value was less than 0.05, the association was considered statistically significant.

Torture types and recorded symptoms both contained missing values. A typical table including the missing values has been presented in Table II,2. In order to simplify the table, missing values of a torture type have been added to the group not tortured (Table II,3). Only few studies, however, support the assumption that missing values for a specific torture type can be interpreted as the absence of exposure (*Petersen et al* 1986). On the other hand, torture victims are said to have revealed new aspects of the torture during psychotherapy (*Ortmann et al* 1987). No specific study has been presented that is designed to examine the extent of the problem. It is therefore possible that persons who have actually been tortured by a specific type of torture might be added to the group of persons who said that they were not tortured by that torture type. In the evaluation of the possible association between a torture type and a specific symptom, the association has been reduced, resulting in a so-called type II error. The statistical evaluation (Table II,3) includes an evaluation of the ratio for having the symptom in the presence of the torture type a1/abc1, compared with the ratio of having the symptom in the absence of the torture type (including missing values) a-2&3/abc-2&3. The Chi-square test has been used on the values as presented in Table II,3, and the subsequent p value called p:1. The missing values of symptoms have been added to the group with "no symptoms" in the evaluation of p:1 (Table II,4).

The p:2 value was calculated after adding the missing values of symptoms to the group with symptoms (Table II,5).

If the association proved to be statistically significant (both the p:1 and the p:2 value less than 0.05), the adjusted risk ratio was calculated to permit comparison between the groups and to avoid the possible confounding effect of age and sex. Two age groups were used, aged 30 and under, and aged 31 and over. The median age for the whole group of examined persons at the time of examination was 30 years, and the two age groups were thus equal in size.

The calculation of the adjusted risk ratio was according to *Fold-spang et al* (1986). The analyses have used a division of the material as indicated in Table II,6, in which sex and age have been entered.

In the statistical evaluation a Mantel-Haenszel test after stratification for possible confounders has been applied. The p value was called p:corr.

DISCUSSION OF DIFFERENT METHODS OF EXAMINING TORTURE VICTIMS

It is the journalist who has probably reported the most torture in newspapers, weekly magazines, television, radio, etc. The research quality behind these reports varies from excellent in-depth investigations with first-hand information to pure rumours. The reports are usually based on testimonies.

With the formation of medical groups within Amnesty International, a systematic way of collecting information on the consequences of torture became available. The most frequently used method for collecting this data has been in-depth interviews and examinations by two doctors, as described earlier. Exceptions to this method, however, exist:

Two Danish doctors on an AI mission to Northern Ireland to investigate allegations of maltreatment (*AI* 1978 (Northern Ireland))

Table II,2. *Distribution of a symptom reported by the examining persons as related to a specific torture type. n=200.*

	Torture type			
	yes	no	n.i.*)	Total
Yes	a1	a2	a3	a
No	b1	b2	b3	b
n.i.	c1	c2	c3	c
Total	abc-1	abc-2	abc-3	abc

*) n.i.= not-indicated.

Table II,3. *Distribution of a symptom reported by the examining persons as related to a specific torture type, after adding missing values of torture types to the group of persons who did not allege that torture type. n=200.*

	Torture type		
	yes	no n.i.*)	Total
Yes	a1	a-2&3	a
No	b1	b-2&3	b
N.i.	c1	c-2&3	c
Total	abc-1	abc-2&3	abc

*) n.i.= not-indicated.

Table II,4. *Distribution of a symptom reported by the examining persons as related to a specific torture type, in order to calculate p:1 value. n=200.*

	Torture type		
	yes	no n.i.*)	Total
Yes	a1	a-2&3	a
No & n.i.	bc-1	bc-2&3	bc
Total	abc-1	abc-2&3	abc

*) n.i.= not-indicated.

Table II,5. *Distribution of a symptom reported by the examining persons as related to a specific torture type, in order to calculate p:2 value. n=200.*

	Torture type		
	yes	no n.i.*)	Total
Yes & n.i.	ac-1	ac-2&3	ac
No	b1	b-2&3	b
Total	abc-1	abc-2&3	abc

*) n.i.= not-indicated.

Table II,6. *Distribution of a symptom reported by the examining persons as related to a specific torture type, in order to control for age and sex as possible confounders (p:corr). n=200.*

	Male		Female		
	symptoms		symptoms		
	+	–*)	+	–*)	Total
≥30 years					
Torture +	a1	b1	a2	b2	a1+2,b1+2
Torture –*)	c1	d1	c2	d2	c1+2,d1+2
<31 years					
Torture +	a3	b3	a4	b4	a3+4,b3+4
Torture –*)	c3	d3	c4	d4	c3+4,d3+4
Total					
Torture +	a1+3	b1+3	a2+4	b2+4	a+b
Torture –*)	c1+3	d1+3	c2+4	d2+4	c+d

*) including missing values.

used a combined method: in 39 instances the mission was able to interview individuals about whom no corroborative medical evidence was available, while in 26 instances the delegates received documentary medical evidence related to individuals whom they were not able to interview, and in 13 cases the delegates interviewed persons about whom medical evidence was available. In this way evidence about 78 persons was collected during the one week mission, and in 5 cases in-depth medical examination was included.

In a mission to Colombia (*AI* 1980 (Colombia)), one Canadian doctor participated, and during the course of one week he studied 30 cases. In 27 of the cases interviews and physical examination were conducted. In most of these cases, the interview and following examination were short and concentrated purely on the inflicted torture.

In a study conducted by the American medical group in Amnesty International (*Randall et al* 1985), 44 torture victims were examined. The ex-victims were to fill out a questionnaire which included questions about the time, place and date of each arrest, the place, duration and conditions of the imprisonment, the names of those who participated in the arrest, detention and torture, the reason for the arrest, and the family and medical history and personal health status before and after torture.

Participants were also asked to describe all episodes of abuse or torture from arrest to the time of release, including dates, duration, type of torture, the area of the body abused, and the immediate and later symptoms, including their duration and intensity, that resulted from torture.

A physical examination was performed by a physician with indicated laboratory tests, and, as necessary, additional consultation. A psychological examination including a mental status evaluation was done by a psychologist or psychiatrist fluent in the participant's native language.

Multiple examination sessions were used when necessary to enable more in-depth examination or for the convenience of the participant.

Questionnaires have been used widely by "The Canadian center for the investigation and prevention of torture" in Toronto (*Allodi & Rojas* 1982, *Allodi & Rojas* 1983a,b).

The questionnaires are not only being used in Toronto, but also in Latin American countries, e.g. Mexico, Argentina, Chile, and Peru (*Renshaw* 1985). The entire questionnaire, which is filled in by the persons themselves, is reproduced in the appendix page 69. The questionnaire is designed in such a way that persons who have not been subjected to torture can participate and serve as a control group.

Amnesty International uses a questionnaire to be filled in by the persons themselves when direct interviews are not feasible (*AI* 1981 (questionnaire)). The questionnaire, which includes a section on torture and maltreatment, is reproduced in the appendix page 73.

Most of the studies on torture victims have been hampered by the fact that no control group has been examined, thus making it difficult to elaborate scientifically on the data collected. During the last few years, two controlled studies have been published (*Thorvaldsen* 1986, *Hougen et al* 1988).

The examination of torture victims in prisons, with non-torture inmates as a control group, has not been feasible because of the obstruction by authorities. In countries where torture continues, it has however been possible for local doctors to examine torture victims (*Marcelino* 1984, *Foster* 1985a, *Foster* 1985b, *Vicaria de la Solidaridad* 1985, *Ceres* 1986, *Martirena* 1986, *Comision de Derechos Humanos de El Salvador* 1986, *Carli* 1987).

The local doctors run a risk of becoming torture victims themselves when they conduct such research (*Onaindio* 1980, *AI* 1986 (Olivares), 1987 (Macaya)). *Petersen & Jacobsen* (1985a) have designed a protocol for use by local general practitioners who should examine torture victims among their clients and select matched control groups from their patients. 15 torture victims have been examined in this way in Spain (*Petersen & Jacobsen* 1985a,b, *Petersen et al* 1986). The protocol is reproduced in the appendix, page 74.

In countries where torture has been practiced and has stopped because of a change in the regime, it is possible without too many difficulties to examine torture victims and establish a matching control group. Countries where such studies could be undertaken include Argentina, Uruguay, and Nicaragua.

In "free" countries where torture victims are living in exile, control groups can be established among refugees from the same country living in exile. Such a study has been designed on Turks living in exile in Denmark (*Hougen et al* 1988).

CHAPTER III. MATERIAL

The survey comprises 200 persons, 39 women and 161 men, who alleged having been subjected to torture. They have been examined in the 7-year period from April 1975 to May 1982, when it was decided to make this study.

19 persons examined by the medical group in the period have been excluded from this study, 12 because they did not fulfil the criteria of torture according to the definition of torture (see chapter I) and 7 because parts of the report were missing or only the person's testimony had been recorded.

51 persons were examined in 1975, 24 in 1976, 26 in 1977, 4 in 1978, 38 in 1979, 29 in 1980, 9 in 1981, and 19 in 1982.

The year and country in which the person alleged having been subjected to torture are shown in Table III,1.

Table III,2 shows the examined persons' nationality, the country where the alleged torture took place, and the country where the person lived at the time of medical examination. 10 persons reported having been tortured in a country different from their national country – 4 Uruguayans and 3 Chileans reported being tortured in Argentina, a Dane in Morocco, a Swiss in Syria, and a Ugandan in Tanzania.

The largest nationality group was Chileans (72, 36%), of which 18 (9%) were examined in Chile, and the rest (54, 27%) in Denmark, where they were living in exile. The second and third largest groups were Greek and Spanish citizens, 35 (17%) and 28 (14%), who were all examined in their country of origin. Of the 18 (9%) Argentinians, 14 (7%) were examined in Rome, where they had been granted refugee status, and the rest in Denmark. The 5 persons from Northern Ireland were all examined in their own country. All the rest, 60 persons (30%), were examined in exile. 16 persons allegedly tortured in Iraq have been examined in another country

Table III,1. *The examined persons' sex, the country and year where the alleged torture took place. n=200.*

The country of alleged torture	Number of persons	Sex F	Sex M	Year of torture
Chile	69	10	59	1973-7, 1979, 1982
Greece	35	7	28	1966-8, 1970-1, 1973
Spain	28	5	23	1973-8
Argentina	25	11	14	1972, 1974-6, 1978
Iraq	16	3	13	1969, 1977-9
Uruguay	9	0	9	1970, 1972-5, 1979
Northern Ireland	5	1	4	1976
Tanzania	3	0	3	1972-3, 1975
Bolivia	1	0	1	1977
Eritrea	1	0	1	1979
Ethiopia	1	0	1	1970
India	1	1	0	1974
Indonesia	1	0	1	1965
Morocco	1	0	1	1978
Rhodesia	1	1	0	1979
Somalia	1	0	1	1970
Syria	1	0	1	1972
Zanzibar	1	0	1	1975
Total	200 100%	39 19%	161 80%	1965-1982

Table III,2. *The examined persons' nationality, the country where the alleged torture took place, and the country where the persons lived at time of examination. n=200.*

	Nationality				Country where alleged torture took place				Country where the person lived at time of examination			
	sex		total		sex		total		sex		total	
Country	F	M	n	%	F	M	n	%	F	M	n	%
Argentina	9	9	**18**	9	11	14	**25**	12	0	0	**0**	0
Austria	0	0	**0**	0	0	0	**0**	0	1	0	**1**	0
Bolivia	0	1	**1**	0	0	1	**1**	0	0	0	**0**	0
Chile	11	61	**72**	36	10	59	**69**	34	4	14	**18**	9
Denmark	0	1	**1**	0	0	0	**0**	0	8	67	**75**	37
Eritrea	0	1	**1**	0	0	1	**1**	0	0	0	**0**	0
Ethiopia	0	1	**1**	0	0	1	**1**	0	0	0	**0**	0
France	0	0	**0**	0	0	0	**0**	0	1	2	**3**	1
Germany	0	0	**0**	0	0	0	**0**	0	0	2	**2**	1
Greece	7	28	**35**	17	7	28	**35**	17	7	28	**35**	17
India	1	0	**1**	0	1	0	**1**	0	1	0	**1**	0
Indonesia	0	1	**1**	0	0	1	**1**	0	0	0	**0**	0
Iraq	3	13	**16**	8	3	13	**16**	8	0	0	**0**	0
Italy	0	0	**0**	0	0	0	**0**	0	8	6	**14**	7
"Middle East"*)	0	0	**0**	0	0	0	**0**	0	3	13	**16**	8
Morocco	0	0	**0**	0	0	1	**1**	0	0	0	**0**	0
N. Ireland	1	4	**5**	2	1	4	**5**	2	1	4	**5**	2
Norway	0	0	**0**	0	0	0	**0**	0	0	1	**1**	0
Rhodesia	1	0	**1**	0	1	0	**1**	0	0	0	**0**	0
Somalia	0	1	**1**	0	0	1	**1**	0	0	0	**0**	0
Spain	5	23	**28**	14	5	23	**28**	14	5	23	**28**	14
Switzerland	0	1	**1**	0	0	0	**0**	0	0	1	**1**	0
Syria	0	0	**0**	0	0	1	**1**	0	0	0	**0**	0
Tanzania	0	2	**2**	1	0	3	**3**	1	0	0	**0**	0
Uganda	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0
Uruguay	1	12	**13**	6	0	9	**9**	4	0	0	**0**	0
Zanzibar	0	1	**1**	0	0	1	**1**	0	0	0	**0**	0
Total	39	161	**200**	100	39	161	**200**	100	39	161	**200**	100

*) For security reasons the country has not been named.

Table III,3. *Age and sex distribution at time of last alleged torture event. n=200.*

	Sex		Total	
Age group in years	F	M	n	%
<21	6	21	27	13
21-25	14	48	62	31
26-30	12	50	62	31
31-35	3	21	24	12
36-40	2	10	12	6
41-45	1	4	5	2
46-50	0	4	4	2
51-55	1	2	3	1
56-60	0	1	1	0
61-65	0	0	0	0
Total	39 19%	161 80%	200 100%	100

where they were living in asylum. For the sake of their security the country has not been named and occurs in the table as "Middle East". At the time of examination, 111 subjects (55%, 21 women and 90 men) were living in exile, while the remaining 89 (44%, 18 women and 71 men) were still living in their own country (see also chapter VI and Table VI;1).

The ages at the time of the alleged torture and at the time of examination are indicated in Table III,3 and III,4. The median age at the time of alleged torture was 26 years (range 15-58 years), and at the time of examination, 30 years (range 17-59 years).

The median interval from alleged torture to examination was 23 months (range 3 days to 12 years).

The family situation at the time of arrest is shown in Table III,5. Approximately half of both men and women were engaged or married.

The number of children in the victims' families at the time of

Table III,4. *Age and sex distribution at time of examination.*

	Sex		Total	
Age group in years	F	M	n	%
<21	3	8	11	5
21-25	10	33	43	21
26-30	11	40	51	25
31-35	9	45	54	27
36-40	3	17	20	10
41-45	2	4	6	3
46-50	0	9	9	4
51-55	1	3	4	2
56-60	0	2	2	1
61-65	0	0	0	0
Total	39 19%	161 80%	200 100%	100

Table III,5. *Family situation at time of arrest. n=200.*

	F		M		Total	
Family situation	n	%	n	%	n	%
Single	17	44	78	48	95	47
Engaged/married	19	49	78	48	97	48
Separated/divorced	2	5	1	1	3	1
Widowed	1	3	1	1	2	1
Not indicated	0	0	3	2	3	1
Total	39 19%	100	161 80%	100	200 100%	100

Table III,6. *Number of children at time of arrest. n=200.*

	F		M		Total	
Number of children	n	%	n	%	n	%
0	27	69	90	56	117	58
1	7	18	19	12	26	13
2	5	13	28	17	33	16
3	0	0	7	4	7	3
4	0	0	6	4	6	3
5	0	0	1	1	1	0
6	0	0	1	1	1	0
7	0	0	1	1	1	0
8	0	0	1	1	1	0
11	0	0	1	1	1	0
Not indicated	0	0	6	4	6	3
Total	39 19%	100	161 80%	100	200 100%	100

Table III,7. *Educational status at time of arrest. n=200.*

	F		M		Total	
Education	n	%	n	%	n	%
Elementary school, grade 6	5	13	27	17	32	16
Secondary school, grades 7-13	8	21	16	10	24	12
Vocational/technical	12	31	63	39	75	37
College or university	14	36	53	33	67	33
Not indicated	0	0	2	1	2	1
Total	39 19%	100	161 80%	100	200 100%	100

Table III,8. *Occupational status at time of arrest. n=200.*

	F		M		Total	
Occupation	n	%	n	%	n	%
Unskilled labourer	8	21	28	17	36	18
Skilled labourer	11	28	58	36	69	34
Professional	6	15	33	20	39	19
Unemployed	0	0	8	5	8	4
Student	14	36	31	19	45	22
Not indicated	0	0	3	2	3	1
Total	39 19%	100	161 80%	100	200 100%	100

Table III,9. *State of health before torture. n=200.*

Disease group	F n	F %	M n	M %	Total n	Total %
No serious disease	32	82	140	87	172	86
Locomotor system	1	3	2	1	3	1
Skin	1	3	0	0	1	0
Heart/lung	1	3	4	2	5	2
Gastrointestinal tract	1	3	9*)	6	10*)	5
Urological	0	0	2	1	2	1
Gynaecological	1	3	0	0	0	0
Central nervous system .	1	3	4*)	2	5*)	2
Mental	1	3	1	1	2	1
Total	39 19%	100	161 80%	100	200 100%	100

*) One patient with both gastrointestinal and CNS disease.

arrest is given in Table III,6. 83 of the 200 torture victims had a total of 174 children.

Table III,7 shows the education status at the time of arrest. 67% of the women and 72% of the men had a vocational/technical or college/university degree.

Table III,8 shows the occupation at the time of arrest.

None of the women and 5% of the men were unemployed.

Skilled labourers were defined as persons with an occupation based on vocational or technical education.

Professionals were defined as persons with an occupation based on college or university degrees. 43% of the women and 57% of the men were either skilled labourers or professionals.

22% (14 women and 31 men) were students at the time of arrest, and if they are added to the group af skilled labourers and professionals, the whole group will amount to 76%.

The state of health before the arrest is listed in Table III,9. 86% did not complain of any serious disease prior to the arrest. 28 persons complained of health problems, and only 2 of them complained of mental problems.

CHAPTER IV. TYPES OF TORTURE

INTRODUCTION

The alleged torture and maltreatment took place after the arrest and mainly during the early periods of detention.

The median number of days of torture indicated by the examined persons was five (range 1-150 days). In two cases the number of days was not reported.

Torture may be divided into physical and mental torture, and because of overlapping it is often extremely difficult to separate them. In most cases the physical and mental torture occurred simultaneously during interrogation. For instance, a person was beaten and received threats at the same time. During electric torture to the genital region, the person may be told that torture will make him impotent or sterile, and during "pure" physical torture, e.g. beating, the victim is powerless, totally in the hands of his torturers, thereby creating a tremendous frustration and feeling of defencelessness and humiliation. "Pure" mental torture also exists, without any physical molestation. Threats and sham executions are examples of this. "Pure" mental torture, however, can have physical consequences for the victims.

When torture victims have been asked to indicate what they thought was the worst experience during the detention, it has often not been the torture itself, but the moment of arrest or the periods between torture sessions, when they were frightened of what was going to happen.

For descriptive and practical purposes, a distinction between physical and mental torture will be made in the following pages.

The different types of torture will be presented according to the accounts given by the examined persons.

PHYSICAL TORTURE AND MALTREATMENT ALLEGED

Table IV,1 lists the types of alleged physical torture, giving the number and sex of the persons. Information about the countries where the torture occurred (if 5 or more persons from a country have been examined) is given in Table IV,2. Table IV,3 lists the types of torture and shows for each type the number of persons who alleged torture, those who denied torture, and those in whom no information was available.

Beating was the most frequent type of torture, reported by 198 persons (99%), 38 women and 160 men. Only 2 persons, a woman from Northern Ireland and a man from Chile, said that they had not been beaten.

The forms of beating varied from a few slaps in the face with the open hand to extensive beating with a blunt instrument like a police baton. Severe beating was defined as beating with an instrument, punching with fists, or kicking with feet. It was reported by 195 persons (97%), 35 women and 160 men. It is therefore seen that, af the 198 who were beaten, only 3 were not severely beaten.

It has been impossible to estimate the number of beatings in this retrospective analysis. A grading scale that includes the intensity and number of the beatings should be employed in future prospective studies.

The part of the body that was severely beaten was registered:

146 persons (73%), 26 women and 120 men, had been severely beaten towards the head.

110 persons (55%) were severely beaten on the upper extremities, 142 persons (72%) on the lower extremities, 138 persons (69%) on chest and back, and 148 (74%) on the abdominal wall or kidney region. 41 persons, all men (20% of the total), had been severely beaten on the genitals.

Some special torture methods by beating were encountered:

Falanga torture: severe beating on the soles of the feet. 59 persons (29%), 19 women and 50 men, alleged this form of torture. This type of torture was reported particularly by Iraqi (75%) and Greek (83%) victims.

Teléfono: This is defined as simultaneous beating of both ears with the palms of the hands, and it was alleged by 19 persons (9%).

31 persons (15%), 5 women and 26 men, had their heads *banged* against the wall or floor.

Table IV,1. *Types of physical torture. n=200.*

Types of physical torture	Sex F	Sex M	Total	%
Beating	38	160	198	99
Severe beating	35	160	195	97
Severe beating head	26	120	146	73
Severe beatings in genitals	0	41	41	20
Falanga	9	50	59	29
Teléfono	2	17	19	9
Banging the head against the wall or floor ...	5	26	31	15
Pushed down stairs, out of windows etc.	0	3	3	1
Torture by heat	2	25	27	13
Electric torture	20	89	109	54
Nail torture	0	5	5	2
Tearing out hairs	1	6	7	3
"Finger" torture	1	12	13	6
Suspension by arms or legs	4	29	33	16
Suspension "la barra"	3	17	20	10
Physical exhaustion	6	62	68	34
"Standing"	3	32	35	17
Maintain abnormal body position	2	24	26	13
Forced gymnastics	1	21	22	11
Climatic stress	15	52	67	33
Asphyxiation	14	45	59	29
Wet submarino ("la bañera")	7	32	39	19
Dry submarino	2	11	13	6
Strangulation	2	4	6	3
Light torture	1	4	5	2
Sexual violation: rape	5	2	7	3
Sexual violation using instruments	8	12	20	10
Other types of physical torture mentioned ...	7	37	44	22

Table IV,2. *Types of physical torture and country where the torture took place (if 5 or more persons alleged having been tortured in that country). n=200.*

Torture type	Country							
	Arg. %	Chi. %	Ira. %	Spa. %	N.I. %	Gre. %	Uru. %	Oth. %
Beating	100	99	100	100	80	100	100	100
Severe beating	100	96	100	96	80	100	100	100
Severe beating head	88	62	88	82	80	71	67	77
Severe beatings in genitals	12	18	19	32	20	26	33	8
Falanga	4	8	75	39	0	83	0	23
Teléfono	16	10	0	4	0	11	22	8
Banging the head against the wall or floor	8	6	37	14	60	31	0	8
Torture by heat	24	13	18	4	0	11	11	23
Electric torture	60	86	63	18	0	17	89	46
Nail torture	0	3	0	4	0	3	11	0
Tearing out hairs	0	1	0	0	20	11	0	0
"Finger" torture	0	3	0	25	20	0	11	15
Suspension by arms or legs	8	20	25	7	0	17	33	15
Suspension "la barra"	0	6	13	32	0	3	0	31
Physical exhaustion	32	23	25	61	60	23	100	23
"Standing"	12	7	18	21	60	17	89	8
Maintain abnormal body position	16	7	13	18	40	14	11	15
Forced gymnastics	4	14	0	25	40	6	0	0
Climatic stress	48	35	13	29	20	31	56	31
Asphyxiation	44	26	0	50	0	11	89	31
Wet submarino ("la bañera")	32	18	0	25	0	0	89	4
Dry submarino	12	6	0	18	0	0	0	8
Strangulation	4	4	0	7	0	0	0	0
Light torture	0	0	0	4	0	0	0	15
Sexual violation: rape	12	4	6	0	0	0	0	0
Sexual violation using instruments	12	14	6	0	0	23	22	8
Other types of physical torture mentioned	12	16	19	25	40	37	11	31
Total number (n=200)	25	69	16	28	5	35	9	13
Male (n=161)	14	59	13	23	4	28	9	11
Female (n=39)	11	10	3	5	1	7	0	2

Arg.=Argentina. Chi.=Chile. Ira.=Iraq. Spa.=Spain. N.I.=Northern Ireland. Gre.=Greece. Uru.=Uruguay. Oth.=Other countries.

3 persons, all men, were *pushed down stairs or out of windows.*

Torture by *heat:* Torture by heat to the skin has been inflicted by means of cigarettes, cigars, hot irons, or flames. 27 persons (13%), 2 women and 25 men, had been burned, 22 by cigarettes, 4 by flames, and one by what he believed to be a hot iron.

Electric torture: 109 persons (54%), 20 women and 89 men, had been subjected to electric torture. Very high percentages were found among the Chilean and Uruguayan victims, 86% and 89% respectively. Among the Argentinian and Iraqi victims the figures were 60% and 63% respectively. Low percentages were found among the Spanish, Northern Irish, and Greek victims, 18, 0, and 17% respectively.

Electric torture was often applied to sensitive parts of the body. In this study 55 persons (27%), 10 women and 45 men, said that the electric torture included the genital region.

It has been extremely difficult to obtain reliable information about the instruments used in the electric torture. This has mainly been due to the fact that the persons have been kept blindfold during the electric torture sessions. In some cases the instrument has been reported to have been a shock baton. Such an instrument has been investigated (*Dyhre-Poulsen et al* 1977). Other persons describe naked cables connected to a generator.

When the electric torture was applied, a sound was often heard. An alteration in intensity has been reported. In some cases a fixed electrode was placed on one of the extremities, e.g. the big toe, and another electrode has been moved around to other parts of the body. In Latin America electric torture was applied while the person was immobilized on an iron bed ("La parilla"). A former torturer from Uruguay informed Amnesty International that picana electrica (electric shock baton) was an instrument of North American origin (*AI* 1979 (*Cooper*)).

5 persons (2%), all men, were subjected to *nail torture,* in which their nails were torn off or pins were inserted under them.

6 persons (3%), one woman and 5 men, had *hair torn out.*

13 persons (6%) one woman and 12 men, were subjected to *"Finger torture",* in which pencil-shaped objects are pushed between the fingers, which are then pressed hard together.

Suspension: 50 persons had been subjected to suspension, usually by the arms (24 persons). 20 persons had been subjected to suspension by "la barra". The wrists are tied together and then lowered in front of the legs, which are in maximum flexion at the knees and hips. A bar is then pushed behind the knees and in front of the elbows. The bar is lifted and suspended, so that the victim is left hanging head downwards (Fig. IV,1). The torture form "la barra" was most frequently reported by Spanish victims. 9 persons, all men (32% of the Spanish victims), had been subjected to "la barra".

Finally, 6 persons had been suspended by the legs, and 3 both by the legs and by "la barra".

Physical exhaustion: 68 persons (34%), 6 women and 62 men, had been subjected to physical exhaustion. The main reported forms were "standing", forced abnormal positions, and forced gymnastic exercises. In "standing", the victim was ordered to stand for prolonged periods.

35 persons (17%), 3 women and 32 men, had been subjected to "standing". The length of forced standing varied from a few hours to more than 24 hours. In the classical example of "standing", a circle is drawn on the floor and the person is ordered to stand in the circle. If the person, however, had been allowed to lean against the wall, this was also classified as "standing".

Forced to maintain *abnormal body position:* 26 persons (13%), 2 women and 24 men, said that they had been forced to maintain an abnormal body position for long periods. Examples included being forced to kneel down and not move, and being handcuffed to the wall by one hand between interrogation sessions.

Forced gynmastics: 22 persons (11%), 1 woman and 21 men, had been forced to do gynmastic exercises. One example of this

Table IV,3. *Types of physical torture, number of persons who alleged having been subjected, number of persons who said they had not been tortured in that way, and number of persons where no information was available (not indicated = n.i.). n=200.*

Torture type	Yes n	No n	N.i. n
Beating	198	2	0
Severe beating	195	4	1
Severe beating head	146	19	35
Severe beatings in genitals	41	43	116
Falanga	59	105	36
Teléfono	19	39	142
Banging the head against the wall or floor	31	48	121
Pushed down stairs, out of windows etc.	3	56	141
Torture by heat	27	55	118
Electric torture	109	26	65
Nail torture	5	56	139
Tearing out hairs	6	55	139
"Finger" torture	13	48	139
Suspension by arms or legs	33	62	105
Suspension "la barra"	20	75	105
Physical exhaustion	68	37	95
"Standing"	35	48	117
Maintain abnormal body position	26	48	126
Forced gymnastic	22	47	131
Climatic stress	67	46	87
Asphyxiation	59	44	97
Wet submarino ("la bañera")	39	55	106
Dry submarino	13	51	136
Strangulation	6	59	135
Light torture	3	59	138
Sexual violation: rape	7	64	129
Sexual violation using instruments	20	60	120
Other types of physical torture mentioned	44	156	0

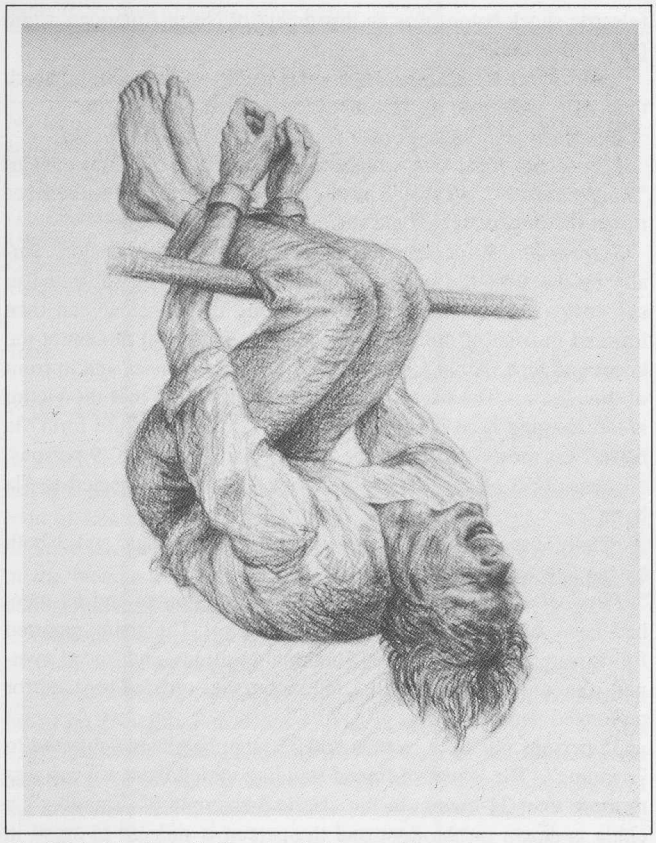

Fig. IV,1. *"La barra". Drawing by Mogens Nørgård.*

was being forced to walk around the interrogation room with flexed knees and hips, hands handcuffed behind the back.

Climatic stress: This was reported in 67 cases (33%), 15 women and 52 men. In 62 cases the climatic stress was in the form of cold environment, in 4 cases it was hot climate, and in one case both cold and hot environment during the detention. The climatic stress usually consisted of the person being confined in a cold cell, sleeping on a cement floor without mattress or blanket.

Asphyxiation: 59 persons (39%), 14 women and 45 men, were subjected to asphyxiation, defined as the obstruction to normal breathing. The most frequent form of asphyxiation was "la bañera", or "wet submarino", reported by 39 persons (19%), 7 women and 32 men. This torture was described as the forcing of the victim's head into a bathtub filled with a mixture of water, blood, vomit, excrement, and food remnants, and keeping the victim there until nearly suffocated. It was frequently reported by Uruguayans and Argentinians (89 and 32% respectively). From Spain and Chile the percentages were 25 and 18 respectively. None of the persons from Iraq, Northern Ireland or Greece had been subjected to wet submarino.

Asphyxiation has also been reported in the form of *"dry submarino"*, in which, as an example, a plastic bag is forced over the head and kept there until the victim is nearly suffocated. 13 persons (6%), 2 women and 11 men, had been subjected to dry submarino. It was particularly reported by Spanish and Argentinian victims, 18 and 12% respectively.

Cases in which the victims were subjected to asphyxiation in the form of having something like a towel pressed against their nose and mouth have been reported, and 6 persons reported strangulation of the neck.

Water torture, excluding "la bañera": 11 persons (5%), all men, had been tortured by water different from "la bañera".

3 persons (1%), one woman and 2 men, were subjected to *torture by light,* for instance by being forced to stare at a bright light for long periods.

Sexual violation: 7 persons (3%), 5 women and 2 men, were raped. 3 of the women said that they were raped while in detention in Argentina, and 2 in Chile. The 2 men came from Chile and Iraq. 3 of the women had been raped by several of their interrogators. As explained in Chapter III, the number of persons alleging this type of torture was probably a minimum. Persons who had been subjected to sexual violation were rather unwilling to disclose the fact because of the risk of losing status and respect from next of kin, since rape is viewed as extremely humiliating (*Lunde* 1981, *Agger* 1986). The reported rape of the women had all been heterosexual, but of both men homosexual.

20 persons (10%), 8 women and 12 men, reported *sexual violations using an instrument.* The instrument varied from a bottle to a stick, inserted into the vagina in the case of women victims, and into the anus in the case of male victims.

Other types of *physical torture* were mentioned by 44 persons (22%), 7 women and 37 men. Table IV,4 lists all the reported types of torture.

4 persons reported *"la Moto"* = the motorcycle. The victim is seated on a chair, wrists handcuffed behind the back of the chair. The legs are brought around to the sides, and the hips and knees flexed as tightly as possible. The legs are then raised and put on chairs at each side of the victim, causing intense pain in the knees. Further pain is induced by pressing the calves against the thighs (Fig. IV,2).

The operating theatre = *"Quirófano"*. 4 persons explained that they were made to lie on a table with the upper half of the body unsupported (Fig. IV,3).

Gunt-twist of the legs consisted in twisting the legs with the use of a rifle and its sling, while the body of the person is kept immobile (4 persons).

Table IV,4. *Other types of physical torture.(n=44)*

Torture forms	n
"La moto" (cf. text and Fig. IV,2)	4
"Quirófano" (cf. text and Fig. IV,3)	4
Lifted by the hair	3
Tongue pulled violently	3
Flogging	2
Twisting the genitals	2
Bare feet in the snow	1
Bare feet on sharp stones	2
Handcuffed very tightly	2
Placed in a coffin and lowered into a grave	2
Placed on a fire, the hair burned off	1
Gun-twist of the legs (cf. text)	4
Scratched with a knife	1
Big toenail pulled off	1
Heavy weight fastened to ear lobe	1
Both ears twisted and then pulled to each side	1
Female breast twisted	1
Stabbed with needles and bayonets	1
Left chained in the desert with jam on the face – fainted because of insects and sun; penis pulled with nylon string	1
Forced to eat chili pepper	1
Locked in a cupboard dressed only in underwear, whereafter it became very cold	1
Al mangana (vice-like grip on the toes)	1
Pressure on the eyes	1
Tongue pulled out, then pressure applied to jaw so that tongue was bitten	1
Striking the barrel at the same time his head is lowered into the barrel containing excrement	1
Tied by the hands to a vehicle which then drove over gravel, grass and asphalt – legs completely raw	1
Lifted by the ears – pulled by the hair	1
Water enema	1
Needle pushed up the nose	1
Powder put into the eyes to irritate them	1
Forced to drink vinegar and oil	1
Shot in the knee during interrogation	1
Drops of cold water dripped on her forehead	1
Wooden horse, and pulled after a boat on a lake	1
Hung up naked on a moving wheel	1
Struck in the kidney region with a sharp metal rod	1
Pressed fingers behind the ears so that the victim fainted	1

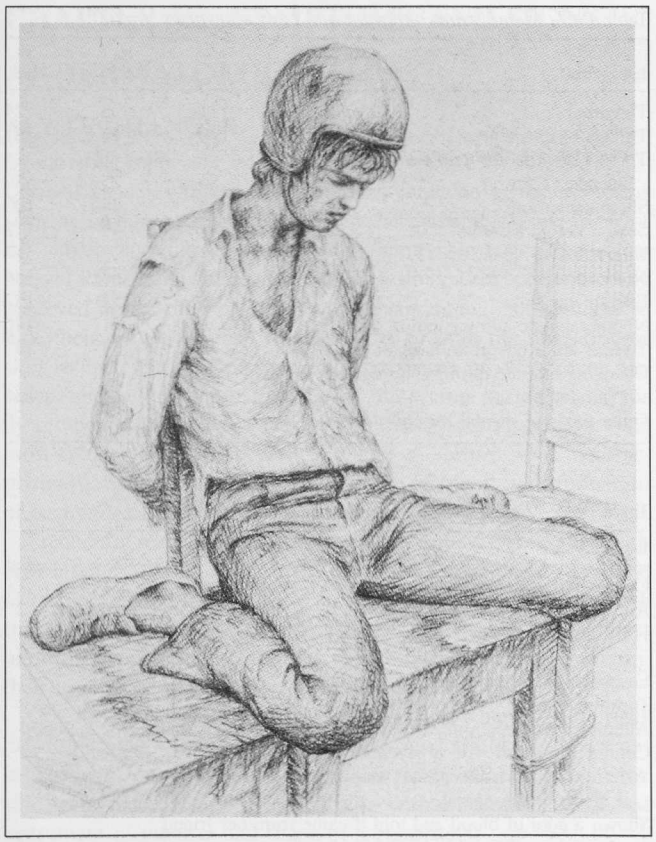

Fig. IV,2. *"La moto". The motorcycle. Drawing by Mogens Nørgård.*

MENTAL TORTURE AND MALTREATMENT ALLEGED

Table IV,5,6 and 7 present the data on mental torture in the same way as Table IV,1,2 and 3 did for physical torture.

Threats: This was the most frequent form of mental torture and maltreatment reported. 172 persons (86%), 38 women and 134, men had received threats. Many forms of threats were reported: threats of further torture, of torture that would kill the person, of specific torture methods, that the family would be arrested, that the children would be arrested and tortured, etc. Threats of execution were experienced by 60%, and 43% had received threats against their families and/or friends.

Sham execution: 63 persons (31%), 13 women and 50 men, had experienced sham execution. A high percentage of reported sham executions was found among Argentinian victims – 15 persons, 7 women and 8 men (60% of the examined Argentinians). The forms of sham execution varied: in some cases a revolver was placed at the victim's temple and the person was told that now he or she would be executed. When the trigger was pressed, the person realized that the weapon was not loaded. In other cases, the person was taken for execution and placed against a wall together with other persons. The guards were ordered to fire, and in fact fired their weapons but the bullets did not hit the person.

41 persons (45%), 22 women and 19 men, had received *verbal sexual assaults.*

91 persons (45%), 22 women and 69 men, reported that they had been *undressed* during interrogation.

Noise torture: 10 persons (5%), 2 women and 8 men, were subjected to noise torture. The high incidence of reported noise torture was found among the Greek victims – 7 persons, 2 women and 5 men, one-fifth of the examined Greek ex-prisoners. In most of these cases, the noise was produced while the persons were kept in detention in a boat, the noise being produced by heavy metal chains being dragged over the deck of the ship for a prolonged period of time.

Excrement abuse: 6 persons (3%), 1 woman and 5 men, reported having been subjected to excrement abuse, 4 of them in Chile. In most of the cases of excrement abuse the persons said they were forced to eat excrement.

Non-therapeutic administration of drugs: 9 persons (4%), 3 women and 6 men, received non-therapeutic administration of drugs.

7 of these persons were Chileans (3 women and 4 men) and the following accounts were given:

- Before she was sexually tortured she was injected with an unknown substance in the right cubital fossa. (She could not tell who gave her the injection.) She was also injected in the right shoulder.
- He was injected with a tranquillizer for high blood pressure, the doctor explaining he needed this to be able to work better with "the boys".
- On her second day at the interrogation centre, she was told she was to see a doctor, and this person told her she was very nervous. He made her swallow a bitter liquid, after which she nearly fainted. She could not remember what happened next.
- After a session of electrical torture, he was forcibly medicated. He was given an intravenous injection into the right cubital fossa which seemed to make him talk unrestrainedly, and he answered every single question he was asked.
- Twice he was given an injection during torture sessions.
- She was forced to take 3 tablets said to be tranquillizers. They smelled like meprobamate. Later she received an intravenous injection in the cubital fossa and she fell asleep. (She was pregnant during the arrest).
- Injected in the back, making it very difficult for him to breathe, and the whole body became numb and he fainted.
- A person from Spain gave the following account: He received a cup of coffee, and believed some kind of hypnotic was added, because shortly after drinking the coffee he fainted and woke up after 24 hours.
- A person from Iraq gave the following account: A strong-smelling piece of cotton was forced on his nose, making him faint. He was unconscious for several hours.

Torture via *exposure to animals:* 2 persons (1%), both Chilean women, had been tortured via exposure to animals.

Spiders or mice were placed on the genital region while the

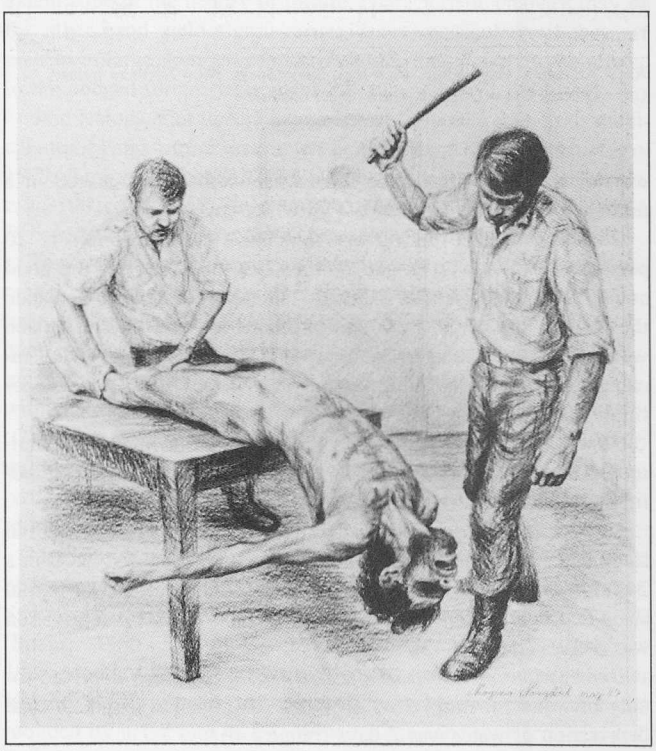

Fig. IV,3. *" El quirófano". The operating table. Drawing by Mogens Nørgård.*

Table IV,5. *Mental types of torture. n=200.*

Torture methods	Sex F	Sex M	Total	%
Threats	38	133	171	85
Threats of execution	24	96	120	60
Threats towards the prisoner's family and/or friends	22	64	86	43
Sham execution	13	50	63	31
Sexual verbal assaults	22	19	41	20
Undressed	22	69	91	45
Noise torture	2	8	10	5
Excrement abuse	1	5	6	3
Nontherapeutic administration of drugs	3	6	9	4
Torture via exposure to animals	2	0	2	1
Changing attitude during interrogation (The good man)	6	19	25	12
Other types of mental torture mentioned	5	8	13	6
Total	39	161	200	100

Table IV,6. *Mental types of torture and country where the torture occurred if 5 or more persons alleged torture in that country. n=200.*

Torture form	Country Arg. %	Chi. %	Ira. %	Spa. %	N.I. %	Gre. %	Uru. %	Oth. %
Threats	88	91	94	93	80	69	89	77
Threats of execution	62	68	56	68	40	40	56	46
Threats towards the prisoners family and/or friends	44	33	44	36	40	31	56	54
Sham execution	60	33	25	43	0	9	33	23
Sexual verbal assaults	32	10	56	14	80	11	33	15
Undressed	60	54	44	43	40	20	67	38
Noise torture	0	3	6	0	0	20	0	0
Excrement abuse	4	6	0	0	0	0	11	0
Nontherapeutic administration of drugs	0	10	6	4	0	0	0	0
Torture via exposure to animals	0	3	0	0	0	0	0	0
Changing attitude during interrogation (The good man)	8	17	0	7	20	14	33	8
Other types of mental torture mentioned	4	9	19	0	0	9	0	0
Total number (n=200)	25	69	16	28	5	35	9	13
Male (n=161)	14	59	13	23	4	28	9	11
Female (n=39)	11	10	3	5	1	7	0	2

Arg.= Argentina. Chi.= Chile. Ira.= Iraq. Spa.= Spain. N.I.= Northern Ireland. Gre.= Greece. Uru.= Uruguay. Oth.= Other countries.

woman was kept immobile. The other woman was placed in a room with rats, and later with a growling dog.

Changing attitude during interrogation (*"the good man"*): 26 persons (13%), 6 women and 20 men, had experienced "the good man". In all the cases the "friendly" interrogator tried to persuade the persons to tell the truth and promised that the torture session would be stopped and everything would be alright. In many instances, the "friendly" interrogator also offered special privileges like coffee, cigarettes, etc.

Blindfolding: 101 persons (51%) reported having been blindfolded during the detention. The median length of reported blindfolding was 5 days (range 1-90 days).

Deprivation of sleep (total and/or partial). In this study, partial sleep deprivation has been defined as less than 2 hours' sleep in a 24-hour period. 49 persons (24%) had suffered total and/or partial sleep deprivation. The median length of reported sleep deprivation was 5 days (range 1-45).

Deprivation of water: 32 persons (16%) had been deprived totally of water for more than 24 hours. The median length of total deprivation of water was 2 days (range 1-6).

Constant interrogation: 20 persons (10%) had been constantly interrogated. For this purpose, constant interrogation is defined as

Table IV,7. *Mental types of torture and reply categories. n=200.*

Torture form	Yes n	No n	N.i. n
Threats	171	5	24
Threats of execution	120	19	61
Threats towards the prisoners family and/or friends	86	25	89
Sham execution	63	37	100
Sexual verbal assaults	41	47	112
Undressed	91	32	77
Noise torture	10	56	134
Excrement abuse	6	57	137
Nontherapeutic administration of drugs	9	51	140
Torture via exposure to animals	2	57	141
Changing attitude during interrogation (The good man)	25	44	131
Other types of mental torture mentioned	13	187	0

Table IV,8. *Other types of mental torture. n=13.*

Torture methods	n
Confronted with a cadaver, said to be her boy friend	1
Attempts to hypnotize the person	2
Forced to watch others being tortured (in one case torture of pregnant wife)	4
Earphones, repeatedly told he was to die	1
Tortured in front of his wife	1
Attempted to force a male inmate to rape her	1
Confined in a cell with a psychotic person	1
Wife brought to interrogation room, threatened with rape if he did not cooperate	1
Shown a pool of blood and told it came from her friend whom they claimed to have killed	1

interrogation for more than 8 hours during a 24-hour period. The median length of constant interrogation was 2 days (range 1-5).

Other types of mental torture: 13 persons (6%), 5 women and 8 men, reported other forms of mental torture. The reported torture methods are shown in Table IV,8.

PRISON CONDITIONS

All performed examinations have focused on the alleged torture methods, but information was also obtained about the prison conditions.

One of the 200 persons examined had not been in prison. The median number of days in prison was 259 (range 1-5475). The median number of places of internment was 3 (range 1-16). (1 person was not interned). The median number of arrests was one (range 1-9). (1 person was not arrested.)

During detention and imprisonment 150 persons (75%) were kept in *solitary confinement.* The median length of solitary confinement was 14 days (range 1-274).

Food deprivation: 155 reports contained information about food deprivation. 58 persons (37%) had been totally deprived of food for more than 24 hours. The median length of total deprivation of food was 4 days (range 1-13)

152 reports contained information whether the food was insufficient or not. 67 out of 152 (44%) indicated that the food they received was insufficient in amount and nutritional value; the median length of insufficient food intake was 4 days (range 1-36).

Toilet facilities: 58 persons (29%), 10 women and 48 men, reported that the toilet facilities during detention were not adequate.

51 persons (25%), 12 women and 39 men, said that *visits* by relatives at least once a month during their detention were not allowed.

31 persons (15%), 8 women and 23 men, indicated that *death of other prisoners or detainees* occurred during their detention.

84 persons (42%), 19 women and 65 men, said that the *medical care* provided during detention was not adequate.

CHAPTER V. SYMPTOMS AND SIGNS

A: DERMATOLOGICAL

ACUTE CHANGES

(A-variable, reply rate = 0.78)

Dermatological symptoms occurred as sequelae to torture forms such as beating, burning, and electrical damage. While 70% of the persons interviewed reported that acute skin lesions had been present immediately after torture, skin lesions were less commonly observed at the time of the medical examination. In attempts to hide their crime, torturers frequently try to limit the formation of skin lesions, for example by wrapping pieces of cloth round the wrists and ankles before fixation of the victim to "la parilla" or by protecting the soles of the feet with shoes during falanga. The most frequently reported early sequelae of torture were, not surprisingly, blue lesions, i.e. extravasation of blood with formation of ecchymoses and haematomas due to beating.

Frequently recorded early sequelae were superficial lesions, with brown scales, following electrical torture. Less frequently this type of torture left red lesions, sometimes with blisters, or pale lesions (necroses?). It must be emphasized that the victims were almost uniformly kept blindfolded, thus preventing them from observing their lesions, particularly the superficial and transient ones.

Other recorded early sequelae were circular wounds with crusts due to burning with cigarettes. Such burning could also leave red lesions with or without blisters. Deep round black holes in the skin were recorded following burning with an electrically heated instrument of the size and shape of a cigarette.

Alopecia was seen as traction alopecia, and the result of electrical torture.

LATE CHANGES

(A-variable, reply rate = 0.79)

The later skin sequelae of torture as recorded at the medical examination were predominantly scars, which were found in 41% of the persons examined. While blunt violence and electrical torture seldom left persistent lesions, scars were often observed following burning.

The size and shape of the scars were only rarely characteristic of the alleged torture instruments, and often their localization was the only link with the torture. Thus, in cases with slight and atypical scar formation, an association with alleged torture several years earlier was sometimes doubtful.

The scars after burning often had characteristic shapes, e.g. circular following burning with cigarettes (Fig. V:A,1 page 17) and with an electrically heated circular instrument (Fig. V:A,2 page 17). While the former left macular scars with ill-defined borders, the latter left atrophic scars with well-defined borders and considerable loss of tissue.

Scars following the picana type electrical torture also had characteristic patterns with groups of macular lesions each of 1-2 mm diameter (Fig. V:A,3 page 17).

Alopecia was seldom observed at the time of the medical examination.

A detailed account of the sequelae reported above may be found in Tables V:A,1-2.

Regional distribution of skin lesions following different torture methods is shown in Table V:A,3.

Table V:A,1. *Association of torture type with acute skin symptoms observed by the victim and skin sequelae registered at the time of examination.*

Torture type	Number of persons	Number of persons who observed acute skin symptoms	Number of persons with lesions at time of examination
Electrical	109	32	33
Burns	27	24	24
Blunt violence	195	136	37

Table V:A,2. *Types of acute skin symptoms observed after different torture types.*

Blunt violence (severe beating)	Total 136
Blue lesions	117
Excoriations	30
Wounds	40
Electrical torture	Total 32
Lesions with brown scales	22
Red lesions	8
Red lesions with blisters	5
Pale lesions	1
Burns with cigarettes	Total 19
Wounds with crusts (3rd degree burns)	13
Red lesions with blisters (2nd degree burns)	3
Superficial red skin lesions (1st degree burns)	3

Table V:A,3. *Persons with scars supporting allegation of torture. n = 200.*

Region	Torture type				
	beating	electricity	cigarettes	injection	other
Head	9	4	–	–	–
Body	9	9	4	–	3
Upper extremities	6	13	7	1	5
Lower extremities	16	5	8	1	4
Genitals	–	2	1	–	–

DISCUSSION

The primary significance of the skin changes is that they may support allegations of torture. Only rarely do they permanently harm the patients, although cosmetic consequences may sometimes be important if they contribute to the feeling of altered integrity, so often induced by torture in patients.

The diagnostic significance of the individual skin lesions is limited since in most cases they could have resulted from spontaneously occurring inflammatory processes. Indications of an external induction are asymmetric and unusual localization of the changes, and linear and sharp-cornered shape of individual scars. While few and uncharacteristic cicatrices may only to a limited extent support the history of torture, characteristic changes may on the other hand yield significant evidence, particularly if they are present in large numbers, and if their size and shape can be related to the alleged torture instrument.

Skin lesions after torture have been described in numerous medical articles and torture reports (*Rasmussen et al* 1977, *Cathcart et al* 1979, *Berger* 1980, *AI* 1980 (Columbia, Argentina), *Warmenhoven et al* 1981, *Puebla & Fuentes* 1981, AI 1981 (Iraq), *Danielsen & Berger* 1981, *Danielsen* 1982, *Randall et al* 1985, etc.).

These studies also indicate that the rate of acute skin lesions ranges among the highest among symptoms being present at the time of torture. Further, torture methods responsible for acute sequelae in the skin are predominantly blunt traumas, while long-lasting sequelae after torture are to be found after burns, most often with cigarettes, electrical torture, or application of corrosive liquids (*Gordon & Mant* 1984, Fig. V:A,4 page 17). In one case disfiguring keloid scars were observed following damage with a burning tyre (*AI* 1985 (Uganda), Fig. V:A,5 page 20); such scars are known to be characteristic for deep burns.

Medical examinations of the acute lesions presumably yield better evidence than examinations performed several years later. Such examinations have been possible in some countries (AI 1980 (Spain), 1980 (Colombia), 1983 (Chile), *Petersen & Jacobsen* 1985a). Shortly after electrical torture (picana), small, circular lesions, 1-5 mm in diamter, covered by red-brown crusts and surrounded by a 1-2 mm broad erythematous zone with irregular and indistinct edges were observed in groups and lines (*Vicaría de la Solidaridad* 1985). Often due to intermittent moves of the electri-

cal instrument the lesions were connected by erythematous lines, 2-5 mm broad (Fig. V:A,6 page 20). In some cases the erythematous zone surrounding the central lesion was lacking (Fig. V:A,7 page 20).

72 hours after the torture, the circular lesions had disappeared and in some persons were replaced by whitish areas, lasting for up to two weeks.

The variability of the acute lesions following electric torture, described in the present and other studies, probably has several explanations. Only reports based upon medical observations must be regarded as of descriptive value, since the victims themselves often pay little attention to small, unimportant lesions. Use of different types of electrical torture might be another explanation. The distribution of skin lesions following different torture methods (Table V:A,3) reflects the regions where torture has been inflicted, often as a consequence of the victim's position during torture sessions. Cigarette burns on the head were not reported.

Macroscopic examination of skin sites of fully anaesthetized pigs exposed to heat or electrical energy (*Danielsen et al* 1978a,b, *Aalund* 1980, *Thomsen et al* 1981, *Danielsen* 1982, *Karslmark et al* 1983, 1984), have extended our knowledge of the acute changes after transfer of low to moderate amounts of electrical energy or heat energy. These findings are consistant with some of the clinical observations from the present and other studies of acute and late sequelae in victims who allegedly had been subjected to torture by electricity or burning. Characteristically, electrical lesions following application of non-pointed electrodes were segmentary.

After application of both pointed and non-pointed electrodes, the lesions varied according to the amount of energy and type of current used, but were independent of the size and shape of the electrodes. Their diameter ranged from 1 to 5 mm and they were either superficial, brown and scaly, or deep, white and necrotic, usually lacking a surrounding inflammatory reaction. The necrotic areas developed into crusts within a few days. Heat lesions were diffuse. They were superficial with wrinkled surfaces and an indistinct peripheral redness after cigarette burns, while electrically heated instruments produced erythematous lesions or lesions with a deep central necrosis surrounded by a distinct inflammatory border, depending on the amount of energy used. Following heat injury, the border of the lesions reflected the shape of the instrument, and the size of the lesions varied with the amount of energy used.The necrotic areas developed into crusts within a few days. Microscopic examinations of such exposed areas of porcine skin (*Thomsen* 1984, *Karlsmark et al* 1983, 1984) have revealed the presence of changes that are diagnostically significant for electrical influence. Experimental studies on vital human skin after electrical exposure have not been found in the literature. However, in a study (*Dyhre-Poulsen et al* 1977) on an electrical torture instrument (the shock baton), it was noticed that maximum stimuli (equivalent to 0.9 watts) caused erythema of the skin below the electrodes. The erythema remained for 10 minutes after the exposure, and no macroscopic traces were left.

It is the sad fact that torture in many cases results in the death of the victim. The authorities are unwilling to conduct a thorough autopsy, or the autopsy might be falsified (*Kandela* 1981, AI 1983 (Chile), 1984 (El Salvador), *Thomsen et al* 1984). Although family or other local doctors are not allowed to conduct an autopsy, a detailed examination and a description of the skin might strongly suggest that the person had been tortured (*Albrectsen & Voigt* 1978, *Rasmussen & Marcussen* 1982). In the appendix, page 76, two case histories, V:A,1-2, are presented that illustrate sequelae of beating and burning.

CONCLUSION

According to anamnestic information, the skin immediately after torture often reflects the terrible act committed against the victim. While skin lesions only rarely constitute a long-lasting problem, they have been an important factor in establishing evidence of alleged torture. It is important to conduct the medical examination as soon as possible after the infliction of torture, since the predominant skin lesions are due to blunt trauma and usually fade after a few weeks, leaving no detectable scars. Furthermore, observation of acute lesions probably yields better evidence than observation of scars. The most characteristic lesions were found following burning and electrical torture, the former leaving permanent lesions more often than the latter.

B: CARDIOPULMONARY

INTRODUCTION

Cardiopulmonary lesions inflicted by torture are particularly related to the traumatic nature of torture. Certain types of torture lead particularly to pulmonary complications. During "wet submarino" (bathtub) for example, in which the head is submerged, the victim often aspirates the liquid, which is certainly not clean water, but often contaminated with hair, vomit, saliva, mucus, urine, etc.

Harsh prison conditions in humid, cold and dark cells probably often facilitate pneumonia, bronchitis or pulmonary tuberculosis.

SYMPTOMS AT THE TIME OF TORTURE

(B-variable, reply rate = 0.64)

83 persons (41%) complained of symptoms from the heart and/or lungs, while 45 did not, and nil was registered in the remaining 72 cases. Table V:B,1, shows these symptoms at the time of torture.

Beating of the chest was reported by 138 persons, and 33 of them subsequently complained of chest pains. 7 persons reported rib fractures, 1 reported fracture of the clavicle, and 1 fracture of the xiphoid process. A case history is presented in the appendix (page 77) that illustrates thoracic injuries with rib fractures and haemothorax.

Asphyxiation can be divided into dry and wet forms (cf. Chapter IV). The wet form is associated with the potential risk of producing acute lung symptoms, due to aspiration of contaminated water. Of the 39 persons who alleged torture by this "wet submarino", 23 complained of cardiopulmonary symptoms (Table V:B,2). Dyspnoea, cough, and expectoration were all reported more frequently after "wet submarino", and the association with dyspnoea was statisstically significant ($p1<0.05$, p2 N.S.).

SYMPTOMS AT THE TIME OF EXAMINATION

(A-variable, reply rate = 0.85)

At the medical examination, 42 persons complained of heart and/or lung symptoms, 127 persons did not, and nil was registered in the remaining 31 (Table V:B,3). No correlation was found between lung symptoms at the medical examination and previous exposure to wet submarino.

11 persons complained of chest pain, and Table V:B,4 indicates its cause. In half the persons it concerned sequelae of blunt traumas.

16 persons complained of what were classified as symptoms from the vegetative nervous systems. Only when the examining doctors concluded from the interviews and medical examinations that symptoms had no obvious organic causes were they classified

Table V:B,1. *Persons with symptoms from heart and/or lungs at the time of torture. n=200.*

Symptoms	n	%
Dyspnoea	44	22
Chest pain	41	20
Cough	22	11
Expectoration	17	8
Palpitations	17	8
Precordial pain	11	5
Others*)	3	1
Total	83	41

*) 2 hypertension and 1 haemoptysis.

Table V:B,2. *Distribution of pulmonary symptoms at the time of torture in relation to alleged wet submarino torture. n=200.*

Symptoms at the time of torture		Wet submarino yes	Wet submarino no and n.i.*)	total
Dyspnoea	yes	14 (36%)**)	30 (19%)	44
	no	10	50	60
	n.i.	15	81	96
Cough	yes	6 (15%)	16 (10%)	22
	no	13	56	69
	n.i.	20	89	109
Expectoration	yes	5 (13%)	12 (7%)	17
	no	13	58	71
	n.i.	21	91	112
Total		39	161	200

*) n.i. = not indicated.
**) Intra-column percentage.

	Dyspnoea	Cough	Expectoration
p: 1	<0.05	N.S.	N.S.
p: 2	N.S.	–	–

Table V:B,3. *Persons with symptoms from heart and/or lungs at the time of examination. n = 200.*

Symptoms	Total n	Thought to be vegetative n
Chest pain	11	1
Palpitation	12	3
Dyspnoea	9	5
Cough	8	2
Precordial pain	7	3
Expectoration	3	0
Syncopes	2	2
Oedema	1	0
Others	1	0
Total	42	16

Table V:B,4. *Cause of chest pain at the time of examination in 11 persons.*

Cause	n
Severe beating and/or kicking (3 reported fractures)	5
Tuberculosis	1
Bronchitis	1
Foreign body in chest wall	1
No cause found	3
Total	11

as "vegetative". Special examinations such as X-rays of the lungs, electrocardiograms, etc. were often not available. Access to them would probably have reduced the number of symptoms labelled as vegetative.

MEDICAL EXAMINATION

The medical examination showed few sequelae. Palpable signs of rib fractures were found in 3 persons. Auscultation of the lungs revealed signs of chronic infection in two cases, and in one case auscultation of the heart was abnormal. X-ray of the thorax was performed in 6 persons, and found to be normal in 3. A foreign body was found in the chest wall in 1 (*Cohn et al* 1978), sequelae of pleurisy in 1, and sequelae of tuberculosis in one.

DISCUSSION

Blunt trauma in the form of severe beating and/or kicking was the most common torture form directed against the chest (138 persons).

Severe intrathoracic injuries have been reported after blunt traumas in non-torture patients admitted to hospital (*Rasmussen et al* 1986), but were very seldom found among the examined torture victims. However, they have been reported in victims who have died after torture (*Martirena* 1987b).

In most of the victims wet submarino led to acute respiratory symptoms during the torture session and also later. Some reported that they had aspirated contaminated water, but many had fainted and thus could not give an exact answer to this question. Victims of wet submarino are at risk of later pulmonary infections, although such a correlation was not established in this study, and permanent symptoms due to wet submarino were not found.

The frequency of pulmonary symptoms at the time of examination was no higher among victims of submarino than in other victims. X-rays of the thorax in 5 out of 7 Spanish victims who had suffered wet submarino were normal (*Jess et al* 1980). The shortest interval between the X-ray examination and the torture episode was 6 months.

As already pointed out, bad prison conditions, such as humid and cold cells, can produce pulmonary complications. Studies of concentration camp victims have shown a frequency of 14% in the camps for both pneumonia and tuberculosis, while infections of the upper respiratory system were present in 70% (*Helweg-Larsen et al* 1949). Follow-up studies 8 years after the liberation showed a high freqency (33%) of recurrent respiratory infections, explained by decreased resistance (*Hermann & Thygesen* 1954). The exact frequency of pulmonary infections among the examined torture victims is impossible to state. From descriptions of symptoms, i.e. presence of cough, expectoration, fever, approximately 20 persons were infected. At the time of examination 6 persons complained of recurrent pulmonary infections, and this number is not higher than that found in a normal Danish population (*Hollnagel* 1985).

Cardiac symptoms in the form of palpitations were found in 73% of concentration camp victims examined 8 years after the liberation (*Hermann & Thygesen* 1954). In-depth medical examination did not normally reveal abnormalities, and the palpitations were partly explained by a poor adjustment by the cardiovascular system to the rapid weight gain after the liberation, and partly by mental instability. Palpitations among the examined torture victims were few (12 persons) and thought to be vegetative in 3. Cardiopulmonary vegetative symptoms were not frequently recorded (16 persons).

Very little has been published on cardiopulmonary consequences of torture (*Rasmussen et al* 1977, *Rasmussen & Lunde* 1980). In a follow-up study on 22 Greek torture victims (*Petersen et al* 1985a), cardiopulmonary symptoms appeared with a higher frequency than at the first examination, 4 to 5 years earlier. Attacks of tachycardia, palpitations and/or dyspnoea, also combined with anxiety, were found in 6/22, pain in the thorax, including angina and muscular pain in 5/22, and chronic bronchitis (cough, exertion dyspnoea) in 8/22 persons. These findings highlight the importance of follow-up studies on torture victims, as in concentration camp victims (*Nielsen* 1986).

CONCLUSION

The most common torture against the chest is in the form of blunt trauma. The traumas led to rib fractures and intrathoracic lesions in only a few of the surviving torture victims. Wet submarino, (the banera), carries a potential risk of producing acute lung infections, although this has not been confirmed by the present study, in which no permanent sequelae were established.

Bad prison conditions can cause acute lung infections and tuberculosis.

C: GASTROINTESTINAL

SYMPTOMS AT THE TIME OF TORTURE

(A-variable, reply rate = 0.76)

123 persons (62%) complained of symptoms from the digestive tract at the time of torture. The distribution is listed in Table V:C,1.

In torture victims, the traumas against the abdominal wall are of

a blunt and not a penetrating nature. 148 persons (74%) reported severe beating of the abdominal wall and kidney region. None of the examined persons were admitted to hospital for observation or operation of intra-abdominal lesions. 66 persons complained of lower abdominal pain, in most cases related to the trauma, in others probably caused by digestive problems.

152 reports contained information about the quantity and quality of the food during detention. 67 persons (44%) indicated that the food was insufficient in both amount and nutritional value; the median length of insufficient food intake was 4 days (range 1-36 days). Weight loss was reported by 111 persons. The mean value of weight loss during detention was 10 kg (range 2-36 kg). Only one person reported a gain in weight (8 kg) during detention (not in the form of hunger oedema).

6 persons complained of haematemesis. A case history, V:C,1, is presented as an example in the appendix (page 78). In one woman and 5 men the haematemesis occurred in connection with or a few days after the torture. The episodes were of short duration in all the cases and ceased without medical intervention. A gastric ulcer had been diagnosed in one of the men before the arrest and the bleeding possibly derived from this. In the remaining 5 persons, the bleeding probably represented a superficial bleeding of the mucosae. Gastritis or a Mallery Weiss lesion are other conditions which could be considered. The last person experienced haematemesis and melaena 6 weeks after liberation, and received no medical treatment. During his 6 days of arrest he had complained of upper epigastric discomfort.

Epigastric discomfort was found in 32 persons, and included heartburn in 21. Only 2 persons reported that they received antacids during detention because of their complaints.

Alteration in defecation was reported by 59 persons, in the form of diarrhoea in 43 and constipation in 16 persons. Toilet facilities were often not available and defecation took place in the cell. 50% stated that the toilet facilities were inadequate during imprisonment. In a number of cases the diarrhoea was accompanied by fever, possibly due to an intestinal infection.

Vomiting without blood staining was experienced by 41 persons. In a few cases it was explosive, following a violent head trauma.

A foreign body was inserted into the anus of 15 persons, 2 women and 13 men. In 6 persons it was allegedly an electrode through which electrical torture was applied. All the victims described immediate terrible pain, 3 persons suffered bleeding or painful defecation for a few days, but leaving no permanent symptoms. One man had a finger inserted in the rectum and he described no sequelae. The remaining 8 persons had had a rod or a bottle inserted, resulting in immediate pain. 5 of them observed fresh blood on the stool and 3 persons complained of painful defecation for a few days to two weeks, again leaving no permanent symptoms.

Table V:C,l. *Number of persons with symptoms from the digestive tract at the time of torture and at the time of examination. n=200.*

Symptoms	At the time of torture		At the time of examination	
	n	%	n	%
Abdominal pain	66	33	37	18
Epigastric discomfort	32	16	32	16
Diarrhoea	43	21	3	1
Constipation	16	8	8	4
Rectal bleeding	13	6	2	1
Painful defecation	7	3	1	0
Haematemesis	6	3	1	0
Vomiting	41	20	9	4
Decrease in appetite	27	13	5	2
Weight loss	111	55	7	3
Weight gain	1	0	5	2
Vegetative symptoms	0	0	3	1
Other	6	3	6	3
Total	123	61	51	25

Melaena was observed by 5 persons who complained of epigastric discomfort without vomiting. 2 persons with bleeding from the mouth and one with haemoptysis observed melaena for a few days.

SYMPTOMS AT THE TIME OF EXAMINATION

(A-variable, reply rate = 0.85)

51 persons (25%) complained of symptoms from the digestive tract at the time of examination (Table V:C,1).

Upper epigastric complaints were registered in 32 persons, including heartburn in 23. Information about smoking and drinking habits at the time of examination was not sufficient (reply frequency <18%) to allow for an examination of a possible correlation.

Lower abdominal complaints were registered in 37 persons. A change in defecation habit, compared with before arrest, was reported by 11 persons, 8 with constipation and 3 with diarrhoea.

7 persons had not regained their pre-torture weight at the time of examination. 5 persons had gained weight, compared with their weight before arrest.

Symptoms thought to be of a vegetative nature were found in 3 persons.

MEDICAL EXAMINATION

Soreness was noticed in 5 persons in the pit of the stomach, and located to the descending colon in 4 persons.

Proctoscopy was performed in 6 persons and was abnormal in one. A scar was present at the mucosal junction, but the sphincter was normal and he had no symptoms. He alleged having a bottle-like object forced into his rectum, giving so much pain that he fainted.

DISCUSSION

Direct blunt traumas caused acute pain located to the abdominal wall, but none of the examined torture victims in this survey gave accounts of intra-abdominal lesions after blunt traumas. It is known that intra-abdominal lesions after blunt traumas include rupture of the spleen and contusion of the liver (*Dudley* 1977). Both of these lesions need early surgical intervention in order to save the patient's life. It is likely that intra-abdominal lesions are common after torture, but that they are not registered because the victims die. In autopsy reports of torture victims, death caused by intra-abdominal bleeding has been described (*AI* 1984 (Uruguay. Doctor dies under torture), 1987 (Kenya), 1987 (China)).

Curling (1842) reported one century ago the occurrence of acute gastroduodenal haemorrhage in patients with severe burns. Diffuse or focal acute ulceration of digestive mucosae has been reported following severe stressful situations (*Lucas* 1981), and the risk seems to be proportional to the severity and duration of stress.

Torture presumably imposes so much stress on the victim that acute gastroduodenal haemorrhage is likely to occur. Torture victims have reported acute haematemesis in connection with the torture (*Warmenhoven et al* 1981). The rate of haematemesis in the present survey was 3%, but the material was selected since it represented the survivors of the torture.

Weight loss in torture victims is generally known to be relatively modest, measuring about 5-10 kg (*Rasmussen et al* 1977, *Warmenhoven et al* 1981), and it is only rarely as severe as that of concentration camp survivors (*Severin et al* 1978).

The food during detention was described as insufficient in nutrition by more than 40% of those who gave detailed accounts on this question. Poor prison food with lack of protein and roughage can result in faulty digestion, and, together with restriction in liquid and lack of exercise, it creates an imbalance between the peristaltic pressure and the intraluminal food mass. This in turn can result in a disturbance of the normal peristaltic wave – analogous to the mechanism which causes certain types of irritable colon (*Rasmussen & Marcussen* 1982).

The finding that 25% reported gastrointestinal symptoms at the time of the examination agrees with previous studies of torture

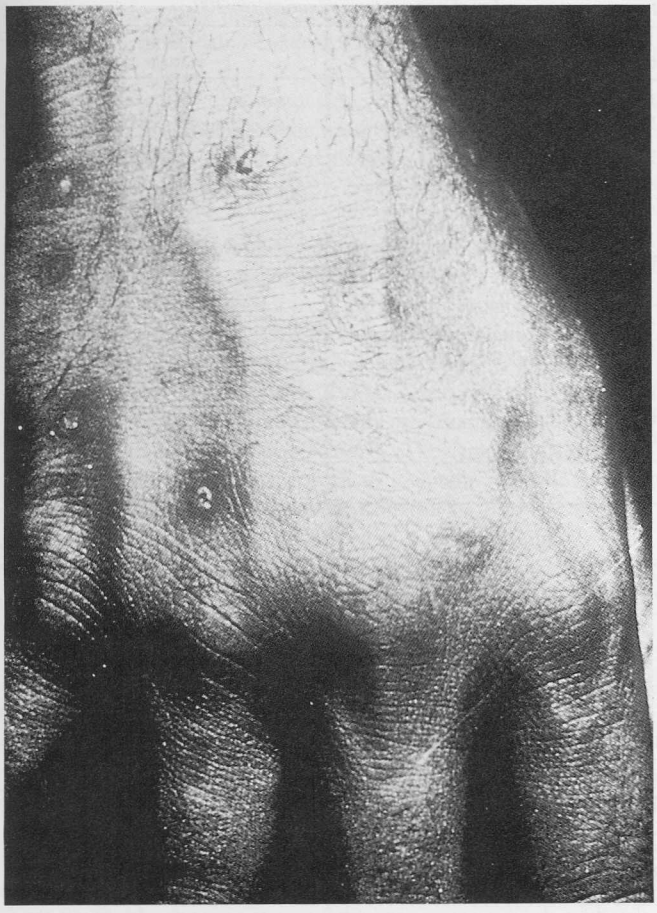

Fig. V:A,1. *Scars on the dorsum of the hand, 4 weeks after burning with a cigarette. The scars have a depigmented circular centre surrounded by an ill-defined hyperpigmented periphery. (Kjærsgaard & Genefke 1977). Reproduced with the permission of the Journal of the Danish Medical Association, Ugeskr Læger.*

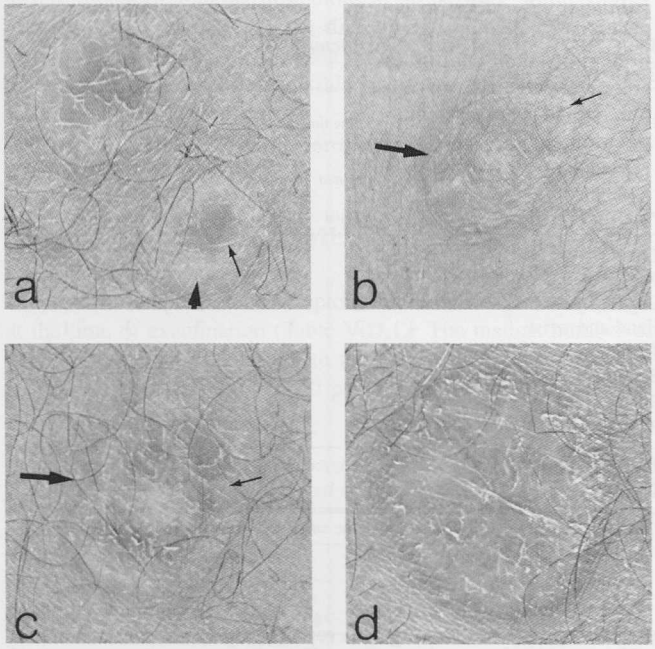

Fig. V:A,2. *Cicatrices on the thigh one year after burning with an electrically heated cylindrical metal rod of the size of a cigarette. The lesions are circular or oval, or have a serpiginous border. Some of the lesions have an atrophic centre, surrounded by two narrow peripheral zones, an inner hypertrophic, distincly demarcated zone (thin arrows) and an outer pigmented zone (thick arrows). One small lesion lacks the atrophic centre (a), one large lesion lacks the hypertrophic zone (d). Some lesions are subdivided into small, confluent areas (c). (Danielsen & Berger 1981). Reproduced with the permission of the Journal Acta Dermatovener.*

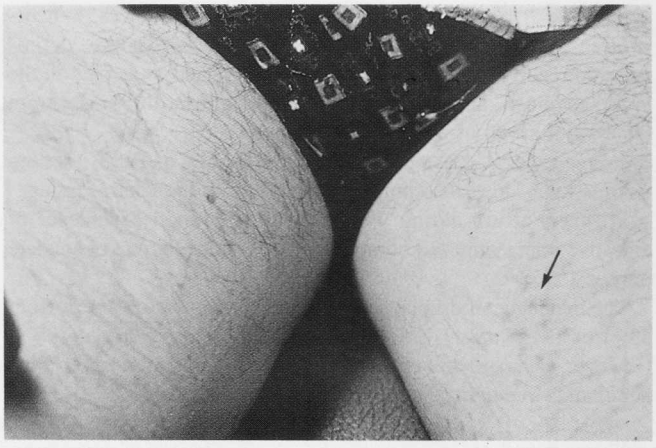

Fig. V:A,3. *A cluster of circular cicatrices with a diameter of 1 mm (arrow) 4 weeks after electrical torture with pointed electrodes (picana). The cicatrices are positioned close to each other but are distinctly separated (Kjærsgaard & Genefke 1977). Reproduced with the permision of the Journal of the Danish Medical Association, Ugeskr Læger.*

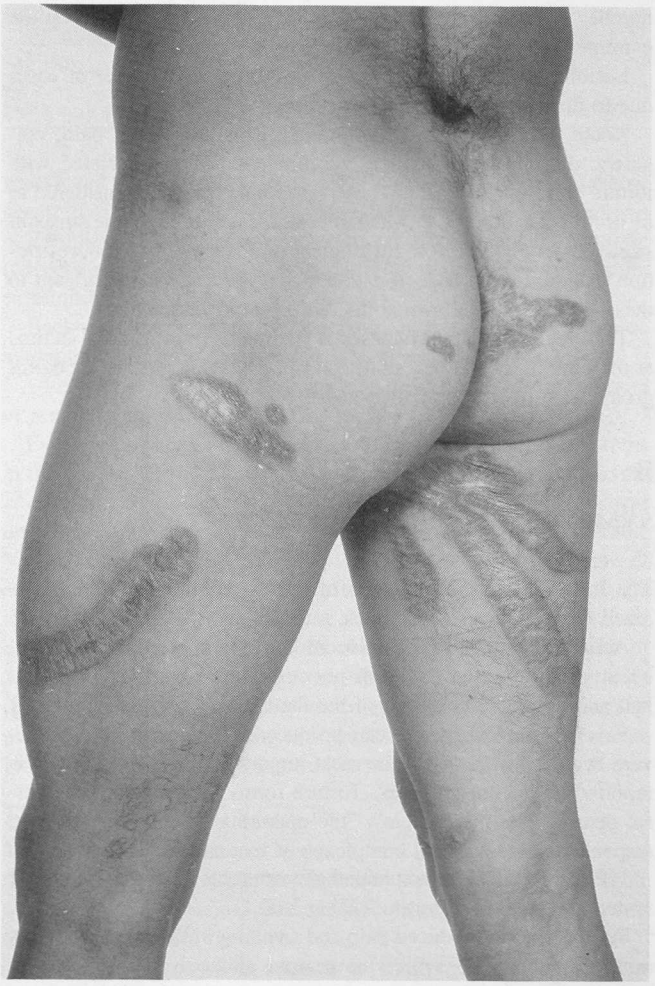

Fig. V:A,4. *30-year-old man, arrested in El Salvador 1982. He said he had been tortured and among other things acid was thrown against him. (Gordon & Mant 1984). Linear scars, a few cm wide and with well-defined borders, are seen on the thighs and buttocks. Their location and form are consistent with the history. The photograph has been reproduced by courtesy of the Medical Illustration Department, Charing Cross Hospital, London.*

victims (*Rasmussen et al* 1977, *Rasmussen & Lunde* 1980, *Petersen & Jacobsen* 1985a, *Petersen et al* 1985, *Randall et al* 1985). *Thorvaldsen* (1986) found that 27% of the examined torture victims suffered recurring episodes of dyspepsia, referred to as pain in the upper abdomen, and that there was no significant difference from the control group of non-tortured victims (20%).

Hougen et al (1988) reported dyspepsia in 43% of Turkish torture victims living in exile, compared with 29% in the control group.

Prisoners of war during World War II had a higher incidence of digestive tract symptoms compared with a control group of soldiers (*Beebe* 1975).

The incidence of dyspepsia in the Danish population varies from 25% to 30% (*Banke* 1975, *Bonnevie* 1979, *Hollnagel et al* 1982). However, comparison between different investigations is very difficult, since methods and criteria vary.

CONCLUSION

Torture victims probably do not often survive severe intra-abdominal traumatic injuries. Fatal intra-abdominal lesions have been observed at autopsies of torture victims.

Weight loss during detention is normally of a limited degree.

Acute gastroduodenal haemorrhage has been reported by a small number of torture victim survivors, and may be explained by the extreme stress.

Lesions of the anus and rectum occurred in a number of cases due to direct torture of the perineal region.

Acute gastrointestinal symptoms such as abdominal pain, epigastric discomfort, diarrhoea, vomiting, etc. are associated with torture and imprisonment. These symptoms must be considered to be of mixed aetiology, in which mechanisms caused by the stressful situation may be a factor. Insufficient or unappetizing food, restriction of liquids, and lack of exercise may also be factors related to these gastrointestinal symptoms during imprisonment.

The incidence of gastrointestinal symptoms in the torture victims at the time of medical examination was the same as that of control groups, and of the population at large.

D: MUSCULOSKELETAL

SYMPTOMS AT THE TIME OF TORTURE

(A-variable, reply rate = 0.88)

The locomotor system consists of the extremities and their organized tissues, such as the bones, muscles, and joints.

Acute symptoms from the locomotor system were reported frequently (Table V:D,1). This is not surprising considering the violent and traumatic character of the the types of torture.

Several kinds of torture can produce locomotor symptoms, severe beating being by far the most important. Severe beating was reported in 97% of all cases. Torture forms like falanga, "the parrot perch", "the motorcycle", "the operating table", etc. are each responsible for symptom complexes of locomotor symptoms.

162 persons (81%) complained of symptoms from the locomotor system at the time of torture (Table V:D,1).

Severe beating produced pain and swelling in the deep structures (muscles and joints), where the persons allegedly had been hit or kicked. 26 persons reported fractures as a result of the torture (Table V:D,2). 15 were hospitalized (Table V:D,3) because of their injuries, and 4 who were not admitted to hospital were examined by a local doctor, who, at the clinical examination, could confirm the diagnosis of fracture. 16 persons had X-ray examinations, which reportedly all supported the suspicion of a fracture.

10 persons gave evidence of fractures of the chest wall, all after blunt trauma. 3 fractures of the jaw were all due to severe beating, and jaw symptoms as a whole were mainly the result of severe beating of the head. Thus, 21 of 24 persons with jaw symptoms reported having been severely beaten in this way.

2 skull fractures occurred, one after severe beating and the other after the head had been banged against a wall. Fracture of the cervical spine from beating was reported by one man, and of the lumber spine by a woman also after beating, this time while she was suspended by her arms.

Certain special torture procedures subsequently resulted in specific acute symptoms: Suspension in *"the parrot perch"* ("la barra", "pau de arara") produced extreme pain, particularly at the wrists, the dorsal part of the lower legs, and the radial parts of the proximal forearms, since these structures carry the whole body weight during suspension (Fig. IV,1). (For further details see case story V:D,1. page 78 in the appendix).

Table V:D,1. *Parts of the locomotor system giving rise to complaints at the time of torture and at the time of examination. n=200.*

Symptoms	At the time of torture	At the time of examination
Jaw	24	4
Neck	20	9
Upper extremities:		
Wrist	26	7
Elbow	5	2
Other parts of upper extremities	17	4
Lower extremities:		
Ankle	67	28
Knee	39	17
Other parts of lower extremities	34	10
Walking difficulties	86	31
Back pain	45	22
Fractures	26	0
Others	5	4
Total	162	70

Table V:D,2. *Distribution of fractures reported by 26/200 examined persons in relation to alleged torture types.*

	Torture types				
Localization	severe beating n=195	falanga n=59	"fall" n=3	banging head against wall n=31	Total
Skull	1			1	2
Jaw	2		1		3
Chest	10				10
Spine	2				2
Arm	1				1
Hand and wrist	2		2		4
Leg and pelvis	3		1		4
Feet		5			5
Total number of fractures	21	5	4	1	31
Total number of persons	18	5	2	1	26

Table V:D,3. *Medical evidence of fractures among 26 persons who reported fractures.*

		At the time of torture			At the time of examination	
Place of fracture	n	admitted to hospital	examination by local doctor	X-ray taken	clinical signs of fracture sequels	X-ray evidence of fracture *)
Chest	10	8	0	7	5	1
Feet	5	2	1	4	2	1
Leg and pelvis	4	2	1	2	4	0
Hand and wrist	4	2	1	3	3	1
Jaw	3	3	3	3	1	0
Skull	2	2	2	1	1	0
Spine	2	1	1	1	2	1
Arm	1	0	1	0	1	1
Total number of fractures	31	20	4	21	19	5
Total number of persons	26	15	4	16	17	5

*) All x-rays performed could establish the suspicion of an earlier fracture.

Suspension by the arms or legs also produced pain where the person had been tied, usually at the wrist or ankle. The frequency of neck and back pain related to suspension is shown in Table V:D,4.

"The *motorcycle*" ("la moto") caused intense pain in the knees, and the pain increased when the torturers further pressed the calves against the thighs. The knee joints were subjected to both direct pressure and twisting (Fig. IV,2). (For further details see Chapter IV).

Finger torture, in which the victims' fingers were pressed hard together around pencil-shaped objects, produced intense pain as the proximal phalanges were subjected to direct pressure.

"The operating table" ("el quirófano") produced intense pain in the back, located to the spinal column, due to the maximum extension of the vertebral articulations, especially in the lumbar region (Fig. IV,3). (For further details see Chapter IV).

Maintaining *abnormal body position:* The symptoms depend on the position the person was forced to maintain. Standing for an extended period of time produced swollen legs, in a few cases to such an extent that blisters developed in the ankle region.

Falanga torture, whether or not the victim wore shoes, produced acute pain located to the soles of the feet in all 59 persons who had been tortured in this way. 5 persons reported fractures of the feet due to falanga.

In 9 persons the pain inflicted by falanga produced a kind of shock wave through the body, and in 2 cases it progressed to the head, when the victim felt as if the head was going to explode. 5 persons had felt pain in the heart region during falanga, and 3 had lost consciousness. Extensive swelling of the feet was described by 39 persons, the feet becoming pyramid-shaped, with oedema located especially at the inner side of the ankle. The duration of the swelling was indicated by 18 persons (median 9 days; range 1-60 days). In 2 cases the oedema was so intense that blisters developed.

4 persons noticed that the skin of the feet became blue or even black. Victims had often been forced to walk in cold water after the torture session in order to decrease the oedema. The falanga torture produced walking difficulties in 50 persons, while 3 other persons complained of walking difficulties not related to falanga torture. The frequency of walking difficulties and symptoms from the lower extremities, related to falanga torture, are shown in Table V:D,5.

The closed compartment syndrome as related to falanga torture will be discussed later.

SYMPTOMS AT THE TIME OF EXAMINATION

(A-variable, reply rate = 0.93)

70 persons complained of symptoms from the locomotor system at the time of examination (Table V:D,1). The median number of years from the alleged torture to the examination by the medical group was 3 years for these 70 persons (range one month to 11 years), and thus the interval was not different from that of the whole group of 200 persons (2 years; range, one month to 12 years).

Table V:D,4. *Distribution of reported neck pain (20/200) and back pain (45/200) at the time of torture related to alleged suspension.*

Symptoms		Suspension: yes, by arms	by legs	la barra	more than one method	no and n.i.*)	Total
Neck pain	yes	3	0	2	1	14	20
	no	0	0	4	0	47	51
	n.i.*)	21	6	11	2	89	129
Back pain	yes	3	2	1	1	38	45
	no	0	0	6	0	38	44
	n.i.*)	21	4	10	2	73	111
Total		24	6	17	3	150	200
		12%	3%	8%	1%	75%	100%

p: 1 >0.5.

Table V:D,5. *Distribution of symptoms reported by 111/200 examined persons from lower extremities at the time of torture in relation to alleged falanga torture. n=200.*

Symptoms at the time of torture		Falanga: yes	no and n.i.*)	Total
Walking difficulties	yes	53	33	86
	no	1	42	43
	n.i.*)	5	66	71
Ankle pain	yes	47	20	67
	no	1	42	44
	n.i.*)	11	78	89
Knee pain	yes	22	17	39
	no	26	51	77
	n.i.*)	24	65	89
Symptoms from lower extremities in general	yes	9	25	34
	no	4	34	38
	n.i.*)	24	65	89
Total		59	141	200
		29%	70%	100%

*) n.i. = not indicated.

	Walking Walking-difficulties	Ankle pain	Knee pain	Symptoms from lower extr. in general
p:1	<0.001	<0.001	<0.01	N.S.
p:2	<0.001	<0.001	N.S.	–
p:corr	<0.01	<0.01	–	–

Complaints about the lower extremities were especially common (44 persons). 12 persons complained of symptoms from the upper extremities.

Back pain was reported by 22 persons and neck pain by 9. These symptoms are correlated to alleged suspension in Table V:D,6.

14 of the 26 persons with fractures still complained of pain and or restricted movements.

Falanga torture has been reported to leave permanent symptoms in the victims (*Bro-Rasmussen & Rasmussen* 1978, *Bro-Rasmussen et al* 1982). Pain located to the sole of the feet when walking was described by 13 persons who had been tortured by falanga. In Table V:D,7, other symptoms from the lower extremities at the time of examination are listed in relation to the falanga torture. Falanga torture had been inflicted on 23 of the 31 persons who complained of walking difficulties, 23 of 28 persons with ankle pain, 11 of 17 persons with pain in the knee, and on 5 of 10 persons who reported symptoms from the lower extremities in general. The possible pathophysiological explanation for the chronic sequelae of falanga torture will be covered in more detail later.

MEDICAL EXAMINATION

The parts of the locomotor system where medical examination revealed signs which might be related to torture are listed in Table V:D,8. Painful muscles, although not necessarily directly related to torture, were also included.

Abnormalities of joints, such as impaired movements, pain during movements, abnormal position (e.g. dislocation, sequelae of fracture or contraction) and/or signs of osteoarthritis were found in 39 persons (Table V:D,9).

The lower extremities were most frequently affected, especially the foot, ankle, and knee. A relationship between falanga torture and abnormal findings in the foot and ankle regions was demonstrated (Table V:D,10).

At the time of examination clinical evidence of a fracture (palpaple discontinuation of a bone and/or callus formation) was found in 17 persons; X-rays, all confirming the clinical signs, were taken in 5 persons (Table V:D,3).

Signs of fractures of the ribs were found by palpation in 3 persons. Sequelae of fractures of the upper extremities (deformity,

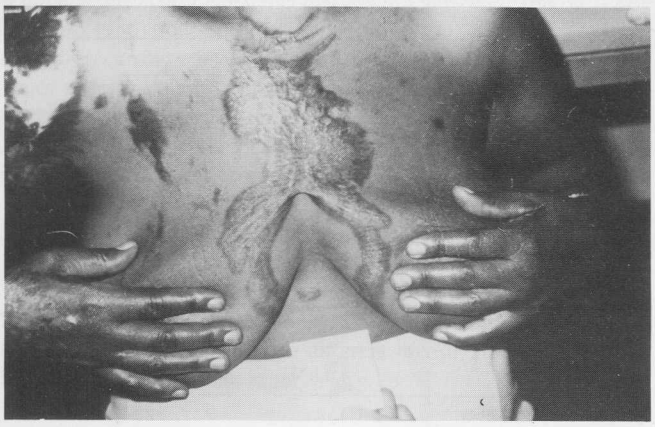

Fig.V:A,5. *56-year-old woman, arrested in Uganda 1982. She had her hands tied behind her back, and a rubber tire was set alight above her. The burning material fell on her scalp, face, arms and chest. (Amnesty International, 1985 (Uganda)). Keloid scars with well-defined borders and irregular outline are seen. Disfiguring keloid scars are characteristic for deep burns.*

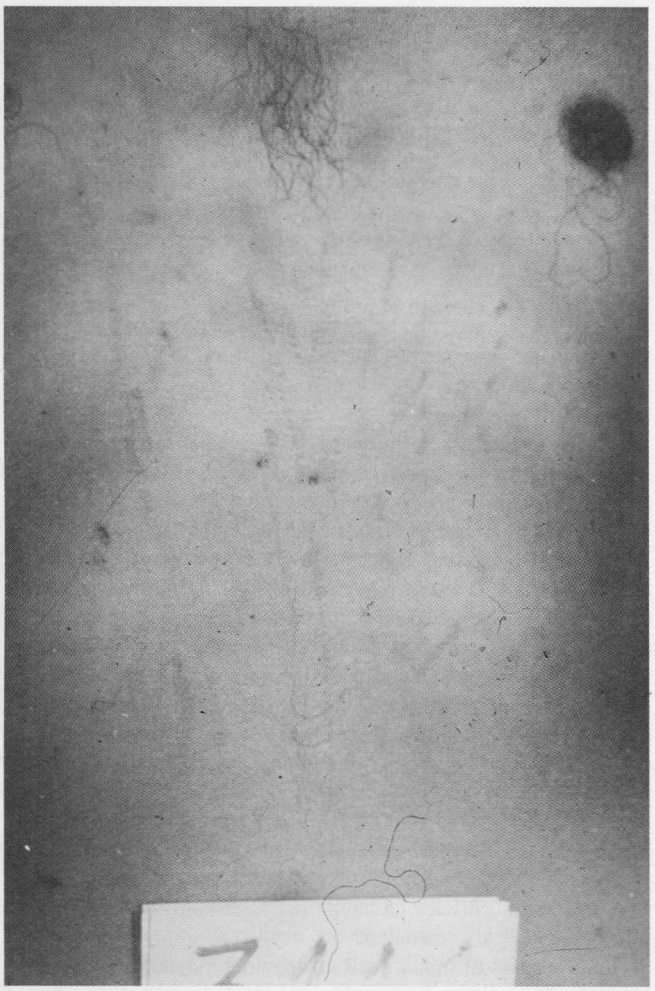

Fig. V:A,6. *Male Chilean torture victim who alleged torture by picana. The photo was taken within 72 hours of the torture (Vicaria de la Solidaridad 1985). The skin of the abdomen shows many erythematous lines, some 2-5 mm wide. Scattered along them are dark red-brown spots consisting of a central crust surrounded by an erythematous zone, with an ill-defined and irregular border. The appearence of the lesions is consistent with the history of exposure to a pointed electrode, intermittently moved across the skin, intermittently left resting. They do not resemble any other known dermatological lesions, excoriations included.*

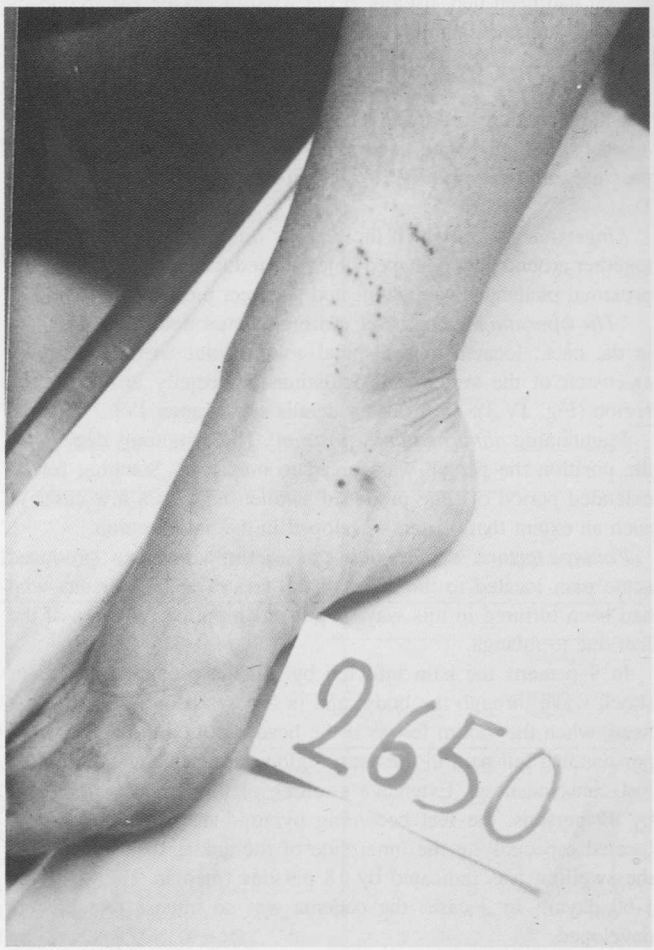

Fig. V:A,7. *Male Chilean torture victim who alleged torture by picana. The photo was taken within 72 hours of the torture (Vicaria de la Solidaridad 1985). The inner side of the right ankle shows large numbers of circular lesions, some 2-5 mm across, in groups or lines. These dark red-brown crusts were not surrounded by a zone of erythema. The appearance of circular crusts in lines and groups is consistent with the history of picana. The only rather unlikely differential diagnosis could be insect bites and herpes zoster.*

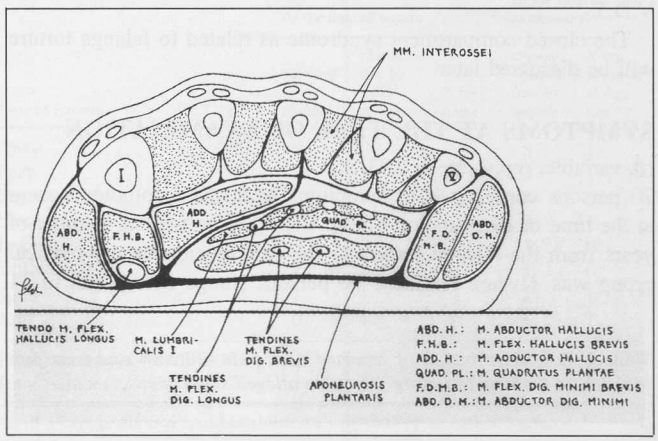

Fig. V:D,I. *Cross section through the metatarsus. A: Medial muscle compartment. B: Lateral muscle compartment. C1 and C2: Central muscle compartments (drawing by Eldon F) (Bro-Rasmussen & Rasmussen 1978). Reproduced with the permission of the Journal of the Danish Medical Association, Ugeskr Læger.*

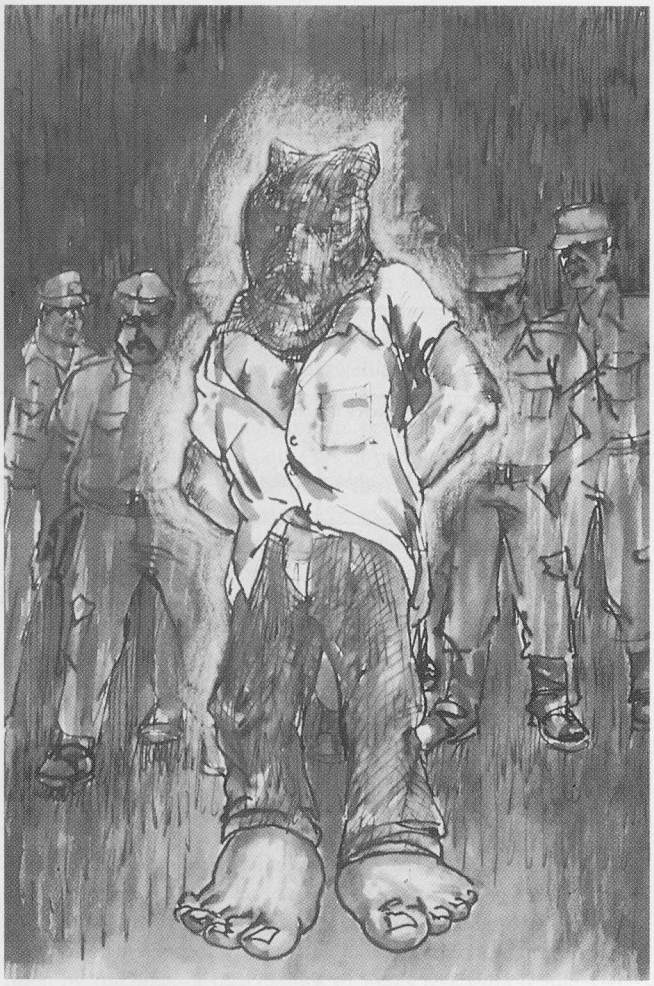

Fig. V:F,1. *Painting by torture victim, see text.*

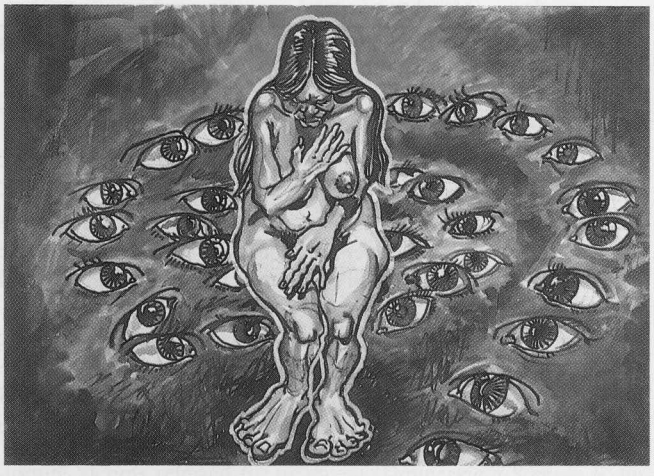

Fig. V:F,2. *Painting by torture victim, see text.*

Fig. V:F,3. *Painting by torture victim, see text.*

Fig. V:F,4. *Painting by torture victim, see text.*

Table V:D,6. *Distribution of reported neck pain (9/200) and back pain (22/200) at the time of examination related to alleged suspension.*

Symptoms		Suspension: yes: by arms	by legs	la barra	more than one method	no and n.i.*)	Total
Neck pain	yes	0	0	1	0	8	9
	no	18	2	16	2	107	145
	n.i.*)	6	4	0	1	35	46
Back pain	yes	2	2	0	1	17	22
	no	17	2	17	1	102	139
	n.i.*)	5	2	0	1	31	39
Total		24	6	17	3	150	200
		2%	3%	8%	1%	75%	100%

*) n.i. = not indicated.
p:1 N.S.

Table V:D,7. *Distribution of symptoms from lower extremities reported by 41/200 examined persons at the time of examination as related to alleged falanga torture. n=200.*

Symptoms at time of examination		Falanga: yes	no and n.i.*)	Total
Walking difficulties	yes	23	8	31
	no	31	109	140
	n.i.*)	5	24	29
Ankle pain	yes	23	5	28
	no	29	111	140
	n.i.*)	7	25	32
Knee pain	yes	11	6	17
	no	36	113	149
	n.i.*)	12	22	34
Symptoms from lower extremities in general	yes	5	5	10
	no	42	114	156
	n.i.*)	12	22	34
Total		59	141	200
		29%	70%	100%

*) n.i. = not indicated.

	Walking difficulties	Ankle pain	Knee pain	Symptoms from lower extr. in gen.
p:1	<0.001	<0.001	<0.01	N.S.
p:2	<0.001	<0.001	<0.05	–
p:corr	<0.01	<0.01	<0.01	–

Table V:D,8. *Number of persons with objective abnormalities suggestive of torture of the locomotor system. n=200.*

Location where signs were recorded		n	%
Joints:	Hand	7	3
	Wrist	4	2
	Elbow	3	1
	Shoulder	6	3
	Feet	9	4
	Ankle	10	5
	Knee	14	7
	Hip	3	1
Bones:	Head and neck	5	2
	Chest	3	1
	Upper extremities	2	1
	Lower extremities	8	4
Muscles:	Head and neck	18	9
	Chest	0	0
	Abdominal wall	1	0
	Upper extremities	1	0
	Lower extremities	10	5
Spinal column:	Cervical	0	0
	Thoracic	6	3
	Lumbar	3	1

Table V:D,9. *Abnormalities of the joints registered at the time of examination in 39/200 examined persons.*

Abnormality	Joint: hand	wrist	elbow	shoulder	foot	ankle	knee	hip
Pain during movements	0	0	0	3	4	1	11	0
Abnormal position*)	5	1	0	1	4	1	1	0
Restricted movement	2	4	3	3	1	5	2	3
Signs of arthrosis	1	0	0	2	1	3	1	0
Total	8	5	3	9	10	10	15	3
Total number of persons	7	4	3	6	9	10	14	3

*) e.g. dislocation, sequels to fractures or contraction.

Table V:D,10. *Distribution of objective abnormalities of joints, related to alleged falanga torture. n=200.*

Joints examined		Falanga: yes	no and n.i.*)	Total
Foot	yes	8	1	9
	no	51	136	187
	n.i.*)	0	4	4
Ankle	yes	10	0	10
	no	49	137	186
	n.i.*)	0	4	4
Knee	yes	8	6	14
	no	51	128	179
	n.i.*)	0	7	7
Hip	yes	3	0	3
	no	56	137	193
	n.i.*)	0	4	4
Total		59	141	200
		31%	69%	100%

*) n.i. = not indicated.

	Foot	Ankle	Knee	Hip
p:1	<0.001	<0.001	<0.05	<0.05
p:2	<0.05	<0.01	N.S.	N.S.
p:corr	<0.01	<0.01	–	–

restricted movements, and/or pain during movements) were encountered in 2 persons, while 8 had sequelae in the lower extremities. Pain during movements and/or restricted movements of the spine were registered in 8 persons, localized in 5 to the thoracic part, in 2 to the lumbar, and in one person to both the thoracic and lumbar parts.

Changes in the muscles were predominantly found in the neck and shoulder region. In 18 persons the muscles in this region were found to be hard and painful. The examining doctors all described their findings as "painful muscles" without direct relation to the inflicted torture.

Muscular abnormalities of the lower extremities were noted in 10 persons. In 2 persons painful areas were found in the soles of the feet, and in 3 in the lower leg. Atrophy was found in 6 persons, localized to the thigh in 4 (related to electric torture (2), to falanga (1) and "the motorcycle" (1)), to the lower leg in 2 (related to falanga (1) and a "fall" (1)), and in addition a total rupture of the quadriceps muscle was present in one person who had been subjected to electrical torture. For further details see case history No. V:D,2. page 79, in the appendix.

DISCUSSION

The significance of changes in the locomotor system is related first to their tendency to cause permanent symptoms and changes, and second to the evidence for alleged torture.

While the relationship to torture can be established with strong evidence in cases of acute symptoms, it is far more difficult to evaluate such a relationship on the basis of late symptoms, since they are usually not specific and could thus have been caused by several conditions that are unrelated to torture. However, the present study gives good statistical evidence for the existence of both acute and late symptoms caused by falanga. Such symptoms have been explained as a closed compartment syndrome in the foot (*Bro-Rasmussen & Rasmussen* 1978). Dissection of the foot, review of anatomical preparations, and injection experiments into the soles of the feet of fresh, unfixed cadavers were performed, and the results were compared with other studies of the foot's anatomy. The muscles were found to be arranged in three muscle compartments, one medial, one lateral, and one central (Fig. V:D,1 page 20). Injection into the compartments induced swelling proximally in the ankle region. Regardless of which compartment was injected, the injections resulted in the compartments becoming hard as wood, and subsequent injection of fixative under pressure through the femoral arteries prevented the spread of the fixative into the compartments. These observations were sufficient to suggest the existence of a closed compartment syndrome, defined as painful ischaemic circulatory disturbances in connection with an increased pressure and volume in a well-defined muscle compartment with fairly unyielding walls. (A detailed account of the condition has been translated from Danish into English and reproduced in the appendix page 79 with permission from the Journal of the Danish Medical Association: Ugeskr Læger). The hypothesis has been supported by the observation of an aseptic bone necrosis following falanga (*Bro-Rasmussen et al* 1982). Closed compartment syndrome of the foot, unrelated to torture, has since been described (*Bonutti & Bell* 1986).

Acute locomotor symptoms have also been reported in a high percentage of torture victims by others (*Cathcart et al* 1979, *Warmenhoven et al* 1981, *Randall et al* 1985, *Petersen & Jacobsen* 1985a, *Petersen et al* 1986). It is likely that the pains are mainly caused by swelling of the muscles following blunt trauma, and less often by fractures or dislocations of joints (AI 1983 (Chile)).

By contrast, late symptoms and abnormalities of the muscles can be directly related only rarely to physical trauma (falanga sequelae and symptoms from previous fractures excepted).

The commonest symptoms and abnormalities of the muscles, suggested not to be directly related to physical trauma, were painful muscles of the head and neck. This condition might be classified "fibrositis", but the terminology is rather confusing, reflecting the unknown aetiology of the condition. The term "muscular rheumatism" was introduced in 1900 and the later names like "fibrositis", "fibrositis syndrome", "interstitial myofibrositis", "myofascial pain syndrome", "myofascitis", "myalgia" or "myalgic spots", and "trigger points" probably all describe the same condition (*Danneskiold-Samsøe et al* 1982). "Fibrositis" was however observed with a low frequency (9%) compared with its occurrence among healthy persons (16%) (*Yunus et al* 1981). The low frequency might represent an underreporting since a direct relationship with the torture was not suspected. Fibrositis located in the neck and shoulder region has previously been recorded with a much higher frequency in torture victims referred for treatment (*Danneskiold-Samsøe B.* unpublished data 1986), perhaps because in that case the examination was performed by a rheumatologist. To obtain a closer estimate of the incidence of fibrositis in torture victims compared with the normal population, standard examination procedures must be applied (*Smythe* 1985).

Apart from the association with falanga, the presence of late sequelae from the joints is difficult to evaluate, since changes such as osteoarthritis might be unrelated to torture. Both acute and chronic back pain have been reported more frequently in torture victims by others than in the present study. Acute back pain was found by *Randall et al* (1985) in 36% of the cases, (16/44), compared with 22% in this study. The frequency of chronic back pain has been reported with frequencies of 63% (7/11) by *Cathcart et al* (1979), 33% (14/43) by *Warmenhoven et al* (1981), compared with 11% in this study. *Randall et al* (1985) found that 14% (6/44) suffered from chronic upper back pain and 20% (9/44) from chronic lower back pain. They described a correlation between chronic upper back pain and suspension in the arms, since all 6 persons with chronic upper back pain had experienced this. No description of a possible mechanism was found. In the present study, suspension in the arms has usually not been reported to lead to back pain, and no such correlation could be established (Tables V:D,9 and V:D,10). Chronic back pain was found in 22 persons (11%), and 3 of them had been suspended by their arms.

In a Danish study of back complaints among 1,069 young recruits (*Darre et al* 1982), 97% between 18 to 20 years, 565 (53%) complained of back symptoms, 100 (9%) said that they had symptoms with a frequency of up to once a week.

In an epidemiological study of a Danish population of older age (median 50 years), *Biering-Sørensen* (1984) found low back trouble with an incidence of 16% (153/928). (symptoms daily or at least once a week). Chronic back pain among torture victims in the present study, with a similar frequency of symptoms of up to once a week, was found to be 11% (22/200). These findings suggest that back complaints are not reported to a significantly higher degree by torture victims than by Danish army recruits, or in a Danish population of older age.

Fractures due to torture can serve in the acute situation as important evidence of alleged torture. It is of utmost importance to have an X-ray performed in order to document the lesion, besides the obvious diagnostic need for the correct treatment of the fracture. Fractures usually leave permanent changes visible on x-rays, and in some cases the sequelae are palpable. In the present study, palpation supported the allegation of fracture following torture in 65% (17) of the cases, supplementary X-rays performed in 5 of these cases serving as further support. In agreement with this observation, *Allodi* (1985) observed late sequelae of fractures in 73% (8/11) of fractures allegedly following torture, but the basis for the evaluation was not indicated. Fractures were reported with a frequency of 13% in the present study, of 27% by *Allodi* (1985) and of 4% by *Randall et al* (1985).

As x-ray examination appears to be one of the best methods of documenting earlier fractures, this examination seems to be a valuable contribution in supporting the allegation of torture, most often independent of the time of examination. On the other hand, a negative X-ray examination will not exclude the possibility of a previous fracture, since, according to an anthropologist (*Steinbock* 1976), healing in an anatomically correct position might occur without any visible sequelae. How often this occurs is not known, since this fact has not been given much attention previously. Orthopaedic surgeons have studied late sequelae following malunion, different healing positions or complications with ostitis (*Edmonson & Crenshaw* 1980), while specialists in forensic medicine have been mainly interested in acute fractures in order to describe the lesions, and older fractures for identification purposes and possible child abuse (*Fitzpatrick* 1984, *Tedeschi et al* 1977). Thus for the evaluation of torture reports, studies are needed on the frequency of changes detectable by x-ray following fractures that have healed in an anatomically correct position.

CONCLUSION

Acute symptoms from the locomotor system were often reported by torture victims. Long-lasting changes in the locomotor system appear to occur in a significant number of cases following falanga torture. Otherwise, only a few cases of persistent changes could specifically be related to torture, since most symptoms and abnormalities are unspecific and do not occur with a higher frequency among torture victims than in the normal Danish population.

X-ray examination for the documentation of fractures is a valuable contribution in supporting the allegation of torture, particularly as it is usually independent of the time of examination.

E: NEUROLOGICAL

INTRODUCTION

In spite of the fact that a number of symptoms, such as headache, impaired memory, impaired concentration, or cognitive difficulties are not necessarily caused by lesions or abnormalities in the brain, these symptoms are included in this section since traditionally they come within the field of the neurologist.

CENTRAL NERVOUS SYSTEM SYMPTOMS AT THE TIME OF TORTURE

(A-variable, reply rate 0.84).

At the time of torture 150 persons (75%) complained of neurological symptoms, 17 did not, and nil was registered in the remaining 33 cases. The symptoms are listed in Table V:E,1. No apparent association was found with sex or age (Table V:E,2).

The most frequently reported symptom was headache, present in 108 persons (54%). Of the 146 persons who had been severely beaten on the head, 89 (61%) complained of headache, 19 did not, and nil was registered in the remaining 38 (Table V:E,3). A significant correlation between severe beating on the head and headache was found (p:1 <0.01, p:2 <0.001 and p:corr <0.05).

Loss of consciousness due to head injury was reported by 38 persons (19%). One person was unconscious in a hospital for 3 days while under observation for intracranial bleeding. 8 persons had amnesia following the head injury. Skull fractures were reported by 2 persons, and one person underwent surgery for a subdural haematoma. A case history is presented in the appendix that illustrates sequelae of head trauma (Appendix case history V:E,1 page 81).

62 persons (31%) lost consciousness from reasons other than head injury, e.g. extreme pain, exhaustion, etc.

Vertigo was reported by 40 persons (20%), of whom 35 (87%) had been severely beaten on the head. There was a significant difference (p:1 <0.05) in the prevalence of vertigo in those who had been severely beaten on the head, compared with those who had not. Vertigo was not associated with teléfono torture.

5 persons had reported convulsions/spasms in connection with the electrical torture sessions. However, the reply rate was very low (0.29). One person, who did not receive his medicine, reported that his epilepsy was aggravated during and after the torture sessions.

22 persons (11%) complained of disorientation in time or location, or both, during the detention. 12 (55%) of these had been blindfolded. This percentage does not differ from the whole group (50%).

Table V:E,4 shows the correlation between neurological symptoms and solitary confinement. No statistically significant association was found.

PERIPHERAL NERVEOUS SYSTEM SYMPTOMS AT THE TIME OF TORTURE

(B-variable, reply rate 0.52)

46 persons (23%) complained of acute symptoms consistent with lesions of peripheral nerves, 58 persons did not, and nil was registered in the remaining 96.

20 persons had paraesthesiae of the hands caused by handcuffs or tight ropes at the wrists. In 12 of these cases, all the fingers were said to be affected, in 5 only the thumb, and in 3 the ulnar fingers. The symptoms lasted from a few days to more than a year.

Electrical torture, carried out in 109 persons, was said to produce changes in the sensation in 9 persons. Six persons developed paraesthesiae of the fingers following electrical torture on the lower arm. The symptoms lasted from a day up to 2 weeks. One person developed paraesthesiae of the feet after electrical torture on the leg, and 2 described how they experienced a short period of paraesthesiae over the whole body after electrical torture on the head. The electrodes were placed all over the body, but especially to sensitive parts like the genitals (50%). Damage to a nerve is probably not more likely to occur in the fingers than in other parts of the body. The relatively high number of persons with complaints from the fingers can possibly be explained by a higher attention to sensation change here than in other parts of the body.

Severe beating resulted in areas with decreased or absent sensation, which could have been caused by peripheral nerve damage in

Table V:E,1. *Neurological symptoms at the time of torture. n=200.*

Symptoms	n	%
Headache	108	54
Loss of consciousness not due to head injury	62	31
Loss of concentration, attention	51	25
Vertigo	40	20
Loss of consciousness due to head injury	38	19
Memory disturbance	33	16
Confusion, disorientation	22	11
Convulsion/spasms	6	3
Cognitive difficulties	5	2
Other consequences of head injury	8	4
Other CNS symptoms reported	13	6
Total	150	75

Table V:E,2. *Age and neurological symptoms at the time of torture. n=200.*

	Neurological symptoms						
	yes		no		n.i.*)		Total
Age group	n	%**)	n	%**)	n	%**)	n
<21 years	19	70	2	7	6	22	27
21-25 years	50	81	4	6	8	13	62
26-30 years	43	69	7	11	12	19	62
31-35 years	20	83	1	4	3	12	24
>35 years	18	72	3	12	4	16	25
Total	150	75	17	8	33	16	200
Male/female ratio	4.00		3.25		5.60		4.13

*) n.i. = not indicated.
**) Row percentage.
p:1 (age group: 31-35/>35) N.S.

Table V:E,3. *Allegations of severe beating on the head and complaints of headache at the time of torture. n=200.*

	Complaints of headache						
	yes		no		n.i.*)		
Severe beating towards the head	n	%**)	n	%**)	n	%**)	Total
Yes	89	61	19	13	38	26	146
No & n.i.*)	19	35	10	19	25	46	54
Total	108	54	29	14	63	31	200

*) n.i. = not indicated.
**) Row percentage.
p:1<0.01
p:2<0.001
p:corr<0.05

Table V:E,4. *Neurological symptoms at the time of torture and the duration of alleged isolation. n=200.*

	Neurological Symptoms						
	yes		no		n.i.*)		
Isolation	n	%**)	n	%**)	n	%**)	Total
No & n.i.	40	78	1	2	10	20	51
Yes <8 days	30	70	6	14	7	16	43
> 7 days and <15 days	23	77	6	20	1	3	30
>14 days and <31 days	24	75	1	3	7	22	32
>30 days and <61 days	16	76	1	5	4	19	21
>60 days	17	74	2	9	4	17	23
Total	150	75	17	8	33	16	200

*) n.i. = not indicated.
**) Row percentage.
p:1 (no isolation/<8 days) N.S.

11 persons. Six of these cases had developed symptoms following falanga. Five persons reported symptoms from the peripheral nerves for other reasons.

CENTRAL NERVOUS SYSTEM SYMPTOMS AT THE TIME OF EXAMINATION

(A-variable, reply rate 0.86)

129 (64%) persons complained of neurological symptoms at the time of examination (Table V:E,5). No significant association was found with sex and age (Table V:E,6). No correlation between duration of isolation and complaints of neurological symptoms was found (Table V:E,7).

85 persons (42%) complained of loss of *concentration* or attention or both. They had difficulty, for example, in reading a book, had to repeat the same paragraph again and again, could not follow deep discussions, and the mind was absent when they watched television. No significant correlation between duration of isolation and loss of concentration was found (Table V:E,8).

Frequent *headaches* (more than once a week) were reported by 76 persons (38%), 60 men and 16 women (ratio 3.75) compared with 101 men and 23 women (ratio 4.39) from whom no complaints were registered. This sex difference is not significant. No association was found with age in the two groups. The correlation between severe beating on the head and complaints of headache is shown in Table V:E,9, where a significant difference between the two groups can be seen (p:1 <0.05). The correlation between duration of isolation and headache is seen in Table V:E,10. No significant correlation was established.

Memory disturbances were reported by 71 persons (35%).

Persons with previously normal memories now had to write everything down, including their own telephone number. No significant correlation with duration of isolation was shown (Table V:E,11).

Vertigo was reported by 27 persons (13%). No correlation with an allegation of "teléfono" torture was established. 25 persons experienced difficulty in *reading*, typically as blurring of letters (from exhaustion), after a short period. Reading difficulties caused by optical disturbances have not been included as reading difficulties.

22 persons (11%) reported a *general feeling of tiredness*. No significant difference was found regarding sex, age or duration of isolation (Table V:E,12).

17 persons (8%) complained of *cognitive* difficulties. However, for this symptom the reply frequency was low (0.39). Difficulties

Table V:E,5. *Neurological symptoms at the time of examination. n=200.*

Symptoms	n	%
Loss of concentration, attention	85	42
Headache	76	38
Memory disturbance	71	35
Vertigo	27	13
Reading difficulties	25	12
General feeling of tiredness	22	11
Cognitive difficulties	17	8
Intolerance to alcohol	12	6
Other CNS symptoms reported	8	4
Total	129	64

Table V:E,6. *Age and neurological symptoms at the time of examination. n=200.*

	Neurological Symptoms						
	yes		no		n.i.*)		Total
Age group	n	%**)	n	%**)	n	%**)	n
<21 years	18	67	4	15	5	19	27
21-25 years	38	81	16	26	8	13	62
26-30 years	37	60	17	27	8	13	62
31-35 years	14	58	4	17	6	25	24
>35 years	22	88	2	8	1	4	25
Total	129	64	43	21	28	14	200
Male/female ratio	3.96		2.91		13.00		4.13

*) n.i. = not indicated.
**) Row percentage.
p:1 (age group 31-35 / >35) N.S.

Table V:E,7. *Neurological symptoms at the time of examination correlated to duration of alleged isolation. n=200.*

	Neurological Symptoms						
	yes		no		n.i.*		
Isolation	n	%**)	n	%**)	n	%**)	Total
No & n.i.	33	65	10	20	8	16	51
Yes <8 days	27	63	12	28	4	9	43
> 7 days and <15 days	14	47	14	47	2	7	30
>14 days and <31 days	23	72	2	6	7	22	32
>30 days and <61 days	15	71	1	5	5	24	21
>60 days	17	74	4	17	2	9	23
Total	129	64	43	21	28	14	200

*) n.i. = not indicated.
**) Row percentage.
p:1 (> 7 days and < 15 days / > 60 days) N.S.

Table V:E,8. *Loss of concentration, attention at the time of examination correlated to duration of alleged isolation. n=200.*

	Loss of concentration, attention						
	yes		no		n.i.*		
Isolation	n	%**)	n	%**)	n	%**)	Total
No & n.i.	26	51	11	22	14	27	51
Yes <8 days	17	40	19	44	7	16	43
> 7 days and <15 days	8	27	14	47	8	27	30
>14 days and <31 days	16	50	5	16	11	34	32
>30 days and <61 days	9	43	4	19	8	38	21
>60 days	9	39	8	35	6	26	23
Total	85	42	61	30	54	27	200

*) n.i. = not indicated.
**) Row percentage.
p:1 (>7 days and <15 days / no & n.i.) N.S.

Table V:E,9. *Allegations of severe beating on the head correlated to complaints of headache at the time of examination. n=200.*

	Complaints of headache						
	yes		no		n.i.*		
Severe beating on the head	n	%**)	n	%**)	n	%**)	Total
Yes	63	43	51	35	32	22	146
No & n.i.*)	13	24	18	33	23	43	54
Total	76	38	69	34	55	27	200

*) n.i.= not indicated.
**) row percentage.
p:1<0.05.
p:2 N.S.

Table V:E,10. *Headache at the time of examination correlated to duration of alleged isolation. n=200.*

	Headache						
	yes		no		n.i.*)		
Isolation	n	%**)	n	%**)	n	%**)	Total
No & n.i.	18	35	15	29	18	35	51
Yes <8 days	17	40	20	47	6	14	43
> 7 days and <15 days	10	33	14	47	6	20	30
>14 days and <31 days	13	41	7	22	12	37	32
>30 days and <61 days	8	38	5	24	8	38	21
>60 days	10	44	8	35	5	22	23
Total	76	38	69	34	55	27	200

*) n.i. = not indicated.
**) Row percentage.
p:1 (>7 days and <15 days / >60 days) N.S.

were experienced especially among those who had to learn a new language.

The importance of head injuries in the subsequent development of neurological symptoms can be seen from Table V:E,13, in which torture victims who had had severe head trauma with subsequent loss of consciousness are compared with those without loss of consciousness and those who did not receive severe head trauma. The findings are highly suggestive of organic brain damage caused by the head trauma in persons who lost consciousness due to the reported injury. Compared with those who did not report severe head trauma the difference was highly significant, but compared with those who did report severe head trauma the difference was not significant. Loss of consciousness due to head injury was significantly correlated with the symptoms impaired memory and headache at the time of examination (Table V:E,14-15), while the symptoms impaired concentration and general feeling of tiredness did not show a significant correlation (Table V:E,16-17).

Table V:E,11. *Memory disturbance at the time of examination correlated to duration of alleged isolation. n=200.*

	Memory disturbance						
	yes		no		n.i.*		
Isolation	n	%**)	n	%**)	n	%**)	Total
No & n.i.	21	41	11	22	19	37	51
Yes <8 days	10	23	24	56	9	21	43
> 7 days and <l5 days	10	33	16	53	4	13	30
>14 days and <31 days	12	37	9	28	11	34	32
>30 days and <61 days	9	43	6	29	6	29	21
>60 days	9	39	8	35	6	26	23
Total	71	35	74	37	55	27	200

*) n.i. = not indicated.
**) Row percentage.
p:1 (<8 days / >30 days and <61 days) N.S.

Table V:E,12. *Feeling of general tiredness at the time of examination correlated to duration of alleged isolation. n=200.*

	Feeling of general tiredness						
	yes		no		n.i.*)		
Isolation	n	%**)	n	%**)	n	%**)	Total
No & n.i.	7	14	27	53	17	33	51
Yes <8 days	6	14	24	56	13	30	43
> 7 days and <l5 days	2	7	21	70	7	23	30
>14 days and <31 days	3	9	15	47	14	44	32
>30 days and <61 days	3	14	4	19	14	67	21
>60 days	1	4	14	61	8	35	23
Total	22	11	105	52	73	36	200

*) n.i. = not indicated.
**) Row percentage.
p:1 (>7 days and <15 days / no & n.i.) N.S.

Table V:E,13. *Neurological symptoms at the time of examination correlated to alleged severe head traumas and loss of consciousness due to the head traumas. n=200.*

	Severe head trauma							
	yes							
	+l.o.c.**)		-l.o.c.**)		no & n.i.*)		Total	
Neurological Symptoms	n	%***)	n	%***)	n	%***)	n	%***)
Yes	31	82	68	62	30	58	129	64
No	5	13	27	25	11	21	43	21
n.i.*)	2	5	15	14	11	21	28	14
Total	38	100	110	100	52	100	200	100

*) n.i. = not indicated.
**) l.o.c. = loss of consciousness.
***) Column percentage

	+ l.o.c.	Severe head trauma
p:1	<0.05	N.S.
p:2	N.S.	

Table V:E,14. *Loss of consciousness due to head injury and impaired memory at the time of examination. n=200.*

	Impaired memory						
	yes		no		n.i.*		
Loss of consciousness due to head injury	n	%**)	n	%**)	n	%**)	Total
Yes	21	55	9	24	8	21	38
No & n.i.*)	50	31	65	40	47	29	162
Total	71	35	74	37	55	27	200

*) n.i.= not indicated.
**) row percentage.
p:1<0.01.
p:2 N.S.

Table V:E,15. *Loss of consciousness due to head injury and headache at the time of examination. n=200.*

	Headache						
	yes		no		n.i.*)		
Loss of consciousness due to head injury	n	%**)	n	%**)	n	%**)	Total
Yes	23	61	7	18	8	21	38
No & n.i.*)	53	33	62	38	47	29	162
Total	76	38	69	34	55	27	200

*) n.i.= not indicated.
**) row percentage.
p:1<0.01.
p:2<0.05.
p:corr<0.01.

Table V:E,16. *Loss of consciousness due to head injury and impaired concentration at the time of examination. n=200.*

	Impaired concentration						
	yes		no		n.i.*)		
Loss of consciousness due to head injury	n	%**)	n	%**)	n	%**)	Total
Yes	22	58	8	21	8	21	38
No & n.i.*)	63	39	53	33	46	28	162
Total	85	42	61	30	54	27	200

*) n.i.= not indicated.
**) row percentage.
p:1 N.S.

Table V:E,17. *Loss of consciousness due to head injury and feeling of general tiredness at the time of examination. n=200.*

	Feeling of general tiredness						
	yes		no		n.i.*)		
Loss of consciousness due to head injury	n	%**)	n	%**)	n	%**)	Total
Yes	4	11	19	50	15	39	38
No & n.i.*)	18	11	86	53	58	36	162
Total	22	11	105	52	73	36	200

*) n.i.= not indicated.
**) row percentage.
p:1 N.S.

PERIPHERAL NERVOUS SYSTEM SYMPTOMS AT THE TIME OF EXAMINATION

(B-variable, reply rate = 0.68).

25 persons complained of peripheral nerveous system symptoms at the time of examination (12%), 110 did not, and nil was registered in the remaining 65.

Five persons had paraesthesiae of the fingers due to handcuffs or tight ropes at the wrists. One woman complained of persistent tingling of the fingers which she related to electrical torture of the fingers.

Another woman said that her fingers became cold more easily as a consequence of electrical torture.

Eight persons had persistent areas with decreased or no sensation caused by severe beating. In 3 of these cases it was a consequence of falanga affecting the feet.

9 persons complained of peripheral nervous system symptoms for other reasons, and in 3 of these cases the lesions were located in the spine.

MEDICAL EXAMINATION

At the medical examination few neurological abnormalities were found. The memory function was reduced in 7 persons, and concentration in 4 persons. These assessments were based on the long interview, without the use of clinical tests.

Homonymous hemianopia was found in one person, and unilateral hemianopia in another. In both, further neurological examinations were recommended.

Abnormalities of the peripheral nervous system were found in 20 persons.

Decreased sensation was by far the commonest abnormal finding. In 2 persons decreased sensation of the thumb and the thumb plus the first finger was found, allegedly caused by handcuffing. Decreased sensation of the toes of the feet, reportedly caused by falanga, was found in 7 persons.

Areas with hypalgesia on the body, said to be caused by violent beating, were described in 6 persons. Other abnormal findings were found in 5 persons: two had symptoms consistent with a spinal lesion, one had signs of nerve damage caused by a knife lesion, and abnormal reflexes of unknown origin were described in 2 persons.

DISCUSSION

As indicated at the beginning of this section, the expression "neurological symptoms" does not necessarily indicate that the symptoms described can be explained by lesions or changes in the brain. Unconsciousness following severe trauma to the head, for instance, was reported by 19%, but was due to other causes in 31%.

Another example is headache, which at the time of torture was the neurological symptom most often reported (54%).

Acute headache can be caused by head injuries inflicted at arrest and during subsequent torture. A significantly higher incidence of headache was found among those who had been severely beaten on the head. Other explanations for headache could be muscle tension, anxiety, depression, dental problems, fear or fatigue.

A significantly higher proportion of women complained of neurological symptoms in an epidemiological survey of 40-year-old women and men (*Hollnagel* 1985). Whether this is due to an under-reporting by the men or a real difference in the health is not known. Acute as well as long-lasting neurological symptoms did not differ according to sex in the present survey.

Neurological symptoms increaseed in frequency with increasing age in concentration camp victims (*Thygesen et al* 1970) and sailors in wartime convoys (*Askevold* 1976, 1980).

In a follow-up examination of torture victims (*Abildgaard et al* 1984) and in the present survey no significant relation could be found. Re-examination of the torture victims, however, took place a maximum of 14 years after the torture, and a longer observation period might show late sequelae corresponding to the findings in convoy sailors and concentration camp survivors.

Acute neurological symptoms after reported torture are rarely found in the literature apart from medical reports by *Amnesty International: AI* 1978 (Northern Ireland), 1980 (Colombia, Argentina, Spain), 1981 (Iraq), 1983 (Chile).

Neurological symptoms in torture victims *at the time of examination* have been published by several authors (*Genefke & Aalund* 1982, *Randall et al* 1985, *Allodi* 1985, *Thorvaldsen* 1986, *Petersen et al* 1985a). The findings are uniform, and a comparison between different investigators is shown in Table V:E,18.

Little has been published about the frequency of neurological symptoms in the normal population, but the symptoms of headache and fatigue have been examined in a Danish population study of 40-year-old persons by *Hollnagel & Nørrelund* (1980). They found that 12% (14% women and 9% men) suffered from headache weekly, or even more frequently. In the same study, fatigue (positive answer to the question whether they felt tired at present) was reported by 33% (41% women and 25% men).

Table V:E,18. *Neurological symptoms at the time of examination in torture victims.*

	Study				
	1 n=37 %	2 n=41 %	3 n=44 %	4 n=9 %	5 n=200 %
Impaired concentration	59	32	56	56	42
Headache	38	54	37*)	22**)	38*)
Impaired memory	59	29	56	11	35
Vertigo	3	–	7	0	13
Reading difficulties	–	–	–	–	12
Fatigue	43	–	54	33	11
Cognitive difficulties	–	–	–	–	8

1. *Randall et al* 1985
2. *Allodi* 1985
3. *Thorvaldsen* 1986
4. *Petersen & Jacobsen* 1985a
5. Present Study 1990

*) Weekly or more.
**) Daily presence.

Thorvaldsen (1986) examined Latin American torture victims living in Denmark and compared them with a group of Latin Americans in Denmark who had not been tortured. He found that headache was reported weekly, or even more frequently in 36% of the torture victims (men 30% and women 62%) and in 11% of the control group (20% men and 10% women). The difference was significant ($p<0.05$). In the same study, tiredness was reported by 54% in the group of tortured persons (44% men and 100% women) and by 43% in the control group. (35% men and 47% women). Tiredness was not significantly associated with torture, but tiredness and headache at the same time were.

It is crucial to incorporate the frequency of headaches when comparing different studies. In the present survey, a frequency of headaches occurring weekly, or even more frequently was used. However, since it is a retrospective study, an assessment from the reports has sometimes been necessary. The 38% in the present survey who complained of headache agrees well with the investigation by *Thorvaldsen* (1986) (37%), and was 3 times as high as in a normal Danish population (*Hollnagel & Nørrelund* 1980) or in the control group in the *Thorvaldsen* (1986) study.

Concentration camp victims have demonstrated massive acute as well as long-term neurological symptoms (*Thygesen* 1970). Fatigue, headache, vertigo, impaired memory, and impaired concentration were very frequent. These symptoms have been explained by organic cerebral damage caused by hunger and lack of vitamins, and the severity of the symptoms could be related to the degree of weight loss. Other factors such as head injuries during the captivity (*Eitinger* 1964), fear and anxiety have been shown to play an important role in the development of these symptoms. Investigators of concentration camp survivors living in the United States of America have explained the symptomatology as a survivor syndrome (*Koranyi* 1969, *Niederland* 1968), and the important factor responsible for the syndrome is thought to be anxiety, and not necessarily the weight loss.

Fear and panic in Nazi concentration camps have also been analysed by *Trautman* (1964), and he argued for a syndrome called the chronic anxiety syndrome in the survivors, whom he described as living in a permanent state of fearful tension, in apprehension and expectation of danger or disaster, although they are now living in a normal and peaceful environment.

The war sailor syndrome is a constellation of neurological symptoms very similar to the concentration camp syndrome (*Askevold* 1980). Fatigue, impaired memory, and concentration difficulties were reported with particularly high frequencies. The war sailors did not suffer hunger or malnutrition. They shared the fear of death, separation from the family, and lack of sleep with the concentration camp victims, and the syndrome has been explained by organic brain damage originating from the anxiety, although the

finer mechanism by which the brain damage may come into existence is unknown.

Grinker & Spiegel (1945) studied U.S. combat soldiers from the Army Air Force and described mental as well as neurological symptoms after severe stress inflicted during the Second World War in these pilots. The sequelae were explained as follows: "thus anxiety passes through the stage where it is a relatively appropriate biological response, serving to alert the organism and prepare it for flight, to a pathological phase, where it is no longer appropriate or is actually self-destructive". Other authors have found similar symptoms after combat and anxiety (*Archibald* 1965, *Kettner* 1972, *Putten & Emory* 1973, *Klonoff et al* 1976, *Beebe* 1975, *Faurbye* 1976, *Sund* 1976).

Studies of the biological features, such as urinary free-cortisol levels, in patients suffering post-traumatic stress disorders are as yet scanty (*Mason et al* 1986).

Anxiety is the symptom that all torture victims have in common. It begins at the arrest with the fear of what is going to happen, and continues during and under the torture with fear of dying, fear of further torture, fear of what is happening to relatives threatened with arrest and death, and fear that their person and personality will be totally destroyed.

Specific factors can produce neurological symptoms in torture victims. Although the weight loss is normally rather limited, cases have been found with severe weight loss due to malnutrition and lack of essential vitamins. *Severin et al* (1978) described a case of an Asiatic man who was subjected to severe torture and malnutrition during his stay in a prison in Tanzania. He was found to suffer from cerebral asthenopia considered to be a manifestation of diffuse brain damage (*Willanger* 1970) resulting from the torture and malnutrition.

Solitary confinement without torture has had negative effects on the health of the inmates (*Jørgensen* 1981). The symptoms are concentration and memory difficulties, lack of ability to sleep, depersonalization, lack of emotional control, anxiety, hallucination and paranoia (*Koch* 1982). It has, however, not been possible to find any controlled prospective studies on the mental effect of solitary confinement compared with ordinary imprisonment.

In this survey, persons who in addition to the torture had been in solitary confinement did not complain of neurological symptoms with a higher frequency than those who had not been kept in solitary confinement. However, the comparison is based on a very rough evaluation and it is likely that a finer evaluation incorporating the severity of acute as well as persistent neurological symptoms would show a more specific effect of solitary confinement on the health.

Cranial trauma can develop into a *postconcussion syndrome* if the trauma has been violent enough to cause cerebral concussion. The syndrome is characterized by headache, fatigue, lack of concentration, impaired memory, vertigo, irritability, anxiety, and intolerance to alcohol. *Kosteljanetz et al* (1981) have demonstrated a high frequency of cerebral atrophy and intellectual deterioration in patients suffering postconcussion syndromes, suggestive of an organic brain dysfunction, but no causal relationships could be established. Cerebral atrophy in young torture victims has been demonstrated (*Jensen et al* 1982, *Somnier et al* 1982). The importance of head injuries in the development of neurological symptoms was established in the present survey. Symptoms suggestive of organic brain damage were seen particularly in the victims who became unconscious after trauma to the head.

Peripheral nerve lesions were most often located in the hand. In the majority of these cases it was allegedly caused by handcuffing or the presence of tight ropes around the wrists. It has been reported that handcuffs usually injure the superficial branch of the radial nerve, due to its superficial position over the hard surface of the radius (*Massey & Pleet* 1978, *Smith* 1981).

Handcuffs have also been implicated in injury of the median nerve (*Dorfman & Jayaram* 1978), as of the ulnar nerve (*Levin & Felsenthal* 1984). All fingers were said to be affected in 12 persons, the thumb in 5 persons, and the ulnar fingers in 3 persons. At the time of examination 5 persons complained of persistent paraesthesiae of the fingers, in one person located only to the first finger on the right hand, and in another only to the 3 radial fingers of both hands. The medical examination revealed decreased sensation in 2 of the 5 persons. It is possible that electrodiagnostic examination might have clarified the complaints in the remaining 3 persons.

Falanga torture resulted in complaints of sensory disturbance of the feet in 6 persons, and at the time of examination 3 persons expressed persistent symptoms, while signs of decreased sensation were found in 7 persons, usually located to the first toe or the medial plantar part of the foot. Damage of the medial plantar nerve, which serves the skin of the toes, could be caused by direct pressure during falanga torture. However, development of a closed compartment syndrome (*Bro-Rasmussen & Rasmussen* 1978) in the medial compartment where the nerve is located is another possibility.

CONCLUSION

Severe neurological damage can occur in torture victims. Head injuries leading to skull fractures, intracranial haemorrhage, and brain laceration have been reported. In nearly 20% of the victims in the present study, the head trauma was so violent that consciousness was lost. In these cases a postconcussion syndrome was suspected and organic brain damage could explain the symptomatology.

In the majority of torture victims, the head trauma was not of such a degree that a postconcussion syndrome was likely to develop.

Other factors than head trauma seem to play an important role in the development of acute as well as long-lasting neurological symptoms. Studies on sailors in wartime convoys and combat soldiers have demonstrated that anxiety and fear can lead to neurological symptoms very similar to the concentration camp syndrome. Torture victims present a similar symptomatology, and they have all been through a period of great fear.

The finer mechanism by which fear can produce long-lasting neurological symptoms has not been established, but there are different theories. Anxiety normally triggers a stage of alertness in man, and it may be that this trigger mechanism has been altered in such a way in torture victims that small degrees of fear induce overreaction. This theory gives the hope that the so-called brain damage is not permanent, but reversible with early intervention and therapy.

F: PSYCHIATRIC

INTRODUCTION

The horror of the concentration camps during the Nazi persecution in the Second World War was surely beyond normal imagination, and only those who actually experienced it were able fully to understand its extent. The same is true for torture, and it has been questioned by *Forest* (1982) whether the psychological experience and mental consequences can be fully unveiled through medical and psychological examination: "The most important aspects of torture are almost never told in the testimonies. Torture is such a violent experience that it leaves a wound so deep that it is very difficult to heal and might persist for many years. ... what has happened is so strange and insane that you want to forget it and only tell facts which you know people will understand: they suspended me from the bar, they beat me on the head and drowned me in the bathtub. It is the technical things which were mentioned in the testimonies.

I believe that the most important factors, those which have been most harmful, are not told. We need more time, and maybe another more sensitive kind of communication. We need to develop another language, one which can go deeper and shock. We do not possess words that can describe those *Dante*-like situations which occur during torture and are so filled with madness, surrealism and nightmares." (Translated from Spanish by the present author).

Alternative "languages" like films, poems, novels, music, and

paintings have helped us to increase the understanding and perception of torture. The following paintings made by a torture victim who underwent treatment at the Rehabilitation Center in Copenhagen illustrate the feelings after having been tortured.

Genefke (1986a) makes the following comments: "Fig. V:F,1 page 21 shows how ugly he finds himself, his feet are grotesquely swollen, his body is ugly, he is worth nothing at all. Fig. V:F,2. page 21 is called sexual torture, and the picture readily illustrates how much she has been humiliated, everyone stares at her, she has low self-esteem, she feels useless, ugly with a distorted grotesque body. She has lost everything in life, is extraordinarily lonely.

Fig. V:F,3 page 21 shows a person having left prison, but he looks as though he is still behind bars, and in fact, he just feels that way. Also he feels very ugly, having swollen hands and feet, and a hideous face. He fights and cannot escape. He is lonely, isolated with low self-esteem. Fig. V:F,4. page 21 depicts again a grotesque body, swollen hands and feet, ugly and without hope. It speaks for itself and shows how a victim of torture feels, without any hope, all alone, quite isolated. If we do not help, they have no future."

The immediate reaction during torture, how it feels to be tortured, the process of fear, anxiety, helplessness, anger, etc. have not been dealt with at the medical examinations in the present study, not at any rate in such a way that they can be analysed retrospectively.

Bearing in mind the difficulties in understanding and describing accurately the mental reactions to torture, there now follows an attempt to describe from the present survey 1) the mental symptoms at the time of torture, and 2) the mental symptoms and signs at the time of the medical examination.

MENTAL SYMPTOMS AT THE TIME OF TORTURE

(A-variable, reply rate = 0.75).

Mental symptoms and mental complaints at the time of torture were registered in 136 persons (68%). Fear due to the arrest and torture has not been included. The different mental symptoms recorded are listed in Table V:F,1.

Sleep disturbances were the most frequent complaint (103 persons = 51%). Nightmares were the commonest sleep disturbance, reported by 80 persons. Difficulty in falling asleep, were reported by 54 persons, and interrupted sleep by 32 persons.

Anxiety was the next most frequent mental symptom (52 persons), followed by irritability (48 persons).

37 persons (18%) reported severe depression. In 24 of these cases suicidal wishes were present, and in 8 cases actual suicide attempts were described.

14 persons described hallucinations in connection with the torture and detention (Table V:F,2). They were purely visual in 9 cases, audiovisual in 3, visual and olfactory in one, and auditory in one. The circumstances leading to the hallucinations were described as follows:

6 persons developed the hallucinations after very hard and intensive torture 2 to 14 days (median 3 days) after the arrest and start of torture.

2 persons suspected that the hallucinations resulted from taking "secret" medication, without a medical indication.

In a further 2 persons, the hallucinations began during psychiatric treatment of other mental symptoms, including depression and suicidal attempts. In one case, visual hallucinations began in relation to a head injury inflicted by the torture. One person, who also attempted suicide, developed visual and olfactory hallucinations about food during a long period when he was blindfolded.

Two women developed visual hallucinations 2-3 weeks after the arrest: in one the hallucinations began after she was forced to witness the torture of a cell mate; the other, who attempted suicide after being set free, was later admitted to a mental hospital for treatment.

4 persons with hallucinations were later admitted to psychiatric hospitals.

Disorientation in time or location or both were described by 21 persons (10%). It developed either as a result of sensory deprivation, such as being kept in a dark cell, or because of extreme exhaustion, as from constant sleep interruption.

At the time of torture, 24 persons (2 women and 22 men) com-

Table V:F,1. *Mental symptoms at the time of torture. n=200.*

Symptoms	n	%
Sleep disturbances	103	51
Anxiety	52	26
Irritability	48	24
Depression	37	18
Aggressiveness	27	13
Sexual problems	24	12
Suicide wishes	24	12
Orientation disturbances	21	10
Introvert	20	10
Hallucinations	14	7
Weeping labile	9	4
Suicide attempts	8	4
Total	136	68

Table V:F,2. *Hallucinations at the time of torture.*

Sex/ Age	Latency 1)	Form of Hallucination: visual	Form of Hallucination: auditory	Psychiatric treatment: prison	Psychiatric treatment: hospital	Comments
M 39	4 days	X	X		X	Suspected that the hallucinations were caused by an injection.
M 59	3 weeks	X	X	X		Suicide attempt. Hallucinations began after receiving medicine from prison doctor because of a "nervous breakdown".
F 39	3 weeks	X			X	Hallucinations began after she was forced to watch the torture of another prisoner.
M 24	4 days	X				
M 35	1 day	X				The visual hallucinations began in relation to a head injury.
M 25	3 days	X	X		X	Suicide attempt. The hallucinations first began after the admission to hospital because of suicidal attempt when treatment with sedatives were initiated.
M 34	2 days	X				
M 28	3 days	X				Hallucinations began after having drunk coffee in which he suspected was medicine.
F 25	4 days	X				
M 23	4 weeks	X[2])		X		Suicide attempt. Blindfolded during 2 months. Hallucinations about food.
M 49	2 weeks	X				
M 35	2 days		X			
M 35	3 days	X				
F 19	2 weeks	X			X	Suicide attempt.

1) The period from arrest to the development of hallucinations.
2) He also reported olfactory hallucinations.

plained of sexual problems, 40 did not, and nil was registered in the remaining 136. As mentioned earlier, these figures reflect the sensitive nature of the subject, for both victims and examining doctors. Frank talk about sex life demands an atmosphere of confidence and trust, and this was not always achieved. It is easy to understand that discussing these problems can be too embarrassing, particularly in strange surroundings through an interpreter.

21 persons received psychiatric or psychological treatment or both immediately after their release. 6 persons were admitted to psychiatric hospitals: 4 persons with hallucinations have been described earlier, one person was admitted after 3 days and nights without food or liquids, and one after serious trauma to the head.

Table V:F,3 shows the prevalence, by age, of mental symptoms at the time of torture. The highest prevalence was in the group aged 21 to 25 years, but the association with age was not statistically significant.

In Table V:F,4, the mental symptoms at the time of torture are cross-tabulated with different types of mental torture. No one type could be singled out as being most productive of mental symptoms.

MENTAL SYMPTOMS AT THE TIME OF EXAMINATION

(A-variable, reply rate = 0.87).

137 persons (68%) had mental symptoms at the time of examination (Table V:F,5). Of these 137, 113 had also complained of mental symptoms at the time of torture. 40 persons did not have mental symptoms at any time, 23 had them only at the time of torture, and 24 only at the time of examination.

Sleep disturbance was the most frequently recorded symptom (102 persons). Nightmares were reported by 75 persons, 48 had difficulty in falling asleep, and 28 complained that their sleep was interrupted by periods of wakefulness.

Irritability was the next most frequent mental symptom, recorded in 71 persons (35%).

A change of mood was reported by 62 persons, 35 towards feeling sad, 24 towards being more labile, and 3 more resigned or indifferent emotionally.

Mental problems that reduced the working capacity were reported by 45 persons.

39 persons complained of energy problems – 19 said they fatigued very quickly, 16 that they felt tired all the time, and 4 that they had become very passive.

35 persons expressed problems with contacting other people. In most cases (24) these difficulties were general, but 9 had problems only in their relations with friends, and 2 only with their spouses.

Depression was reported by 34 persons, of whom five were at times suicidal.

Attacks of panic without obvious reason occurred in 8 persons, and serious phobias in 2.

Problems in controlling emotions occurred in 31 persons.

24 persons, 21 men and 3 women, complained of sexual problems, 72 did not, and nil was registered in the remaining 104. The registered sexual problems were decreased libido in 16 persons (13 men and 3 women), difficulty in obtaining erection in 5 men, and difficulty in achieving ejaculation in 8 men. 7 men and 2 women had difficulty in achieving orgasm.

At the time of examination, 17 persons were having psychiatric treatment.

Table V:F,6 cross-tabulates mental symptoms at the time of examination with the age of the persons at the time of torture. The incidence of mental symptoms was highest in persons under the age of 20 (78%) and in the over 35-year-olds (72%). It was lowest in the age group 31-35 years (58%). None of these associations was statistically significant.

Table V:F,7 correlates mental symptoms at the time of examination with different types of mental torture. The incidence of mental symptoms was significantly higher in those who had been threat-

Table V:F,3. *Age and mental symptoms at the time of torture. n=200.*

	Mental symptoms						
	yes		no		n.i.*)		
Age group	n	%**)	n	%**)	n	%**)	Total
< 21 years	18	67	1	4	8	30	27
21-25 years	48	77	2	3	12	19	62
26-30 years	39	63	7	11	16	26	62
31-35 years	14	58	2	8	8	33	24
> 35 years	17	68	2	8	6	24	25
Total	136	68	14	7	50	25	200

*) not indicated.
**) row percentage.
p:1 (21-25 years/31-35 years) N.S.

Table V:F,4. *Mental symptoms at the time of torture correlated to isolation, blindfolding, threats and sham execution. n=200.*

		Mental symptoms						
		yes		no		n.i.*)		
		n	%**)	n	%**)	n	%**)	Total
Isolation > 14 days	yes	50	66	4	5	22	29	76
	no & n.i.*)	86	69	10	8	28	23	124
Blindfolded	yes	75	74	8	8	18	18	101
	no & n.i.*)	61	62	6	6	32	32	99
Threats	yes	117	68	11	6	43	25	171
	no & n.i.*)	19	66	3	10	7	24	29
Sham execution	yes	46	73	5	8	12	19	63
	no & n.i.*)	90	66	9	7	38	28	137
Total		136	68	14	7	50	25	200

*) n.i. not indicated.
**) row percentage.

	Isolation >14 days	Blindfolded	Threats	Sham execution
p:1	N.S.	N.S.	N.S.	N.S.

Table V:F,5. *Mental symptoms at the time of examination. n=200.*

Symptoms	n	%
Sleep disturbances	102	51
Irritability	71	35
Change in mood	62	31
Anxiety	55	27
Reduced working capacity	45	22
Energy problems	39	19
Introversion	39	19
Contact problems	35	17
Depression	34	17
Problems in controlling emotions	31	15
Aggressiveness	30	15
Sexual problems	24	12
Weeping lability	12	6
Suicide wishes	5	2
Total	137	68

Table V:F,6. *Age (at the time of torture) and mental symptoms at the time of examination. n=200.*

	Mental symptoms						
	yes		no		n.i.*)		
Age group	n	%**)	n	%**)	n	%**)	Total
< 21 years	21	78	2	7	4	15	27
21-25 years	43	69	9	15	10	16	62
26-30 years	41	66	15	24	6	10	62
31-35 years	14	58	6	25	4	17	24
> 35 years	18	72	5	20	2	8	25
Total	137	68	37	18	26	13	200

*) not indicated.
**) row percentage.
p:1 (<20 years / 31-35 years) N.S.

ened (p:1 <0.05) and in those who had undergone sham execution (p:1 <0.01).

Table V:F,8 correlates sexual problems with trauma to the head or genitals or both. No significant differences were demonstrated.

MEDICAL EXAMINATION

At the medical examination a very rough evaluation of possible mental abnormalities was registered. No psychological tests were done. Great reservations were exercised in the evaluation of the victims as psychopathological, due to differences in cultural backgrounds, language barriers, and the use of an interpreter. Psychopathological traces have only been registered when the behaviour during the interview clearly demonstrated them.

The attitude to the examination was recorded as positive in 165 persons, neutral in 26, and negative in only 2 persons (in 7 persons no record was found).

The emotional contact between the examining doctors and the person being examined was registered as distant in 22 persons and as bad in 2. Good contact was established with the rest.

Depression was the most frequently recorded mental sign (28 persons).

The state of consciousness was noted as "wide awake and clear in thinking" in 191 persons. "Slow functioning, lethargic, but clear in thinking" was noted for 2 persons, and one appeared confused. (In 6 persons no record was found.)

Table V:F,7. *Mental symptoms at the time of examination correlated to isolation, blindfolding, threats and sham execution. n=200.*

		Mental symptoms						
		yes		no		n.i.*)		
		n	%**)	n	%**)	n	%**)	Total
Isolation	yes	57	75	7	9	12	16	76
> 14 days	no & n.i.*)	80	65	30	24	14	11	124
Blindfolded	yes	73	72	17	17	11	11	101
	no & n.i.*)	64	65	20	20	15	15	99
Threats	yes	123	72	128	116	120	112	171
	no & n.i.*)	14	48	9	31	6	21	29
Sham	yes	52	83	8	13	3	5	63
execution	no & n.i.*)	85	62	29	21	23	17	137
Total		137	68	137	118	126	113	200

*) n.i. not indicated.
**) row percentage.

	Isolation >14 days	Blindfolded	Threats	Sham execution
p:1	N.S.	N.S.	<0.05	<0.01
p:2	–	–	N.S.	N.S.

Table V:F,8. *Sexual problems at the time of examination correlated to head and genital trauma. n=200.*

		Sexual problems							
		yes		no		n.i.*)			
		n	%**)	n	%**)	n	%**)	Total	%
Head trauma	yes	19	13	56	38	71	49	146	100
	no & n.i.*)	5	9	16	30	33	61	54	100
Genital	yes	6	15	18	44	17	41	41	100
trauma	no & n.i.*)	18	11	54	34	87	55	159	100
Head & genital	yes	5	14	16	44	15	42	36	100
trauma	no & n.i.*)	19	12	56	34	89	54	164	100
Total		24	12	72	36	104	52	200	100

*) not indicated. **) row percentage.

	Head trauma	Genital trauma	Head & genital trauma
p:1	N.S.	N.S.	N.S.

13 persons were found to be passive, with lack of response, one was aggressive, and 8 abnormally labile during the examination.

DISCUSSION

To describe the immediate mental experience during torture, the victims' feelings of being tortured, lies beyond the scope of the present study, and the total implication of the state of fear is probably best understood by means of art. The immediate mental reaction to extreme stress was described by *Bettelheim* (1943). He, being a concentration camp victim himself, described the initial shock and torture after the arrival at the camp as the worst he and other persons had ever experienced; it seemed unreal and imaginary. They developed a state of detachment, feeling as if what happened did not really happen to them as persons. The main problem was "to safeguard his ego in such a way, that, if by any good luck he should regain liberty, he would be approximately the same person he was when deprived of liberty". *Kieler* (1980) wrote about a mental stripping in which "the more subtle facets of personality were gradually obliterated, and the personality of the individual stood out more clearly characterized under the conditons imposed in the form of an extremely altruistic, a highly egoistic, or a passively helpless attitude to the daily fight for existence".

The same immediate reaction has been reported in some torture victims by *Reszczynski et al* (1984): "This new "life condition", imposed by violence and power, was experienced by some as a *depersonalisation:* the prisoner felt that it was not really himself who was suffering, but "another", while he himself was far-off, distant.

Other persons felt the situation as a *derealisation:* the prisoner felt that it was himself, not another, and that he was totally living and feeling all that was happening to him, but that all that happened was strange and unknown. A third group, the majority, however, felt that it was all real and they could incorporate all the stimuli, events and various acts". (Translated from Spanish by the author).

Kieler (1980) described the immediate attitude to capture and deportation as heroic against the capturers. When in the concentration camps, the victims are changed into suffering martyrs.

Long-term imprisonment and sensory deprivation are known to bring a person to a state of apathy and melancholia (*Wexler et al* 1958, *Storr* 1984).

The victims of the Hiroshima atomic bomb experienced such unbelievable and horrifying events that they acted as if they were not true. *Lifton* (1963) described their mental state as "psychological closure", which would last sometimes for a few hours, and sometimes for days or even months, and merge into long-term feelings of depression and despair.

The immediate reaction of torture victims to the inflicted torture has been discussed by *Biderman* (1957) and *Somnier & Genefke* (1986). The latter described four possible coping techniques for torture victims: The victims might 1) react by isolating themselves from the surroundings (*introversion*); 2) take refuge in fantasies and dreams of escape (*re-establishment*); 3) create an admiration and respect for the torturers (*conversion*); or 4) use a defence mechanism by which the victim appears as a neutral observer and tries to reject the influence of the torture (*intransigence*). They stated that the strategies of *introversion* and *re-establishment* were frequently used, while *conversion* and *intransigence* were rarely used by torture victims.

The admiration and respect of Hostages for their capturers (conversion) has also been called the Stockholm Syndrome (*Eitinger & Weisæth* 1980).

The question whether one can actually prepare oneself against torture has been discussed especially among political opponents who are themselves at risk of being tortured (*Forest* 1982). *Sacchi* (1982), a Uruguayan doctor, himself a torture victim, found that it was possible: "The fear is one of the most fundamental factors. The person who fears at the first blow is logically going to feel tenfold

the suffering compared to the person who is calm. There is an enormous difference between the person who is prepared compared with the non-prepared". By means of a kind of meditation, when he accepted the physical pain as a normal reaction taking place in the brain, being transmitted by nerves, etc., he was able to concentrate on other things and thus oppose the state of fear and suffering.

A group of doctors in the Philippines have published a book about torture, and one of the aims was to prepare the victims and their families so that they could better resist the torture (*Pagaduan-Lopez* 1987).

Politically active persons coped better with concentration camp experiences, compared with non-politically active persons (*Bettelheim* 1943, *Kieler* 1980).

In the present survey, the examined persons were as a matter of confidence not systematically questioned about their political activities, and consequently this question cannot be dealt with.

The present survey has not dealt with the question of possible loss of identity. According to *Grupo Colat* (1982) this is a very frequent complaint by torture victims. The victims are deprived of all relations to their daily identity. They are not wearing their own clothes, and are often undressed and hooded. "Their face and identity have disappeared" (*Amati* 1977), and *Amati* concludes: "The torture tests the whole personality, it tries to break the identity, meaning the inner feeling of continuation and connection".

Early symptoms after torture have been described (*AI* 1978 (Northern Ireland), *AI* 1980 (Argentina, Colombia, Spain), 1981 (Iraq), 1983 (Chile), *Pesutic* 1985). Most of these studies agree with the present survey that the most frequently reported mental symptoms are sleep disturbances, anxiety, and irritability. Nightmares were particularly frequent, during which the person re-experienced the torture without any possibility of escape and woke up wet with sweat.

Psychotic reactions were uncommon in the present survey. 14 persons developed hallucinations, but a psychiatrist may well not not have labelled them all as psychotic. In the evaluation of a possible psychotic state during and after torture, suicidal wishes or even suicidal attempts have not been considered grounds for labelling a person as psychotic. This should be viewed in the light of the extremely severe pressure and subsequent fear and anxiety when suicide can actually be considered to be a normal reaction. In the literature, psychotic reactions are also rarely described during or immediately after torture.

Psychotic reactions to other kinds of extreme stress are also rarely observed. In war combat soldiers (*Putten & Emory* 1973, *Sedman* 1961) psychotic reactions are rarely reported. *Sørensen et al* (1983) described mental "breakdown" in 6 of 37 Danish sailors during the Second World War, but there is no information as to how many of these were psychotic. *Lifton* (1963) reported very few severe mental illnesses such as psychosis in Hiroshima victims. Psychosis in Nazi concentration camps was rare (*Helweg-Larsen et al* 1952), but the survivors were highly selected, since any sign of mental disturbance might have led to the gas chamber (*Thygesen & Kieler* 1952, *Eitinger* 1980a,b).

It has been discussed whether torture victims of younger age are more vulnerable and less able to cope with the stress and therefore develop more severe mental disturbances than victims of older age. Those children who survived the concentration camps were more damaged than adults (*Eitinger* 1980b). *Kettner* (1972) found that soldiers under the age of 21 were more apt to succumb to combat exhaustion than older men.

The present study did not show any statistical difference in mental symptoms related to the age of the torture victim.

If one looks at all the different types of torture, physical as well as mental, each constitutes a possible determining factor for the development of acute mental symptoms. Threats and sham execution were particularly associated with mental symptoms at the time of torture.

At the time of examination, 68% of the persons complained of mental symptoms. The same high percentages have been found by others (*Puebla & Fuentes* 1981, *Warmenhoven et al* 1981, *Randall et al* 1985, *Allodi* 1985, *Thorvaldsen* 1986).

The mental complaints consisted mainly of sleep disturbances, irritability, and anxiety. However few studies have described the prevalence of mental symptoms. *Reich* (1986), in a literature review, has estimated the prevalence of anxiety disorders in the population at only 3% for generalized anxiety, with a 2:1 female preponderance. Depression was the most frequently recorded sign by the doctors at the time of examination.

Similar late mental symptoms have been reported with the same high frequency after severe stress in concentration camp victims (*Helweg-Larsen et al* 1949, *Hermann & Thygesen* 1954, *Thygesen et al* 1970, *Eitinger* 1964, *Strøm* 1968, *Nielsen* 1986), war sailors (*Askevold* 1976, *Sørensen* 1983), and combat soldiers (*Archibald* 1965).

Sexual problems after torture have been the subject of a closer study by *Lunde et al* (1980, 1981). They studied 17 Greek men who had been subjected to torture during the junta period (1967-1975). Sexual dysfunction (reduced libido and erectile dysfunction) occurred in 29%. In the present study, sexual dysfunction was recorded in 12%, but in more than half of the individual reports there was no mention of whether or not the person suffered sexual problems. The recorded 12% therefore represent the minimal occurrence. The sensitivity of touching on sexual life in torture victims is probably reflected in the fact that several authors do not mention it at all (*Randall et al* 1985, *Thorvaldsen* 1986, *Puebla & Fuentes* 1981, *Foster & Sandler* 1985b), or give it very little attention (*Warmenhoven et al* 1981, *Allodi* 1985, *Cathcart et al* 1979, *Petersen & Jacobsen* 1985a, *Pesutic* 1985, *Somnier & Genefke* 1986). When the frequency of sexual problems is reported, it is rather constant at about 20%.

Hormone analysis of Greek male torture victims has been performed by *Lunde et al* (1981). Plasma concentrations of luteinizing hormone, follicle-stimulating hormone, prolactin, and testosterone were all within the range found in the control group. *Daugaard et al* (1983) re-examined the above-named Greek torture victims and found no significant difference in the plasma concentrations of luteinizing hormone, follicle-stimulating hormone, prolactin and testosterone in those subjected to genital torture when compared with those who had not received genital trauma. Plasma spermatocoagglutinins were not increased in either group, but sexual disturbances were higher in the group subjected to genital trauma (3/10) compared with the other (0/9). No statistically significant differences regarding exposure to head or genital traumas and sexual disorders were found in the present study.

Psychological aspects of sexual torture against women have been described by *Agger* (1986).

The exact frequencies of sexual disorders in the normal populations of the countries whence the torture victims came or live are not available. An incidence of 3.4% in males aged 26-45 years has been reported in the USA (*Kinsey et al* 1948), and of 24% in woman aged 40 in Denmark (*Garde & Lunde* 1982).

Examinations of concentration camp victims from the Second World War have frequently disclosed sexual disorders. *Strøm* (1968) found impotence with a frequency of 35.2% in men under 50 years.

Follow-up study of torture victims world-wide has only been carried out by *Petersen et al* (1985). Their study indicated that mental symptoms do not disappear with time: "About 90% of the examined persons had psychological symptoms at the time of examination and no marked difference was found in the frequency of the individual symptoms from first to second examination" (5 years' interval).

Mental problems in the individual torture victim have an influence on the family life, affecting the spouse and the children (*Allodi* 1980, *AI* 1981 (Labor de la profesión médica contra la tortura,), *Cohn et al* 1980, 1981, 1985). This aspect is however outside the scope of the present study.

CONCLUSION

Torture consists of physical as well as psychological violence. The latter leads to immediate as well as long-lasting mental sequelae in the victims.

Fear and anxiety constituted the dominant immediate reaction in the present study. Long-lasting mental symptoms were present in approximately two-thirds of the torture victims. The most frequently recorded symptoms were sleep disturbances, irritability, anxiety, and depression.

G: UROLOGICAL AND GENITAL

SYMPTOMS AT THE TIME OF TORTURE

(B variable, reply rate = 0.61)

50 persons (25%), 44 men and 6 women, complained of symptoms from kidney or bladder or both at the time of torture (Table V:G,1).

Haematuria was reported by 27 persons, 1 woman and 26 men, with a median duration of 2 days (range 1-60 days). Its cause was probably direct trauma to the urethral mucous membrane in 22 persons as follows: direct electrical torture of the penis in 8 men, beating of the genitals in 9 persons, and both electrical torture and beating in a further 3. The glans penis was injured with a tweezer in one and burned with a cigarette in another. In the remaining 5 persons, no direct trauma to the mucous membrane could explain the haematuria. Two of the men who had severe haematuria after the beating were transferred to hospital. The haematuria lasted 6 days and 30 days, respectively, and ceased without medical treatment.

Dysuria was reported by 24 persons, 4 women and 20 men. 4 of the men had been tortured by electricity in the genital region. Two of the women had been raped, and in one of them, a foreign body had been inserted in the vagina. Dysuria was accompanied by back pain in 3 persons. Swelling and pain of the scrotum was noticed by 11 men.

Other urological symptoms at the time of torture included short-lasting strangury in 3 men, incontinence in 2 men, and passing stones in 2 persons. One woman was admitted to hospital semiconscious after being beaten all over: her urine production was very low, and she was told that a dialysis was under consideration. She recovered after intravenous fluid therapy and had no urological symptoms at the time of examination. One man who became unconscious after severe beating all over the body, including head, kidney, and genital region, was admitted to the intensive care unit of a civil hospital. He underwent haemodialysis for 3 weeks because of anuria. He had no urological complaints at the time of examination.

SYMPTOMS AT THE TIME OF EXAMINATION

(A-variable, reply rate = 0.82).

12 persons (6%), 11 men and 1 woman, complained of symptoms from the kidney or bladder or both at the time of the examination (Table V:G,1).

5 men and 1 woman complained of recurrent episodes of cystitis, such as they had not had before arrest. 2 men had pain in the renal region, but urine examination was normal and no explanation could be found. 2 men complained of minor changes in their micturition. One 40-year old man suffered chronic glomerulonephritis and hypertension. He had never had urological symptoms before arrest, and the kidney disease was probably brought on during detention. 15 days after torture he was admitted to hospital with a fracture of the jaw and symptoms of cystitis with haematuria. He received no treatment for the infection. After arrival in Denmark, glomerulonephritis and hypertension were diagnosed and medical treatment commenced.

Table V:G,1. *Symptoms from kidney and/or bladder at the time of torture and at the time of examination.*

	At the time of torture		At the time of examination	
Symptoms	n	%	n	%
Haematuria	27	13	0	0
Dysuria	24	12	6	3
Back pain	10	5	2	1
Other symptoms	9	4	3	1
Total	50	25	11	5

MEDICAL EXAMINATION

Medical examination revealed atrophy of the testis in 6 men, bilateral in 2 and unilateral in the rest. All 6 had allegedly been kicked in the genital region as part of the torture, before which the testes were reportedly normal in size. One of the atrophic testes was very tender on palpation. One man, whose testes were normal in size, complained of unilateral pain on palpation, and one epididymis was swollen and sore.

DISCUSSION

Acute haematuria could be explained by injuries to the urethra in the majority of the persons. Obviously, however, no confirmation by diagnostic tests was available. The assumption of a lesion of the mucous membrane of the urethra was solely based on the accounts given by the torture victims themselves. Due to blindfolding or fixation during torture, the victims were often unable to see what exactly took place.

Blunt trauma of the urethra can be very serious because of the danger of partial tearing or total rupture. These lesions require skilled urological treatment, since they carry a high incidence of urethral stricture, incontinence, and impotence (*Al-Askari* 1982). Apart from the two men who were admitted to hospital due to severe haematuria, it is unlikely that any of the other men with haematuria had tearing of the urethra.

Blunt trauma of the kidney region is known to be a possible cause of haematuria, but it usually subsides after a few days of bed rest, leaving no permanent damage (*Al-Askari* 1982).

In a few cases, the haematuria could not be explained by direct trauma of the genital or kidney regions. Haemoglobinuria has been described in runners due to "footstrike" haemolysis (*Eichner* 1985). The same mechanism might explain the "haematuria" in some of the torture victims. Falanga in particular (beating on the soles of the feet) is somewhat similar to the constant friction of the feet as they strike the ground in runners. *Warmenhoven et al* (1981) reported acute macroscopic haematuria in 10 out of 43 torture victims: "chiefly following beating and kicking in the abdominal and kidney region". No case of haematuria following trauma of the urethral mucosa was described, but 6 persons reported painful urination, especially following electric shock torture in which the electrode had been placed in or near the urethra.

Dysuria at the time of torture could be explained in 25% of the cases in the present study by an infection after direct genital torture. In the remaining 75%, cold cells without bed or mattress, lack of washing facilities, and unhygienic toilet conditions might have been the cause.

The finding that, at the time of examination, the most common symptom was recurrent bladder infection with dysuria, is in agreement with other studies (*Randall et al* 1985, *Warmenhoven et al* 1981). In a prospective controlled study (*Hougen et al* 1988), dysuria was recorded with the same frequency in torture victims as controls (21%), and *Thorvaldsen* (1986) reported symptoms from the bladder or kidney or both with the same frequency among torture victims and their controls (18%).

CONCLUSION

Trauma to the genital region can cause haematuria in torture victims. Haematuria can also be caused by renal trauma. Some cases of "haematuria "following beating may have been haemoglobin-

uria, caused by a mechanism similar to footstrike haemolysis in runners.

Dysuria is a frequent complaint among torture victims, probably caused by torture instruments in some of the cases, and by cold plus bad hygienic conditions in the rest.

At the time of examination, bladder or kidney complaints or both were not found more frequently than were reported in control groups.

H: GYNAECOLOGICAL

SYMPTOMS AT THE TIME OF TORTURE

(A-variable, reply rate = 0.90).

Torture is almost exclusively carried out by men. Female torture victims, because of their sex, are subjected to special types of torture, including sexual humiliation and rape.

Verbal sexual assaults were experienced by 22 of the 39 examined women (56%); 5 said they had been raped (13%), and another 5 that foreign bodies were forced into their vagina (cf. Chapter IV). Sexual problems after torture have been discussed earlier (cf. Chapter V:F).

At the time of torture, 24 women (61%) complained of symptoms from the genital tract, 11 (28%) did not, and nil was registered in the remaining 4 (10%) (Table V:H,1).

Irregular uterine bleeding was the most common symptom, reported by 22 women. 10 developed amenorrhoea after the arrest and beginning of torture. It lasted a median of 3 months (range 2-13 months) and was usually followed by a period of irregular menstruation. 5 women had unexpected vaginal bleeding in connection with the torture. One of these was a 39-year-old Greek woman who developed very heavy metrorrhagia after severe torture. Her menstruations prior to arrest had always been regular.

She was transferred to hospital and a hysterectomy was performed, after which she was returned to prison. 2 women began to bleed when they were deprived of their contraceptive pills. 5 women had minor changes in their menstrual cycles.

Abnormal menstrual bleeding was reported by 12 women, 5 with hypermenorrhoea and 7 with hypomenorrhoea.

Intermediary bleeding between normal menstrual periods was reported by 7 women.

Painful menstruations, not present before the arrest, were mentioned by 5 women.

5 women complained of inflammatory symptoms from the genital tract, 4 had increased fluor vaginalis, and 3 of these said they had suffered from salpingitis. 2 of these women had been raped.

Sexual assault also includes deliberate injury of the breast. Electrical torture of the nipple resulted in small areas of necrosis in 3 women.

2 women were pregnant at the time of arrest. One of them was in her third month of pregnancy when arrested in 1973 in Santiago. After very severe torture, including beating of the abdomen, rape, and electrical torture in the vagina, she began to bleed. The bleeding continued, and three months later she had a spontaneous abortion while still in detention. She was referred to a hospital, where she stayed for one month before she was returned to the prison. The other woman was in her second month of pregnancy when arrested. She began to bleed in connection with severe torture. The bleeding persisted throughout her pregnancy. She gave birth to her child while still in detention. A detailed account on her history is given in the appendix, case history V:H,1.

Table V:H,1. *Symptoms from the female genital tract at the time of torture and at the time of examination. n=39.*

Symptoms	At the time of torture		At the time of examination	
	n	%	n	%
Irregularity in menstruation	22	56	6	15
Increased menstrual bleeding	5	13	1	3
Diminished menstrual bleeding	7	18	2	5
Intermediary bleeding between menstruation	7	18	1	3
Painful menstruation	5	13	4	10
Increased fluor vaginalis	4	10	5	13
Salpingitis	3	8	0	0
Pregnant during imprisonment	2	5	–	–
Abortions during imprisonment	1	3	–	–
Total	24	61	12	31

SYMPTOMS AT THE TIME OF EXAMINATION

(A-variable, reply rate = 0.97).

12 women (31% of the examined women) complained of genital tract symptoms at the time of examination (Table V:H,1).

A change in menstruation was reported by 8 women, in 6 of whom the cycle was irregular. The examination of these women took place a median of 25 months (range 1-72 months) after torture.

Persistent abnormal bleeding was reported by 3 women, hypermenorrhoea in 1, and hypomenorrhoea in 2. Intermediary bleeding persisted in 1 woman. Painful menstruations were reported by 4 women, and fluor vaginalis by 5 women.

MEDICAL EXAMINATION

Gynaecological examination was performed in one case only, and no abnormalities were found.

DISCUSSION

Torture of female detainees includes sexual assault in more than 80% (chapter IV, *Lunde* 1981, *Genefke & Nielsen* 1985). The mental consequences after sexual torture are tremendous and have been discussed earlier. From a somatic point of view, sexual torture, including rape, insertion of foreign bodies in the vagina, etc., can have dreadful results. The vagina can be damaged by broken glass. Venereal disease, including AIDS, might be transmitted. Other female tract infections might be contracted, either through genital torture or due to the very bad hygienic conditons which the inmates often suffer. Pregnant women are not spared, and the torture can induce an abortion. Conversely, the victim may become pregnant following rape and have to carry her torturer's child.

Fright and emotional disturbance are well-known factors in the development of secondary amenorrhoea. It is therefore not surprising that the most frequently reported symptom in connection with the arrest and subsequent torture was a change in uterine bleeding.

Amenorrhoea is known to occur due to dietary restrictions (*Anonymous* 1978), but in female German concentration camp victims the disorder generally appeared before the women had been affected by underfeeding (*Helweg-Larsen et al* 1952). Direct affection of the ovaries after stress has been observed (*Stieve* 1952), but stress-induced secondary amenorrhoea is usually the result of a hypothalamic-pituitary dysfunction characterized by a low secretion of gonadotrophic hormones (*Ufer* 1969).

The menstrual disturbances ceased in approximately half the cases and those that persisted were mainly irregularities in the menstrual cycle. Studies of female torture victims are rarely found in the medical literature. The existing studies contain only few samples, and general conclusions are therefore difficult to make (*Randall et al* 1985, *Petersen & Jacobsen* 1985a, *Hougen et al* 1988). No hormone analysis of female torture victims has been found in the literature. Epidemiological studies of gynaecological symptoms in the general population are still few (*Ballinger et al* 1985).

CONCLUSION

Contraction of female genital tract diseases has been observed in connection with sexual torture and bad hygienic prison conditons.

No direct mutilation of the female genital tract due to torture was

found in the present survey. However, only one gynaecological examination was made.

Pregnant torture victims risk abortions.

Rape can result in pregnancy, but was not reported in this survey.

The most frequently reported gynaecological symptom reported at the time of torture was a change in uterine bleeding. Amenorrhoea occurred in more than 25% of the female torture victims. Fear-induced amenorrhoea is known to be the result of a hypothalamic-pituitary failure disorder, with decreased secretion of gonadotrophic hormones. The same mechanism probably lies behind the bleeding disturbances found in female torture victims.

Menstruation irregularity is the dominant persisting symptom. No hormonal analysis of female torture victims was available.

I: OTORHINOLARYNGOLOGICAL

SYMPTOMS AT THE TIME OF TORTURE

(B-variables, reply rate = 0.58).

63 persons (31%) complained of symptoms from the ear, nose or throat at the time of torture (Table V:I,1).

Hearing problems and pain in the ear were the commonest complaints. The type of torture that carries a high risk of damaging the hearing function is beating, particularly in the form of "teléfono", in which both ears are beaten simultaneously with the flat of the hand. Hearing problems and pain in the ear were significantly associated with "teléfono" (Table V:I,2).

SYMPTOMS AT THE TIME OF EXAMINATION

(A-variable, reply rate = 0.86).

42 persons (21%) complained of symptoms from ear, nose or throat at the time of examination (Table V:I,1).

A significant association between "teléfono" and ear symptoms was found (Table V:I,3), but not between severe beating on the head and ear symptoms (Table V:I,4).

Two persons complained of difficulty in breathing through the nose because of septal deviation following blows to the nose during torture.

MEDICAL EXAMINATION

A whispering test for the hearing function, performed in 79 persons, was reduced in 13. Audiometry was performed in 33 persons and showed reduced hearing in 7.

Otoscopy (185 persons) showed abnormalities of the eardrum in 7. Scar tissue consistent with an earlier perforation was found in 4 persons, and signs of infection in another 4.

Of the 19 persons who had been tortured with "teléfono", 6 had reduced hearing by the whispering test, 2 an abnormal audiometry, and 3 an abnormal eardrum.

In 3 persons a fractured nose was found.

Table V:I,1. *Symptoms from ear, nose and/or throat at the time of torture and at the time of examination. n=200.*

Symptoms	At the time of torture		At the time of examination	
	n	%	n	%
Hearing problems	40	20	33	16
Ear pain	30	15	9	4
Tinnitus	10	5	7	3
Ear infection	8	4	4	2
Nose bleeding	7	3	0	0
Sinusitis	4	2	4	2
Nose fracture	3	1	3	1
Bleeding from the ear	2	1	0	0
Obstruction of nose	0	0	2	1
Frequent tonsillitis	0	0	1	0
Total	63	31	42	21

Table V:I,2. *The torture form "teléfono" correlated to hearing problems and ear pain at the time of torture. n=200.*

	"Teléfono"					
	yes		no & n.i.*)		Total	
	n	%**)	n	%**)	n	%**)
Hearing problems						
yes	11	58	29	16	40	20
no	5	26	55	30	60	30
n.i.*)	3	16	97	54	100	50
Ear pain						
yes	9	47	21	12	30	15
no	6	32	56	31	62	31
n.i.*)	4	21	105	58	109	54
Total	19	100	181	100	200	100

*) Not indicated.
** Column percentage.

	Hearing problems	Ear pain
p:1	<0.001	<0.001
p:2	N.S.	N.S.

Table V:I,3. *Symptoms from the ears at the time of examination correlated to the torture form "teléfono". n=200.*

	Ear symptoms					
	yes		no & n.i.*)		Total	
"Teléfono"	n	%**)	n	%**)	n	%**)
Yes	10	53	9	47	19	100
No & n.i	28	15	153	84	119	100
Total	38	19	162	81	200	100

*) Not indicated.
**) Row percentage.
p:1 <0.001.
p:2 <0.001.
p:corr<0.001.

Table V:I,4. *Symptoms from the ears at the time of examination correlated to severe beating of the head.*

	Ear symptoms					
	yes		no & n.i.*)		Total	
Severe beating of the head	n	%**)	n	%**)	n	%**)
Yes	33	23	113	77	146	100
No & n.i.*)	5	9	49	91	54	100
Total	38	19	162	81	200	100

*) Not indicated.
**) Row percentage.
p:1 N.S.

DISCUSSION

It is rather surprising that fracture of the nose was reported by only 3 persons and nose bleeding by only 7, considering that more than 70% of the victims were severely beaten on the head. However, torture is very different from a "normal fight", in that the victim is quite defenceless and totally at the mercy of the torturers. When a person is prevented from fighting back, he or she tries to avoid the beating and turns the face away, and this may explain the small number of nasal fractures.

"Teléfono" produced immediate as well as long-lasting symptoms from the ears. It produces a shock wave against the eardrum, probably very similar to the one produced by explosions. It seems therefore reasonable to quote *Kerr's* (1978) clinical observations after blast injuries in Belfast:

"Usually sensorineural deafness occurs accompanied by tinnitus. In mild cases this tinnitus and deafness may recover fully in a matter of hours. Severe cases may never recover fully. Perforation of the tympanic membrane is common and occurs in the pars tensa

which is the lower five-sixths of the tympanic membrane. These perforations vary in appearance and may be linear tears, small holes or subtotal defects. From time to time, there is also damage to the ossicular chain.

Especially high frequency sensorineural deafness occurs with preserved normal hearing for the speech frequencies.

The hearing loss may recover up to six months after the explosion."

Experimental animal studies have described damage of the cochlear sensory hairs following exposure to a blast (*Yokoi & Yanagita* 1984).

A case history of a person who had been tortured with "teléfono" is presented in the appendix. The symptoms and findings in this person are very similar to the blast injuries just described.

CONCLUSION

Otorhinolaryngological sequelae after torture are mainly associated with the hearing function.

Of particular importance is the type known as "teléfono", which seems to cause immediate as well as long-lasting symptoms. It is suggested that its mechanism of action is similar to that of blast injuries.

J: OPHTHALMOLOGICAL

SYMPTOMS AT THE TIME OF TORTURE

(B-variable, reply rate = 0.42).

20 persons (10%) complained of ocular symptoms at the time of torture. 14 persons had visual disturbances, including blurred or double vision or both. In the majority of cases, these symptoms were said to be of short duration. 6 persons complained of infections in the eyes, thought in 4 to be caused by filthy cloths used for blindfolding, in one the result of some kind of powder thrown in his eyes, and in one the infection was due to "bañera".

SYMPTOMS AT THE TIME OF EXAMINATION

(A-variable, reply rate = 0.82).

16 persons (8%) had symptoms from the eyes at the time of examination. Visual disturbances were present in 15 persons, typically in the form of optical problems requiring glasses, mostly for short sight. No significant association between visual disturbances and length of blindfolding or length of isolation could be found. One person complained of repeated infections of the eyes, which began during detention.

MEDICAL EXAMINATION

Conjuctivitis was recorded in 3 persons. The field of vision was reduced in 2 men, homonynous hemianopia in one and unilateral hemianopia in the other. Both were sent for further neurological examination. Vison testing was not performed at the medical examination.

DISCUSSION

None of the persons with eye symptoms could correlate the symptoms with direct trauma to the eyes, and no specific event during torture or imprisonment could be correlated to the permanent visual disturbances.

Traumatic injuries to the eyes have been reported after torture (*AI* 1980 (Colombia)).

Infection was the most frequently recorded acute ocular symptom in torture victims, probably caused by dirty cloths used for blindfolding which the victims often had to wear day and night for many days.

Short sight has been blamed by torture victims on prolonged blindfolding or isolation, but no evidence for it was found in the present study, nor in the literature.

CONCLUSION

Acute eye symptoms from conjunctivitis were the most frequent complaints. Reports of direct eye damage from blows have been found only in the literature.

Very few long-lasting eye symptoms which could possibly be related to torture and detention were found.

K: DENTAL

SYMPTOMS AT THE TIME OF TORTURE

(B-variable, reply rate = 0.59).

Acute dental symptoms were reported by 64 persons (32%) (Table V:K,1). As a consequence of severe beating towards the head, fractures of the teeth occurred in 27 persons, and loosening of teeth in 19 persons. Bleeding from gingiva was reported by 9 persons. 8 persons said that they bled from the mouth, without knowing the exact localization of the bleeding. In some of these last, the bleeding might have come from the gums.

2 women reported that their fillings fell out about one month after the torture. One of the women had been electrically tortured against the teeth.

SYMPTOMS AT THE TIME OF EXAMINATION

(A-variable, reply rate = 0.79).

12 persons (6%) complained of dental symptoms at the time of examination. 5 persons were complaining of toothache, and 8 of gingival infection, to such an extent that the teeth were beginning to fall out.

MEDICAL EXAMINATION

The dental examination was performed by the examining doctors, except in 48 in which it was carried out by a dentist. 35 of these were examined because a dentist participated in a medical mission, while in the remaining 13 the examination by a dentist was performed in Denmark, mainly because dental problems were expected.

27 persons showed sequels of injury to the teeth, reportedly after torture, some of which were missing in 18 and broken in 15. One man, who was examined one month after torture, had an irregular frenulum of the lower lip with small sores on it, allegedly caused by beating. He also had a broken tooth and a detailed account of his case is presented in the appendix.

The lower jaw was abnormal in 2 men, both following fractures during arrest or detention. One of the men could only open his mouth half way, and the other had a considerable deviation on opening the mouth.

The presence of gingivitis or parodontitis was registered in 18 persons.

Description of caries was lacking in most of the cases.

DISCUSSION

Clavel (1973) described dental torture as follows: "Fayal de Lire in Brazil was subjected to "the mad dentist", which consisted of his being tied in a chair, having his mouth forced completely open with an instrument, his teeth drilled with a dentist's drill.

Table V:K,1. *Number of persons with dental symptoms at the time of torture in 200 examined persons. n=200.*

Symptoms	n	%
Teeth broken	27	13
Teeth loosened	19	9
Tooth pain	19	9
Bleeding from gingiva	9	4
Total	64	32

During this treatment three of his teeth broke. He was then taken to a doctor who gave him an injection, and shortly after, the torture continued."

No comparable accounts were given in the present study. However, in some cases electrical torture involved the teeth. Damage to the teeth was mainly caused by severe beating of the mouth, resulting in fractures or loss of teeth. The dental status of the victim at the time of arrest was sometimes very poor, and the teeth which became damaged were actually "rotten". Poor oral hygienic conditions during detention with the lack of optimal dental cleaning by regular use of a toothbrush no doubt caused deterioration in the dental state and development of varying degrees of parodontal diseases, ranging from gingivitis and necrotizing gingivitis to more profound forms of parodontitis. Similar findings have been reported among prisoners of war (*Diem & Richlin* 1978), including "trench mouth" or acute necrotizing ulcerative gingivitis among persons suffering stress (*Gonzales* 1983). Dental treatment during detention was usually lacking, and, if available, it was of a very poor standard, often limited to extractions. Torture victims have reported that amalgam fillings fell out after electrical torture of the teeth, but X-ray examinations of teeth with amalgam fillings, reportedly electrically tortured, have not shown changes in the bone or pulp (*Bølling* 1978).

The examination revealed sequels of damage to the teeth in 13% of the victims, allegedly caused by torture. It is quite impossible to assess whether the damage of a tooth originates from torture or not. In the case of fracture, X-ray examination gives only little information of the age of the fracture.

Considering that the prevalence of gingivitis is some 90% in a normal Danish population (*Kirkegaard et al* 1987), the figure of 9% in the present study seems ridiculously low. However, gingivitis gives only few symptoms in the early stages. The inflammation was said to worsen or begin during imprisonment as a consequence of the poor oral hygienic conditions. However, this is impossible to verify without knowing the dental state prior to arrest, and this was not sought. Such information could possibly be obtained from the local dentists who have treated the victims prior to arrest, but no such studies have been found in the literature.

In the few controlled studies of torture victims (*Thorvaldsen* 1986, *Hougen et al* 1988) dental examination was not included.

66 torture victims have been treated at the Rehabilitation Centre for Torture victims in Copenhagen, and *Jerlang* has reported (1987, personal communication) that 111 teeth with caries were filled, 56 persons were treated for gingivitis, 23 teeth were extracted, 10 crowns and/or bridges built, 23 dentures fitted, and 4 roots treated.

Thorough examinations of torture victims by dentists have shown that tenderness and actual pain in the temporo-mandibular joint and masticatory muscles (fibrositis) are very frequent (*Jerlang & Marstrand* 1984). The painful, fibrotic muscles are often associated with grinding of the teeth and headache. Dental treatment comprises occlusal splints, occlusal adjustments, muscle blocks using local infiltration anaesthesia, and physical therapy such as massage.

CONCLUSION

Broken teeth and loss of teeth are common in torture victims.

Dental treatment during detention is often lacking or consists only of extraction of damaged teeth.

Poor oral hygienic conditions during detention with lack of optimal dental cleaning can cause a deterioration in the dental state.

Long-lasting symptoms mainly comprise affection of gingiva.

Examination of the masticatory muscles should be included in the medical examination of torture victims, since fibrositis has been described to be present at a high frequency.

CHAPTER VI. THE INFLUENCE OF EXILE ON HEALTH COMPLAINTS IN TORTURE VICTIMS

INTRODUCTION

Ødegård (1932) was the first to examine, in a controlled study, the effect of exile on mental disorder. He studied Norwegian emigrants living in the United States, and compared them with a control group of Norwegians at home in Norway. He found a higher frequency of mental disorders among the emigrants, measured as the number of admissions to mental hospitals. He concluded that: "the old belief in emigration to America as the best treatment for peculiar, troublesome, unmanageable and maladjusted youngsters is a fallacy. Many such young people are actually suffering from incipient mental disorders of a very serious nature, and emigration would be disastrous in these cases". Internal migration has been studied by *Astrup & Ødegård* (1960) and *Ødegård* (1982). The internal migration was voluntary and had nothing to do with forced internal exile, as some States use against political opponents. They found that the rate of mental disorders, measured as the rate of first admission to psychiatric hospitals, was lower among the group that had migrated within the country (Norway) than those who had not.

The "emigrants" we are dealing with in the present study, however, are very different from the emigrants studied in the above-mentioned studies. They are not emigrants of their own free will. They are refugees, and thus forced into exile by the political situation in their own country. They have not had a free choice.

Refugees have been examined in a controlled study by *Eitinger* (1958, 1959). He examined all refugees in Norway who had been admitted to mental hospitals since the Second World War, and compared them with a control group of Norwegian matched patients with the same age, sex and diagnosis, and hospitalized at the same time as the refugees. A significantly higher frequency of mental disorders, especially reactive psychotic disorders, was found among the refugees. However, the refugees had spent some time in concentration and refugee camps before arrival in Norway, and this could serve as a part of the explanation.

The only other controlled studies have been made by *Thorvaldsen* (1986) and *Hougen et al* (1988) who found a higher frequency of mental complaints in tortured compared with non-tortured refugees. A study comparing torture victims living in exile with torture victims living in their home country could not be found in the literature.

MATERIAL AND METHOD

In order to study the possible influence of exile on torture victims, the present material was divided into those who were examined when living in exile and those who were living in their country of origin at the time of examination.

In addition, the Chileans living in Chile have been compared with the Chileans living in Denmark. The examination of the Chileans was performed in Santiago in 1982 (*Wallach & Rasmussen* 1983, *AI* 1983 (Chile)), and conducted in Spanish, using the most recent data-collecting form, thus resulting in very few missing values.

RESULTS

PERSONS IN EXILE COMPARED WITH THOSE LIVING IN THEIR COUNTRY OF ORIGIN

At the time of examination, 111 persons were living in exile while 89 persons lived in their country of origin (Table VI,1). Those who were examined in their own country mainly comprise Greeks, Spaniards, and Chileans.

The two groups were comparable with respect to age and sex, but their countries of origin were very different.

Thus, 70 of the 89 persons not in exile lived in Europe, while all 111 persons in exile came from countries outside Europe.

Important alleged torture forms for the two groups are shown in Table VI,2. Significant differences were found concerning expo-

sure to falanga and isolation (>14 days), the use of these having been most frequent in the group of torture victims not living in exile, while electrical torture, torture for more than 3 days, and sham execution were more frequent in persons living in exile. This difference can be related to the fact that falanga torture was predominantly exercised on Greek victims (not living in exile), and electrical torture on Latin Americans (living in exile).

The symptomatology for the two groups is shown in Table VI,3. Symptoms from the brain and the spinal cord were significantly more prevalent in torture victims living in exile ($p<0.01$), compared with those living in their own country. Otherwise the symptomatology was not different in the two groups.

Symptoms from the central nervous system are shown in Table VI,4. Impaired memory and impaired concentration were both significantly more prevalent in torture victims living in exile ($p<0.01$).

The mental symptoms are shown in more detail in Table VI,5. Their prevalence in the two groups was in general similar, but nightmares ($p<0.01$) and depression ($p<0.05$) were significantly more prevalent in the groups in exile.

CHILEANS IN EXILE COMPARED WITH CHILEANS IN CHILE

Differences in nationality could be the reason for the differences in the symptomatology among the torture victims and thus act as important confounders. Chileans who have been examined in Chile have therefore been compared with Chileans examined in Denmark. 18 Chileans were examined in Santiago, Chile, while 54 were examined in Denmark (Tables VI,6-10).

The two groups differed with respect to sex and age: those examined in Chile are younger and have a higher percentage of females.

The two groups experienced very similar forms of torture, but most types of torture were registered with a higher percentage in the exiled victims, and the torture method called suspension and torture for more than 3 days were more prevalent (Table VI,7). The symptomatology in Chileans living in Chile was very similar to that in Chileans living in exile in Denmark (Table VI,8). Dental symptoms and symptoms from ears-nose-throat, however, were only recorded in those living in Denmark. The only mental symptom or symptom from the central nervous system recorded with a significantly higher frequency among Chileans living in their own country was "general tiredness" (Table VI,9-10).

Table VI,1. *Sex, age and country of origin in relation to exile at the time of examination. n=200.*

	Living in exile				
	no (n=89)		yes (n=111)		
	n	%*)	n	%*)	Total
Male					
< 31 years	57	64	62	56	119
> 30 years	14	16	28	25	42
Total male	71	80	90	81	161
Female					
< 31 years	14	16	18	16	32
> 30 years	4	4	3	3	7
Total female	18	20	21	19	39
Argentina	0		18		18
Bolivia	0		1		1
Chile	18		54		72
Denmark	1		0		1
Eritrea	0		1		1
Ethiopia	0		1		1
Greece	35		0		35
Indonesia	0		1		1
India	1		0		1
Iraq	0		16		16
Northern Ireland	5		0		5
Rhodesia	0		1		1
Spain	28		0		28
Somalia	0		1		1
Switzerland	1		0		1
Tanzania	0		2		2
Uganda	0		1		1
Uruguay	0		13		13
Zanzibar	0		1		1
Total	89		111		200

*) column %.

DISCUSSION

There are several descriptive studies of the problems faced by both tortured and not tortured refugees living in exile (*Murphy* 1977,

Table VI,2. *Alleged torture types in relation to exile at the time of examination. n=200.*

	Living in exile				
	no (n=89)		yes (n=111)		
Torture type	n	%*)	n	%*)	Total
Beating	87	98	111	100	198
Severe beating	85	96	110	99	195
Beating on the head	64	72	82	74	146
Electrical torture**)	26	29	83	75	109
Falanga**)	43	48	19	17	62
Suspension	20	22	30	27	50
Physical exhaustion	31	35	37	33	68
Isolation > 14 days***)	56	63	50	45	106
Rape	1	1	6	5	7
Tortured over 3 days****)	64	72	97	87	161
Threats	72	81	99	89	171
Sham execution**)	21	24	42	38	63
Total	89		111		200

*) column %.
**) $p<0.01$.
***) $p<0.05$.
****) $p<0.01$.

Table VI,3. *Symptoms from different organ systems at the time of examination in relation to exile. n=200.*

	Living in exile					
	no			yes		
Organ system	n	%*)	reply %	n	%*)	reply %	Total
Locomotor	29	33	(91)	42	37	(95)	70
Skin	6	7	(67)	4	4	(88)	10
Dental	5	6	(66)	7	6	(88)	12
Eye	9	10	(71)	7	6	(91)	16
Ear-nose-throat	17	19	(78)	25	23	(93)	42
Heart and lung	19	21	(74)	23	21	(93)	42
Digestive tract	19	21	(73)	32	29	(94)	51
Kidney and bladder	2	2	(66)	10	9	(95)	12
Female genital tract	4	22	(94)	8	38	(100)	12
Sexual	8	9	(45)	16	14	(50)	24
Brain and spinal cord**)	48	54	(84)	81	73	(87)	129
Peripheral nerve	12	13	(66)	13	12	(68)	25
Mental	59	66	(87)	78	70	(87)	137
Total	89			111			200

*) column %
**) $p<0.01$.

Table VI,4. *Symptoms from the Central Nervous System at the time of examination in relation to exile. n=200.*

	Living in exile				
	no (n=89)		yes (n=111)		
Symptoms	n	%*)	n	%*)	Total
Headache	28	31	48	43	76
Impaired memory**)	22	25	49	44	71
Impaired concentration**)	28	31	57	51	85
General tiredness	13	15	9	8	22
Total with symptoms from CNS***)	48	54	81	73	129

*) column %.
**) $p<0.01$.
***) $p<0.01$.

Chavez 1981, *Tyhurst* 1982, *Grupo Colat* 1982, *Bustos* 1986, *Bustos & Ruggiero* 1986, *Arenas et al* 1987).

Mental disorders have been found to occur more frequently in refugees than in the native population (*Eitinger* 1958). Refugees who have been tortured have a higher incidence of health complaints, compared with refugees who have not been tortured (*Thorvaldsen* 1986, *Hougen et al* 1988). In particular, headache, sleeplessness, nightmares, and impaired memory were found to an increased extent among the torture victims. Examinations of torture victims living in their own country (*Petersen & Jacobsen* 1985a, *Petersen et al* 1985, *Puebla & Fuentes* 1981, *Ceres et al* 1986, *Kordon et al* 1983a,b), have shown a symptomatology similar to that in torture victims living in exile.

The present very mixed study, including torture victims from many different countries, shows that torture victims living in their own country exhibit a very similar symptomatology compared with those living in exile, though impaired memory, impaired concentration, nightmares, and depression were significantly more frequent in persons living in exile.

The findings must, however, be interpreted with great care, since quite a number of variables might have influenced the results, the most important being:

1. The nationalities in the two groups were very dissimilar.
2. The medical examination was very likely different when it was conducted in a foreign country.
3. Some kind of selection could have been used when selecting exiled persons.
4. Those forced into exile have possibly been tortured more severely than those who stayed in their own country.

The comparison between Chileans living in their own country with Chileans living in exile in Denmark did not demonstrate any differences measured as frequency of different symptoms except for general tiredness, which was more frequently recorded among Chileans living in their own country.

The two groups were comparable in alleged torture forms, but different in sex, age, and the duration of torture. As the examination of Chileans living in Chile was carried out in Spanish by the

Table VI,5. *Mental symptoms at the time of examination in relation to exile. n=200.*

	Living in exile				
	no (n=89)		yes (n=111)		
Symptoms	n	%*)	n	%*)	Total
Sleeping problems	40	45	62	56	102
Nightmares**)	22	25	53	48	75
Irritability and/or anxiety	47	53	63	57	110
Depression**)	9	10	25	23	34
Suicide wish	2	2	3	3	5
Psychiatric treatment	10	11	7	6	17
Mental symptoms	59	66	78	70	137

*) column %.
**) $p<0.01$.

Table VI,6. *Sex and age at time of torture in relation to exile at the time of examination among examined Chileans. n=72.*

	Living in				
	Chile		Denmark		
	n	%*)	n	%*)	Total
Male	14	78	47	87	61
Female	4	22	7	13	11
<31 years	16	89	34	63	50
>30 years	2	11	20	37	22
Total	18	100	54	100	72

*) column %.

Table VI,7. *Alleged torture forms in relation to exile at the time of examination among examind Chileans. n=72.*

	Living in				
	Chile		Denmark		
Torture forms	n	%*)	n	%*)	Total
Beating	17	94	54	100	71
Severe beating	16	89	53	98	69
Beating on the head	10	56	34	63	44
Electrical torture	14	78	47	87	61
Falanga	1	6	6	11	7
Suspension**)	1	6	17	31	18
Physical exhaustion	2	11	15	28	17
Isolation > 14 days***)	7	39	21	39	28
Rape	1	6	2	4	3
Tortured over 3 days***)	10	56	47	87	57
Threats	16	89	47	87	63
Sham execution	5	28	19	35	24
Total	18	100	54	100	72

*) column %.
**) $p<0.05$.
***) $p<0.01$.

Table VI,8. *Symptoms from different organ systems at the time of examination in relation to exile among examined Chileans. n=72.*

	Living in						
	Chile			Denmark			
Organ system	n	%*)	reply %	n	%*)	reply %	Total
Locomotor	5	28	(100)	20	37	(93)	25
Skin	1	6	(100)	1	2	(80)	2
Dental	0	0	(100)	2	4	(87)	2
Eye	2	11	(100)	2	4	(85)	4
Ear-nose-throat	0	0	(100)	13	24	(89)	13
Heart and lung	5	28	(100)	6	11	(87)	11
Digestive tract	4	22	(100)	13	24	(87)	17
Kidney and bladder	1	6	(100)	5	9	(93)	6
Female genital tract	2	40	(100)	3	60	(100)	5
Sexual	2	11	(50)	6	11	(41)	8
Brain and spinal cord	11	61	(100)	37	69	(80)	48
Peripheral nerve	1	6	(100)	6	11	(52)	7
Mental	13	72	(100)	32	59	(78)	45
Total	18			54			72

*) column %.

Table VI,9. *Mental symptoms at the time of examination in relation to exile among examined Chileans. n=72.*

	Living in				
	Chile n=18		Denmark n=54		
Symptoms	n	%*)	n	%*)	Total
Sleeping problems	11	61	24	44	35
Nightmares	10	56	18	33	28
Irritability and/or anxiety	10	56	25	46	35
Depression	2	11	7	13	9
Suicide wish	1	6	1	2	2
Mental symptoms	13	72	32	59	45

*) column %.

Table VI,10. *Symptoms from the Central Nervous System at the time of examination in relation to exile among examined Chileans. n=72.*

	Living in				
	Chile n=18		Denmark n=54		
Symptoms	n	%*)	n	%*)	Total
Headache	5	28	19	35	24
Impaired memory	4	22	25	46	29
Impaired concentration	8	44	26	48	34
General tiredness**)	4	22	2	4	6
Symptoms from Central Nervous System	11	61	37	69	48

*) column %.
**) $p<0.05$.

mission delegates, possibly more symptoms were unveiled. Having taken these reservations into account, the similarity of the two groups could be an indication that the stressful situation of living in a country where rearrest and torture are a daily threat could be similar to the stressful situation of living in exile in Denmark.

CONCLUSION

Studies have shown that refugees have a higher incidence of mental disorder than the native population.

Other studies of torture victims have shown that tortured refugees have a higher incidence of health complaints, compared with non-torture victim refugees.

The present study finds that the symptomatology among refugee torture victims is rather similar to torture victims living in their own country.

Torture sequels might not be more severe among exiled torture victims than among victims living in their own country in a situation full of stress and fear of re-arrest and torture.

CHAPTER VII. TORTURE SYNDROME?

INTRODUCTION

One important aspect in a doctor's relation to the patient is to make a diagnosis. A diagnosis is made by the doctor on the basis of symptoms, clinical signs, and clinical tests. It is crucial for the medical profession, when dealing with diseases, to agree on a common terminology in order to institute correct treatment and be able to compare results of different treatments.

Clinical signs and clinical tests are normally well-defined concepts, while symptoms described by the patient have a tendency to lack delimitations concerning the quality and grading concerning the quantity.

In earlier days doctors described and defined new syndromes, often due to the lack of knowledge of the exact aetiology of a disease. A syndrome was a constellation of symptoms and signs which were thought to have the same causative origin. A classical example is *Robert James Graves* who in 1835 described "toxic exophthalmic goitre" as the combination of thyroid enlargement, nervousness, sweating, and pronounced stare.

Today, syndromes are still used for descriptive purposes when the aetiology is unknown. AIDS was such a case when the medical profession, parallel with intensive search for a causative organism, described the disease, its prognosis, and different treatment models.

Although different definitions of torture can be used, a possible *"torture syndrome"* is different from the syndromes just mentioned in that the *cause* is known. It is the *effect* of torture on the human body and mind which is investigated. Torture types are numerous and disclosure of new horrible types seems to be interminable. Common to all are the stress and especially the anxiety imposed upon the victim. All these types of torture may have so similar an effect on the victims that the concept of a symptom complex, a torture syndrome, has been discussed (*Rasmussen et al* 1977, *Warmenhoven et al* 1981, *Allodi & Cowgill* 1982, *Thorvaldsen* 1986).

Examination of torture victims has mainly been of a descriptive nature, without a control group and often evaluated retrospectively as in the present survey.

METHOD

Torture types and torture sequelae can be both physical and mental. The relationship between these four factors is probably extremely complicated, with considerable overlapping: physical sequelae caused not only by physical torture but also by mental torture, and mental sequelae caused by both physical and mental torture. The quantity of sequelae depends on the intensity of the torture and the constitution of the victims prior to torture. Many of these aspects have already been dealt with earlier and this chapter will focus on:

a) specific physical sequelae caused by specific torture types.
b) the constitution of a possible mental torture syndrome caused by either physical or mental torture or a combination of the two.

RESULTS

A. SPECIFIC PHYSICAL SEQUELAE CAUSED BY SPECIFIC TORTURE TYPES

Alleged physical torture types have been summarized in Table VII,1. Only torture types occurring with a frequency over 10% have been included. Each torture type should in its description include quantity and quality of the torture.

A detailed account has been given in chapter V of the possible damage that these torture types could cause in the different organ systems. Some torture types cause rather specific sequelae, and the following is a presentation of some of these *"specific torture syndromes"*.

Beating is the commonest torture type, ranging from a few slaps in the face to severe beating with a club on the skull. Beating should be differentiated according to a) quality: the instrument used (fists, police baton, etc.), b) quantity: number of times and the force with which the beating is carried out, and finally c) the place on the body and whether the body is protected in any way (clothes, shoes, etc.).

Severe beating on the head can produce *postconcussion syndrome* (*Kosteljanetz et al* 1981). Severe beating under the soles of the feet (falanga) can produce a *closed compartment syndrome* (*Bro-Rasmussen & Rasmussen* 1978, *Bro-Rasmussen et al* 1978, 1982).

Simultaneous beating with the palms of the hands against both ears (teléfono-torture) can lead to lesions of the tympanic membrane similar to *blast injuries* (*Kerr* 1978).

Beating can damage the red blood cells and thereby produce haemoglobinuria similar to *footstrike haemolysis* (*Eichner* 1985).

Tight ropes around the wrists, handcuffing, or suspension by the wrists might damage peripheral nerves to the hand in a similar way to the *handcuff* neuropathy (*Massey & Pleet* 1978, *Smith* 1981).

Electric torture leaves changes in the skin which might be diagnostically significant, similar to changes that have been demonstrated in experimental animal studies (*Thomsen* 1984).

Other skin lesions have been important factors in establishing evidence of alleged torture because different torture types, e.g. *cigarette* burns leave very characteristic changes.

Table VII,1. *Most frequent (>10%) types of alleged physical torture. n=200.*

	Sex					
	female (n=39)		male (n=161)		Total	
Torture forms	n	%	n	%	n	%
Beating	38	97	160	99	198	99
Severe beating	35	90	160	99	195	97
against the head	26	67	120	75	146	73
falanga	9	23	50	31	59	29
in genitals	0	0	41	25	41	20
Banging the head against the wall or floor	5	13	26	16	31	15
Electric torture	20	51	89	55	109	54
Physical exhaustion	6	15	62	39	68	34
standing	3	8	32	20	35	17
maintain abnormal body position	2	5	24	15	26	13
forced gymnastic	1	3	21	13	22	11
climatic stress	15	38	52	32	67	33
Asphyxiation	14	36	45	28	59	29
wet submarino (la bañera)	7	18	32	20	39	19
Suspension by arms or legs	4	10	29	18	33	16
suspension "la barra"	3	8	17	11	20	10
Torture by heat	2	5	25	16	27	13
Sexual violation using instrument	8	21	12	7	20	10

B. THE CONSTITUTION OF A POSSIBLE TORTURE SYNDROME CAUSED BY BOTH PHYSICAL AND MENTAL TORTURE

Types of mental torture and their frequency are tabulated in Table VII,2. Only types of torture occurring with a frequency above 10% have been included.

Threats are the commonest type of mental torture. They may threaten further torture, that the family will be arrested and tortured, or that the detainee will be killed. It is questionable whether threats alone should be called torture, but when combined with other types of mental or physical torture, they clearly aggravate the situation.

31% experienced sham execution. Threats and sham execution were associated with a higher number of mental complaints at the time of examination (cf chapter VI:F).

Table VII,3 shows the most often recorded mental and neurological symptoms. These symptoms were not caused by one specific torture type. They are rather a total accumulated effect of all the different "stressors".

The most often recorded mental and neurological symptoms were 1) sleep disturbances with or without nightmares, 2) irritability, change in mood, and/or anxiety, 3) impaired concentration, 4) headache, and 5) impaired memory .

The individual number of the above-mentioned 5 symptoms at the time of examination is shown in Table VII, 4. It should be noted that more than 40% of all the persons had more than three symptoms, and that more than 20% had none of the above-mentioned symptoms.

Table VII,2. *Most frequent (>10%) types of alleged mental torture. n=200.*

	Sex					
	female (n=39)		male (n=161)		Total	
Torture forms	n	%	n	%	n	%
Threats	38	97	133	83	171	85
of execution	24	62	96	60	120	60
towards the prisoner's family and/or friends	22	56	64	40	86	43
Sham execution	13	33	50	31	63	31
Undressed	22	56	69	43	91	45
Sexual verbal assaults	22	56	19	12	41	20
Changing attitude during interrogation ("the good man")	6	15	19	12	25	12

Table VII,3. *Most frequently recorded mental and neurological symptoms at the time of examination. n=200.*

	Sex					
	female (n=39)		male (n=161)		Total	
Symptoms	n	%	n	%	n	%
Sleep disturbances and/or nightmares	24	62	78	48	102	51
Irritability, change in mood and/or anxiety	21	54	67	42	88	44
Impaired concentration	16	41	69	43	85	42
Headache	16	41	60	37	76	38
Impaired memory	16	41	55	34	71	35
Depression	8	21	26	16	34	17
Feeling of general tiredness	5	13	17	11	22	11

Table VII,4. *The individual number of the following symptoms at the time of examination: 1. Sleep disturbances and/or nightmares. 2. Irritability, change in mode and/or anxiety. 3. Impaired concentration. 4. Headache. 5. Impaired memory. n=200.*

	Sex					
	female (n=39)		male (n=161)		Total	
Number of symptoms	n	%	n	%	n	%
0	4	10	40	25	44	22
1	6	16	28	17	34	17
2	14	36	25	16	39	19
3	4	10	23	14	27	13
4	7	18	23	14	30	15
5	4	10	22	14	26	13

DISCUSSION

It should ideally be possible to treat the sequelae that result from torture in the same way as other injuries like bus accidents, bomb explosions, war lesions, etc. Lesions in each category have a similar pattern although the intensity often varies. It is known that a detailed description of the sustained lesions is a prerequisite for an optimal treatment and its correct evaluation. However, torture victims often receive medical attention, usually in a foreign country, only after a delay of several months, or even years. Follow-up is correspondingly difficult.

The question of a possible torture syndrome was raised for the first time by *Rasmussen et al* (1977): "The identification of a torture syndrome (a well-defined group of symptoms experienced by individuals who have been tortured) had been expected, also that this syndrome would differ from the KZ syndrome (*Eitinger* 1964, *Helweg-Larsen et al* 1949), although there would be similarities which could be related to the common factor of stress. ... The symptomatology recorded closely resembles the post-traumatic cerebral syndrome, and, to some extent, the KZ syndrome, in comparison with which there were fewer complaints or manifestations of lethargy, and only one person had vegetative symptoms".

The clarification of the concentration camp syndrome has been extremely helpful in the rehabilitation and compensation procedure (*Socialministeriet* 1974, *Nielsen* 1986), and the defining of a torture syndrome might have a similar effect on the society's granting of compensation for torture victims (*Daly* 1980).

Warmenhoven et al (1981) concluded: "the question arises whether a post-torture syndrome exists or whether it is likely to develop with the passage of time in the same way that a post-concentration camp syndrome arose. This question cannot be answered at present".

Allodi & Cowgill (1982), who basically found the same sequelae, reported that "the whole picture constitutes the so-called "torture syndrome"", and stated that it was similar to the post-traumatic stress disorder as defined in DSM-III" (*American Psychiatric Association* 1980, *Bech & Jepsen* 1987). However, it is not stated how many of the 41 examined torture victims would fulfil the criteria of DSM-III.

Post-traumatic stress disorder, as defined by DSM-III, includes only mental sequelae.

Kee et al (1987) found that 23% of victims of violence seeking compensation for "nervous shock" in Northern Ireland were suffering from post-traumatic stress disorder as defined in DSM-III.

Thorvaldsen (1986), in his study, did not identify a torture syndrome: "No particular constellation of symptoms was found to be specifically related to exposure to torture, and the findings have not been considered sufficiently consistent to constitute the basis for a syndromatically defined entity, explicitly indicating a causal relationship between such a syndrome and exposure to torture".

The present survey demonstrated a high incidence of both mental and neurological complaints among the examined torture victims. Without a suitable control group, however, it is impossible to determine whether a constellation of symptoms can justifiably be called a "torture syndrome", and likewise to make an estimate of the number suffering post-traumatic stress disorder.

Petersen et al (1985) re-examined 22 Greek persons who were tortured during the period 1967-74. 8 of them (36%) fulfilled the criteria for a chronic organic psychosyndrome (COP). They defined COP as persons with daily symptoms in at least three of the following groups:

1) Reduced memory, reduced ability to concentrate, to fixate.
2) Disturbances of sleep, nightmares.
3) Psychological lability, anxiety, depression.

4) Vegetative symptoms (diffuse gastrointestinal and/or cardiopulmonary symtoms without detectable organic foundation).

Petersen & Jacobsen (1985a), in a prospective controlled study from Spain, used a scoring system for the severity of symptoms in the following way:

a) Somatic symptoms from more than one organ system = 1 point.
b) At least two of the following symptoms: depression, anxiety, emotional lability, reduced ability/desire for contact, self-reproach, sense of guilt, disturbed sleep, nightmares = 1 point.
c) At least two of the following: impaired memory, impaired concentration, fatigue, sexual disturbances = 1 point. They found significant differences between the scores of the torture victims and the controls.

Hougen et al (1988) used the same scoring system, and in their controlled study they found significant differences between torture victims living in exile and their controls.

The scoring system can be useful in comparing two groups in a controlled study, but it is less likely to help identifying a possible torture syndrome.

OTHER RELATED SYNDROMES

The *concentration camp syndrome* was first described by *Hermann & Thygesen* (1954). The syndrome consisted of somatic and mental symptoms. Each single symptom in itself was thought to be non-characteristic and non-pathognomonic. It was the consistency and regularity of the symptom complex which justified its designation as a syndrome. *Eitinger & Askevold* (1968) defined the syndrome with the use of a scoring system. 11 symptoms were included (Table VII,5) and a minimum of 5 was sufficient for the syndrome to be present. In non-selected material *Thygesen et al* (1970) found that the majority were disablement-assessed at the 50% level or higher. The group consisted of 52 concentration camp victims not claiming compensation. The group could thus act as a kind of control group, although they were possibly less affected compared with those claiming compensation. Table VII,6 shows that the frequency of sleep disturbance, headache, impaired memory, and irritability is very similar to the findings in the present study, while the frequency of vegetative symptoms, depression, and tiredness is much higher.

Follow-up investigations of Norwegian concentration camp survivors (*Eitinger & Strøm* 1973, *Nielsen* 1986) have demonstrated increased mortality and morbidity.

Askevold (1980) described a *war sailor syndrome* among sailors in wartime convoys with a similar symptom complex to the kz-syndrome. The complaints were divided into four clusters of symptoms: symptoms of asthenia, autonomic and somatic symptoms, anxiety symptoms, and organic brain symptoms. The frequency of the different symptoms is shown in Table VII,7. All the symptoms are present at a much higher frequency compared with torture victims. One of the reasons might be that the examination took place more than 20 years after the war and some of the symptoms are of the kind usually encountered in the ageing process.

In the discussion of the aetiology of the war sailor syndrome, comparison was made with the concentration camp survivors and two common factors were found: the constant *fear* of death and the isolation because of *communication cut-off* from their family and country. These factors are also part of torture victims' experience.

Post-traumatic stress disorder (PTSD), chronic or delayed, is described by the *American Psychiatric Association* (1980), *Bech et al* (1986), *Bech & Jepsen* (1987), and *U.S. Dept. of Health and Human Service* (1980): "The essential feature is the development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience. The trauma may be experienced alone (rape or assault) or in the company of groups of people (military combat). Stressors producing this disorder include natural disasters (floods, earthquakes), accidental man-made disasters (car accidents with serious physical injury, airplane crashes, large fires), or deliberate man-made disasters (bombing, torture, death camps). Some stressors frequently produce the disorder (e.g. torture) and others produce it only occasionally (e.g., car accidents) ...

The diagnostic criteria for post-traumatic stress disorder:

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.
B. Reexperiencing of the trauma as evidenced by at least one of the following: 1) recurrent intrusive recollections of the event 2) recurrent dreams of the event 3) sudden acting or feeling as if the traumatic event were reoccurring, because of an association with an environmental or ideational stimulus.
C. Numbing of responsiveness to or reduced involvement with the external world, beginning some time after the trauma, as shown by at least one of the following: 1) markedly diminished interest in one or more significant activities 2) feeling of detachment or estrangement from others 3) constricted affect.

Table VII,5. *Symptoms included in the concentration camp syndrome (Eitinger & Askevold 1968).*

Symptoms:
1) Failing memory and difficulty in concentration
2) Nervousness, irritability, restlessness
3) Fatigue
4) Sleep disturbances
5) Headaches
6) Emotional instability
7) Dysphoric moodiness
8) Vertigo
9) Loss of initiative
10) Vegetative lability
11) Feelings of insufficiency

Table VII,6. *Predominant somatic and mental symptoms 20 years after liberation in 52 concentration camp victims not claiming compensation (Thygesen et al 1970).*

Symptoms	n	%
Rapid tiring	38	73
Persistent weight deficit (stated for 51)	10	20
Age appearance	20	38
Periodic diarrhoea	32	62
Hot flushes/sweating	38	73
Disturbance of potency	15	29
Depression/lability of mood	22	42
Lability of affect/hypersensitivity to noise	34	65
Nightmares/other symptoms of anxiety	30	58
Psychoprovocation of somatic symptoms (hot flushes, sweating, palpitations, diarrhoea, frequency of micturition)	21	40
Deterioation of memory/power of concentration	44	85
Emotional incontinence	16	31
Clinically assessed as demented	22	42

Table VII,7. *War sailor syndrome (Askevold 1980).*

Symptoms	%
Asthenia group:	
Fatigue	94
Irritability	84
Lack of initiative	69
Emotional incontinence	73
Autonomic & Somatic group:	
Dizziness	62
Sweating attacks	75
Dyspepsia	52
Impotence	82
Somatic pain	77
Anxiety group:	
Nightmares	94
Restlessness	87
Disturbed sleep	86
Isolation	77
Organic brain symptoms group:	
Impaired memory	96
Concentration difficulties	89

D. At lest two of the following symptoms that were not present before the trauma: 1) hyperalertness or exaggerated startle response 2) sleep disturbance 3) guilt about surviving when others have not, or about behavior required for survival 4) memory impairment or trouble concentrating 5) avoidance of activities that arouse recollection of the traumatic event 6) intensification of symptoms by exposure to events that symbolize or resemble the traumatic event."

The frequency of torture victims who fulfil the diagnostic criteria for PTSD has not been found in the literature and the present retrospective study does not allow such an estimation.

The human organism seems to have a rather limited way of response to different traumatic events and therefore a considerable overlapping of symptoms is found after very different traumatic experiences (*Sund* 1976, *Retterstøl et al* 1982). Many different syndromes have been named according to the cause, but they have a rather similar symptomatology: ***chronic anxiety syndrome*** (*Trautman* 1964, 1971); ***combat exhaustion syndrome*** (*Grinker* 1945, *Archibald* 1965, *Kettner* 1972, *Putten & Emory* 1973, *Klonoff et al* 1976, *Beebe* 1975); ***Traumatic war neuroses*** (*Futterman & Pumpian-Mindlin* 1951); ***survivor syndrome*** (*Koranyi* 1969, *Niederland* 1968); ***Hiroshima survivors*** (*Lifton* 1963); ***persecution syndrome*** (*Lederer* 1965, *Hoppe* 1971); ***traumatic neurosies in Vietnam returnees*** (*Putten & Emory* 1973); ***disaster survivors*** (*Bennet* 1970, *Lifton & Olson* 1976, *Gleser et al* 1981); ***post-traumatic stress disorder in Vietnam veterans*** (*Sonnenberg et al* 1985); ***hostages survivors*** (*Stofsel* 1980, *Burgess* 1981), ***war prisoners*** (*Gill & Bell* 1981, *Kral et al* 1967, *Nefzger* 1970, *Wolf & Ripley* 1947).

CONCLUSION

Specific types of physical torture lead to specific physical sequelae. Specific description of the types of torture, including both quality and quantity, could help to identify the association between physical torture types and physical sequelae in more detail.

Torture victims complain of a range of mental and neurological symptoms which still have to be studied in order to see if they constitute a specific torture syndrome, different from other syndromes after stressful events.

Clarification of terminology and definitions, especially concerning the victims' description of symptoms, should be stressed.

The creation of a well-defined torture syndrome, including somatic aspects, might be to the benefit of the torture victim, particularly in the seeking of compensation, such as has been granted to concentration camp victims.

CHAPTER VIII. MEDICAL INVOLVEMENT IN THE PRACTICE OF TORTURE

INTRODUCTION

The explicit verbal expression for the medical/ethical responsibilities of a doctor goes back to the Hippocratic oath (420 B.C.). Very important aspects of a doctor's responsibility are outlined in the oath: "I will prescribe regimen for the good of my patients according to my ability and my judgement, and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which can cause his death." (*Duncan et al* 1981, *Andersen et al* 1985). The Hippocratic oath has been the basis for the medical oath that doctors swear when they graduate. Most national medical societies have developed their own medical oath, based on the Hippocratic tradition.

After the Second World War, a war crimes tribunal at Nuremberg, 1947, gave judgement on 23 German defendants, mostly physicians, who were accused of crimes involving experiments on human subjects (*Mitscherlich & Mielke* 1985). The judgement laid down 10 standards to which physicians must conform when carrying out experiments on human subjects, and this "Nuremberg code" was accepted by the WMA. In Geneva in 1948, the Association adopted an international code of ethics which included the statement: "The health of my patients will be my first consideration".

In Helsinki in 1964, the WMA adopted more detailed recommendations to guide medical doctors in bio-medical research involving human subjects.

But it was not until 1975 that the WMA adopted a medical declaration on torture, forbidding doctors from taking part in "torture or other forms of cruel, inhuman or degrading procedures" (The Tokyo declaration is reproduced in the Appendix).

On 18 September 1982, the General Assembly of the United Nations adopted unanimously the "Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment" (The resolution is printed in the Appendix).

The Standard minimum rules for the treatment of prisoners and related recommendations adopted by the first United Nations Congress on the prevention of crime and the treatment of offenders in Geneva, 1955, includes guidelines on the medical services in penal institutions. The medical part of the rules is printed in the Appendix.

In spite of these declarations, which clearly stipulate the responsibility of medical personnel with regard to torture, there are numerous examples of unethical medical conduct (*Clavel* 1973, *Kandela* 1981, 1986, *American Association for the Advancement of Science* 1981, *Wagner & Rasmussen* 1983b, *Kirschner* 1984, *British Medical Association* 1986).

Medical doctors are not the only group of medical personnel who have participated actively in torture.

Nurses and others are known to have been involved (*Rasmussen* 1982). It should be stressed that the International Council of Nurses (ICN) adopted the Singapore resolution in 1975, which contains guidelines for the care of detainees and prisoners. This chapter, however, will be limited to the examination of the doctors' role in connection with torture.

RESULTS

41 of the 200 examined torture victims in the present study reported that medical personnel were involved in their torture. Varying degrees of this involvement took place (Table VIII,1).

Non-therapeutic administration of drugs was used against 9 persons. Detailed accounts have been given earlier (see Chapter V).

10 persons said that a doctor was present during their torture and in some cases performed a medical examination, including blood pressure and auscultation of the heart. On the basis of the examination, advice was given as to whether the torture could continue.

15 persons said that they received medical resuscitation because they lost consciousness during the torture. The resuscitation included artificial respiration by mouth to mouth method, and one man woke up and realized that he was receiving heart massage.

It would clearly have been difficult for the detainees to be sure whether the people by whom they were treated were in fact doctors or health workers, or people pretending to be them. In 5 cases the victims knew the actual names of the doctors. In other cases the victims could give a very detailed description of the supposed doc-

Table VIII,1. *Medical involvement and attention at time of detention. n=200.*

Type of medical involvement/attention	n	%
Non-therapeutic administration of drugs	9	4
Medical personnel present during the torture	10	5
Medical resuscitation during the torture	15	7
Medical attention resulting in hospitalization	30	15
Medical attention and treatment	31	15
Total	41	20

tor and would certainly be able to recognize him if a confrontation could be arranged. The medical treatment or the medical terminology used by the supposed doctor gave in some of the cases very strong reasons to believe that the individual was a doctor who had had a thorough medical training.

Only 23 of the examined persons thought that adequate medical care was provided during their detention. 61 persons received some kind of medical attention during their detention. The medical attention resulted in admission to hospital of 27 persons. 24 persons were admitted to hospital for treatment of a somatic disease or injuries. The different reasons for admission to hospital are given in Table VIII,2. 6 persons were transferred to a psychiatric department directly from detention, and 3 from a somatic hospital department.

Table VIII,2. *Cause for admission to non-psychiatric hospitals of 24 torture victims. n=200.*

Cause	n
Fractures*)	15
Haematomas	2
Haematuria and coma	1
Ventricular ulcer and haematomas	1
Metrorrhagia	1
Sequels to hunger strike	1
Urinary infection	1
Genital infection	1
Kidney stone	1
Total	24

*) Details have been presented in Chapter VI, "locomotor systems".

DISCUSSION

IN WHICH WAYS CAN THE MEDICAL PROFESSION BE INVOLVED IN TORTURE?

The present study shows that the medical involvement in torture can be exercised at many different levels. 34 doctors were accused of direct medical involvement, either by non-therapeutic administration of drugs, being present during the torture, or actually performing medical resuscitation during the torture.

The normal relationship between a doctor and his patient can generally be divided into 3 major functions: 1) to make a diagnosis, 2) to treat the patient, and 3) to do prophylactic work. A rather similar classification can be used about doctors' involvement in torture, and it is important to stress that these doctors are acting in the interest of the torturers and not of the "patient".

1) To make a diagnosis

(a) A doctor may examine a prisoner prior to torture to determine whether the victim has any serious illness which must be taken into consideration.

(b) A doctor may examine a victim between torture sessions to determine whether he or she is likely to die if tortured further.

(c) A doctor may examine a victim after torture, e.g. prior to release, in order to issue a medical certificate where the sequelae to torture are not reported. He can also fill out death certificates, falsely listing natural causes of death.

2) To treat the patient

(a) A doctor may treat a detainee prior to torture in order that the future victim can cooperate better with the torturers.

(b) A doctor may treat a torture victim between torture sessions in order that the torture can continue.

(c) A doctor may treat torture victims after torture, for instance to conceal the bruises, etc. The treatment in itself can not be classified as medically unethical behaviour, but the lack of reporting the incident might be (see later).

3) The opposite of prophylactic work

(a) Doctors can use their medical knowledge to create sophisticated types of torture which do not leave any marks but are maximally painful.

(b) Doctors may also in fact be responsible for torturing the victim, e.g. by injection of drugs (*Rasmussen* 1982). In the present survey no cases of doctors falsifying medical documents were reported.

Medical treatment of torture victims did occur in quite a number of cases, although it cannot be classified as unethical.

Quite a lot of torture victims were admitted to hospital to be treated for injuries sustained by torture. This implies that hospital staff had the possibility to observe and report incidences of torture.

In the appendix, case histories that illustrate medical involvement at different levels are reproduced. The histories are taken from the literature and from the present study.

The medical involvement in torture has also been studied by *Allodi & Cowgill* (1982), who found that, in a group of 41 Latin American refugees who alleged having been subject to political persecution and torture under the military rulers of their own country, medical care was not available for more than half of the individuals. 21 doctors saw and treated the torture victims, and the behaviour of the doctors would be classified as ethical in only 5 cases when the doctor offered comfort and protection to the patients. In 4 cases the doctor collaborated, approving and allowing torture to continue. In the rest, the doctor was neutral, never spoke to the patients or inquired about injuries, and never offered comfort.

Testimonies of doctors involved in torture have among others been published by *Clavel* (1973), *Kandela* (1981), *Wagner & Rasmussen* (1983b), *AI* 1983 (Chile), 1984 (Recent torture testimonies implicating doctors in abuses of medical ethics in Chile) and *Martirena* (1987a,b).

Amputations

Doctors in Islamic countries have performed punitive amputations, clearly cruel, inhuman, and degrading punishment, which contravene international law and should be abolished. The doctors who perform the operations are obviously violating the World Medical Association's Tokyo Declaration, which forbids doctors from participating in torture or any form of cruel or inhuman treatment as punishment. The United Nations, in its 1984/22 resolution, explicitly stated that amputations are incompatible with the Universal Declaration of Human Rights.

About 110 judicial amputations were inflicted in Sudan between September 1983 and April 1985 under Islamic laws introduced by President *Nimeiri*'s government. Most were amputations of the right hand, but about 25 cross limb amputations (of the right hand and left foot) were performed for violent or repeated theft. The defendants were mostly convicted in summary trials without legal representation. The Islamic law penalties of amputation are no longer enforced in Sudan. However, the Transitional Military Council has not revoked the penalties or rescinded between 40 and 50 sentences of amputation which have been imposed but not carried out (*AI* 1985 (Sudan)). In Pakistan, President *Zia ul-Haq* also adhered to Islamic law and sentenced 22 convicted thieves to the same punishment. The punishment has never been carried out, however, because there are no doctors who will perform the operation. The same is true in Libya.

However, it is known that the punishment has been used with increasing numbers in Saudi Arabia and Iran during 1986. One amputation was recorded in Saudi Arabia in 1983, while there were 10 in 1985 and 10 in 1986 (*AI* 1987 (Cross-limb amputations)).

Floggings

Floggings are prescribed by the Koran as punishment for certain crimes. Criminals have been sentenced to flogging in Pakistan, Iran, Mauritania, Libya, Saudi Arabia and the United Arab Emirates. In Iran more than 6,400 court sentences of physical punishment were passed during a period of 12 months that ended in March

1987 (*AI* 1987 (Amputations and floggings), (Iran)). This form of punishment is mentioned not merely because it is a form of torture in itself, but also because in several of the countries mentioned, a doctor is required to examine the sentenced person to determine whether he or she is "fit for flogging", which is clearly a violation of the Tokyo Declaration. Doctors have the possibility to protest against such forms of punishment and work against their use, as well as to give support to doctors who do not wish to participate on ethical grounds.

Death penalty

In the United States several states have adopted a new method of capital punishment, using lethal intravenous injection of a drug. The preparation and administration of the drug is monitored by medically trained personnel.

The medical participation in capital punishment by an injection of a lethal overdose of medicine must be considered contrary to the fundamental ethics of the medical profession. The American Medical Association has protested and the World Medical Association, at its meeting in Lisbon in 1981, adopted a resolution against physicians' participation in capital punishment.

Abuse of psychiatry

Abuses of medical skills directed against political state opponents have been practised by psychiatrists particularly in the USSR (*Fireside* 1979, *Drucker* 1979, *AI* 1980 (USSR), *Schulsinger* 1982, *Wagner & Rasmussen* 1983a, *AI* 1983 (USSR)).

The use of the diagnosis "sluggish schizophrenia" in East European countries has been thoroughly analysed by *Merskey & Shafran* (1986). It is well documented that this diagnosis is used forcefully to confine to psychiatric hospitals human rights activists, nationalists, religious believers, and would-be emigrants (*Tonge* 1974, *Nightingale & Stover* 1985, *Wilkinson* 1986).

HOW TO ENSURE THAT THE MEDICAL PROFESSION OBSERVES THE MEDICAL/ETHICAL RULES?

National Medical Associations

International declarations such as the World Medical Association Declaration of Tokyo and the U.N. Principles of medical ethics (1982) have no automatic legal binding for individual doctors or medical associations. These declarations serve as international guidelines only. The *national* medical associations will have to incorporate international conventions and declarations in their national rules, to which the medical profession is responsible.

In paragraph 12 of the medical oath and medical/ethical rules for Danish doctors, it is stated: every member ought to study the provisions of the medical law and other valid regulations, including the international convention and declarations accepted by the Danish medical association, e.g. the Geneva, Helsinki, Sydney, and Tokyo declarations. These declarations have all been translated into Danish and are included in the Annual Medical Directory sent to all members of the Danish Medical Association.

As a rule, a national medical association only has the jurisdiction to condemn, fine or expel a member from the association. In grave cases of medical/ethical abuse, a medical association can refer the case to the national courts, which can prohibit the accused from working as a doctor.

In totalitarian states where torture is practised, the the government often obstructs the national medical association when it tries to prevent members from participating in torture and to make them obey the medical/ethical rules. Fortunately, however, there are instances in countries where torture is practiced when the medical association was able to contact individual doctors accused of participation in torture and subsequently bring this to an end. The following account serves as an example of this:

In the 7th National Medical/Ethical conference held in July 1984 with more than 600 participants in Montevideo, Uruguay, a resolution against doctors' participation in torture and medical neglect of sick prisoners was approved. The declaration included the creation of an ethical tribunal to judge doctors' participation in torture (*Martirena* 1987a,b). As a result of the activities of the ethical tribunal, 5 doctors were expelled for involvement in torture or unethical behaviour in relation to prisoners and many other cases were to be investigated.

In mid-1982, an Amnesty International delegation visited Chile to examine people who said they had been tortured (*AI* 1983 (Chile)). While in Chile, Amnesty International medical delegates (*Wallach M & Rasmussen* OV) met the head of the Chilean medical association, Dr. *Juan Luis Gonzales,* who said the association was aware that doctors had been accused of taking part in torture, and had condemned such participation. However, he had not been able to identify the doctors involved, and had therefore been unable to act against them. He added that the problem had caused great concern among Chilean doctors.

This concern resulted in the creation by the Chilean Medical Union of an investigation commission to look into the participation of doctors in torture (*Colégio Médico de Chile* 1986). In July 1984, the investigation of one case was completed and the doctor was expelled from the medical organization; 7 other Chilean doctors had been charged.

National medical associations play an important role in ensuring that the ethical guidelines for doctors are not violated by their members, and, if they so wish, national medical associations can play a very significant role in the prevention of torture as a whole. A part of the serious preventive work might be to elucidate how such an interest can be created in national medical associations (*Bloche* 1987, *Claude et al* 1987, *Rayner* 1987, *Stover & Nightingale* 1985a,b, *Stover* 1987). It would for instance be very useful to analyse ways by which the Argentinian and Philippine Medical Associations could be stimulated to take their medical/ethical obligations seriously in the same way as the Medical Associations in Chile and Uruguay.

International organisations

Doctors from both Uruguay and Chile (*Martirena* 1987a, *Larrain* 1987) have stressed the utmost importance of national as well as international organizational support in the condemnation of doctors participating in torture and other inhuman or degrading treatment.

There is a need for a greater international medical effort, not only to stop individual doctors from participating in torture, but in the overall use of medical doctors and medical organizations in the fight against torture. The World Medical Association, in its 1975 Tokyo Declaration, initiated this international effort. The World Medical Association, however, does not represent the medical associations on a world-wide basis, since many national medical associations have left the organization. There is therefore need for another international organization that would really represent the medical profession world-wide, and would take up these important issues. With the existence of the U.N. Declaration on medical/ethical principles, an effort by the World Health Organization to implement this declaration by U.N. member countries would be significant.

The WMA's Tokyo Declaration very clearly outlines the medical profession's responsibilities against torture and the cruel, inhuman or degrading treatment of detainees.

It is, however, a sad fact that, although the Tokyo Declaration is incorporated in most National Medical Associations' guidelines for their members, it is often violated.

Conflicts between national legislation and medical ethical guidelines such as the Tokyo Declaration have also been demonstrated in a peaceful country like Denmark (*Daugaard* 1981, *Rasmussen & Kelstrup* 1984, *Ortmann et al* 1986). Guidelines concerning force-feeding deserve special attention (*Kleinman* 1986).

Only a limited number of doctors in a society are likely to become associated with torture. The recruitment is made especially among military doctors, police and prison doctors, and forensic

medical specialists. These groups of doctors have therefore been called "high-risk doctors" by a "Prevention of Torture Group" under the auspices of Amnesty International (*Wagner & Rasmussen* 1983b). One of the goals of this group was to contact these doctors in countries where torture took place, to alert them to the existing ethical codes, and encourage them to abide by them. Another was to give them moral and other support if they were subject to persecution by the authorities as a result of observing the ethical codes and working against torture.

The education of the medical profession in medical ethics and human rights has increasingly been included in the medical curriculum. The forensic medical faculties have been particularly active in this effort, and the topics have been included in International Forensic Congresses (Bergen 1981, Oxford 1984, Sri Lanka 1986, and Vancouver 1987).

It was an important step in the work against torture when the International Forensic Association decided to include concern for human rights in its programme. The World Psychiatric Association (WPA) was another example of an international medical organisation which showed concern for the observation of medical ethical obligations among its members. In its Declaration of Hawaii (1977), the WPA laid down ethical guidelines for psychiatrists all over the world. The WPA has repeatedly protested against the abuse of psychiatry in the USSR.

Other international medical organisations ought to incorporate concern for the observation of medical ethics among their members and give help to members who are endangered because of their human rights activities.

International congresses provide a good forum to discuss these issues and to alert doctors from countries where the human rights are violated of their medical obligations. They also allow important contacts between doctors who are concerned for the observation of human rights in their own countries and colleagues who might be able to give support.

It is the responsibility of the individual doctor to observe the medical code of ethics, but to do this, a firm knowledge of these codes is a prerequisite (*Heijder & Geuns* 1976, *AI* 1984 (Codes of professional ethics), *AI* 1984 (Ethical codes and declarations relevant to the medical profession)). The teaching of medical ethics in medical schools throughout the world is very limited (*Allbrook* 1983). In Denmark, it is only during the last few years that medical ethical questions have been included in examination requirements for medical students. It is the national medical associations' responsibility to raise the consciousness about medical ethics among their members. International organizations such as the World Medical Association and the World Health Organization should encourage a greater activity in this subject.

LEGAL PROCEEDINGS AGAINST DOCTORS WHO ARE ACCUSED OF PARTICIPATING IN TORTURE

Examples of legal actions against doctors accused of participating in torture are rather few. The Nuremberg process was one of the first, and, as indicated in the beginning of this chapter, on the basis of the disclosure of the cruel, inhuman and unethical behaviour of these doctors, the Nuremberg Code and Geneva declaration were adopted.

An attempt was made to bring to trial those doctors who were accused of torture during the junta period in Greece. However, only few were sentenced, and they were released a few years later (*AI* 1977 (Greece)). No attempts were made to bring doctors to trial after the end of the dictatorship of *Salazar* in Portugal (1974), during which many doctors were accused of participation in torture.

The medical associations in Argentina and the Philippines have taken only few actions (*Stover & Nightingale* 1985a) to prosecute their many members accused of torture, in spite of the numerous testimonies which can help to identify the individual doctor. It is thus noteworthy that over 10% of the examined torture victims in the present study said that they thought they could identify the supposed doctor who participated in their torture.

In contrast to, for example, Argentina and the Philippines, the medical associations in Uruguay and Chile have taken steps to prosecute torture doctors (*Danish Medical Bulletin* 1987). The Turkish Medical Association has taken similar initiatives. Such efforts need and should receive international support. The Danish Medical Association, together with the Rehabilitation Centre for Torture Victims in Copenhagen, contributed by organizing the International Meeting on Doctors, Ethics and Torture in August 1986. The World Medical Association contributed with the Secretary General's mission to Chile in August 1986 (*Wynen* 1987).

In an International meeting in Montevideo in December 1987, it was decided to create an International Commission against doctors' participation in torture (*Rasmussen et al* 1988).

RECOMMENDATIONS

Their is a need for a powerful International Medical Organisation to coordinate and work actively for the prevention of torture, and receive and investigate allegations of doctors' participation in torture. WHO has recommended the incorporation of these ideas in their health programme.

Analysis of epidemiology of torture, and in particular of the political and social factors that are related to its use, has increased our understanding of why torture is used, and to a certain extent of how it can best be eradicated (*Fanon* 1963, *Lippman* 1979, *Baker* 1980, *Bergesen* 1982, *Harboe* 1982, *AI* 1983 (Umenneskelighedens ansigter), *Bonaparte* 1984, *Forest* 1982, 1987). Such studies are very important for preventive measures against torture.

The British Medical Association set up a working group in 1985 to "investigate claims that in some countries doctors are cooperating in the use of torture as a routine instrument of repression by governments of all political persuasions". The group's work resulted in an important publication (*British Medical Association* 1986), in which the problem was investigated and recommendations given.

Among the recommendations, the following seem to be especially important:

"National or regional medical associations accept publicly, by ratifying declarations such as the Declaration of Tokyo, a collective responsibility for the determination of the limits of ethical cooperation between doctors and the State."

"The training of doctors should include positive guidance about the ethical framework within which doctors are expected to apply their skills and knowledge. Positive training is necessary to identify the circumstances in which pressure may be applied to distort a doctor's judgement about the moral framework within which decisions have to be taken. Recognition by doctors of overt or hidden pressures is the greatest safeguard against a drift to acquiescence in torture."

"The medical profession has a responsibility to support any practitioner who refuses to keep silent about abuses of human rights."

"All deaths of citizens whilst detained in custody must be the subject of independent objective and competent medico-legal autopsy."

"Doctors having knowledge of any activities covered by the Declaration of Tokyo have a positive obligation to make those activities publicly known. It is easy for the medical professions which practise in free democracies to honour this obligation. In totalitarian regimes it is far more difficult and doctors in countries where torture does not occur have a responsibility to their colleagues to assist them in this matter."

At the International Meeting on Doctors, Ethics, and Torture in Copenhagen in August 1986 (*Danish Medical Bulletin* 1987), the following agreed recommendations deserve special attention:

"... to urge all national medical associations which have not yet done so to ratify, publicize, and implement the Declaration of Tokyo as the definitive statement of the position of the medical profession with regard to this topic;"

"... to urge all scientific and professional medical bodies on the local, regional, national, and international level to incorporate the principles of the Declaration of Tokyo into their statutes;"

"... to urge the profession in all countries of the world to introduce into all their contracts and agreements with the authorities, as relevant, paragraphs emphasizing that physicians may not be forced under any circumstances actively or passively to act against established medical ethical traditions;"

"... to urge the establishment of an international reporting and information system regarding such ethical infractions within the profession to facilitate the international exclusion from the medical profession of doctors found guilty of participating in torture;"

"... to urge that international support be given by the profession to colleagues who take action such as has been taken by the medical profession in Chile and Uruguay and to mount international protests against any efforts taken to hinder the profession in such attempts to uphold the highest ethical principles of physicians;"

"... to urge the inclusion and integration in the medical educational curricula, from the earliest possible stage of information about the existence of this problem and instruction in the ethical responsibilities and ethical regulations by which the doctor is bound and to which he may refer when subjected to pressure to act contrary to the best ethical principles of the medical profession;"

"... to urge that the educational curricula for all health professions as well as for the police, the legal and military professions include information about the ethical and legal prohibition of torture."

CONCLUSION

The medical profession's participation in torture is well-documented. The participation varies from treating torture victims in custody, with lack of reporting the incident, to active participation in the torture itself.

In spite of numerous testimonies in which torture victims identify the doctor, very few legal prosecutions have taken place.

The national medical associations are responsible for the ethical conduct of their members, and very clear declarations, such as the Tokyo Declaration, serve as unambiguous guidance. The national medical associations should be encouraged by all national as well as international means to live up to these obligations.

Doctors who are found guilty of torture should not be allowed to practice as a doctor in any country of the world.

Both governmental and non-governmental International Medical Bodies should be encouraged to incorporate the prevention of torture into their programmes. It is recommended that WHO in particular should include these ideas in its health activities.

CHAPTER IX. MEDICAL PROFESSION AGAINST TORTURE

The role of the medical profession in relation to torture mainly falls into three parts:

1) Rehabilitation and treatment of torture victims.
2) Prevention of torture.
3) Medical participation in torture (this item has been covered in chapter VIII).

1) REHABILITATION AND TREATMENT OF TORTURE VICTIMS

CHILE

Systematic rehabilitation and treatment of torture victims and their families were initiated in 1973 in Chile as a consequence of the many people who suffered from the massive repression and torture which began when President *Pinochet* came to power in September 1973 (*AI* 1981 (Labor de la profesión médica), *Allodi* 1980). Doctors and health workers were alarmed at the consequences of the torture on the victims, their families, and the whole society. Different political and religious groups began to form minor centres where treatment could be initiated. The author had the privilege of visiting some of these in 1979 and was impressed by their work. The applied treatment model mainly constituted family therapy and group therapy. The use of testimonies in treatment was emphasized: by telling the story the victim could begin to recover from the pain and suffering. The pain should actively be shared in a group of solidarity. The group solidarity also included political solidarity with the main goal of reinstituting the respect for human rights in Chile. Children affected by the political repression are treated in special centres (*Latin American Documentation* 1986, *Sveaass* 1987, *Carli* 1987). In other Latin American countries, as well as in refugee centres in Europe, treatment models inspired by the "Chilean School" have been created. The literature about the treatment in the different centres is mainly in Spanish and mostly descriptive (*Puebla & Fuentes* 1981, *Barudy* 1981, *Kordon et al* 1984, *Gomez* 1985, *Vicaría de la Solidaridad* 1985, *Neto* 1985, *Ceres et al* 1986, *Kordon & Edelman* 1986, *Bustos* 1986, *Deutsch* 1986, *Dominguez & Weinstein* 1987, etc.).

AMNESTY INTERNATIONAL

At the Amnesty International Medical Seminar: "Violation of Human Rights: Torture and the Medical Professions" Athens 1978 (*AI* 1978 (Violation of Human Rights)), a working party on *the rehabilitation and financial compensation of torture victims* was established (hereinafter referred to as the AI rehabilitation working party). It was noted that "from medical studies on torture victims, sufficient evidence has been gathered to substantiate that, in most cases, torture and cruel and inhuman or degrading treatment have long-term effects on the victims, which impair his/her physical, psychological and social functioning, and these effects invite strongly the attention of the medical profession in regard to care and treatment; and that questions of financial compensation and of free medical, dental and mental care for victims of torture play an important part in their medical treatment and rehabilitation".

From the first evaluation (*Rasmussen et al* 1977), it was striking how much symptoms found in torture victims resembled the symptoms found in concentration camp victims, convoy sailors, and hostages. On this background, an international seminar was arranged in Copenhagen in 1979 inviting doctors with experience in these areas to discuss mutual aspects and give guidance for future research (*Danish Medical Bulletin* 1979).

There was general agreement that treatment and rehabilitation should be carried out by a team with expertise as well as social and human understanding and appreciation of the victims' situation. This team should include doctors, nurses, psychologists, and social workers. The establishment of centres for the rehabilitation and treatment of torture victims was recommended. These centres should function independently of Amnesty International.

When the working party met in London in 1980 it was agreed to encourage the development of the first centre for the rehabilitation of torture victims in Copenhagen. Other rehabilitation centres have since been established in Europe and other parts of the world (*Danelius* 1986).

REHABILITATION AND RESEARCH CENTRE FOR TORTURE VICTIMS IN COPENHAGEN (RCT)

The RCT was founded in Copenhagen in 1982 (RCT 1985, 1986, 1987, *Nielsen et al* 1985).

During the period 1980-1982 a specific therapeutic method was developed at the Department of neurology, Rigshospitalet, University of Copenhagen. The centre was officially inaugurated in 1984.

Treatment model

The treatment of torture victims was based on individual psychotherapy. Victims of torture seaking treatment have both somatic and psycho-social problems. Consequently a holistic model

was being applied. The treatment model has proved to be applicable and the first results have been published (*Barfoed et al* 1982, *Agger et al* 1985, *Bloch & Møller* 1988, *Ortmann et al* 1987, *Jakobsen* 1987). The fundamental principle of the treatment, which is the basis for the RCT's treatment today, has been defined by *Lunde et al* (1987):

"1) that procedures which may remind the patient of the torture he or she has been exposed to should be avoided as far as possible;
2) that the treatment shall be both physical and mental, with physiotherapy as an important element of the physical treatment;
3) that the physical and the psychical treatment shall run in parallel with each other;
4) that the treatment shall include not only the individual victim of torture but also his or her entire family;
5) that the social conditions shall be included as a factor, and personal social service shall form part of the treatment".

Research

The treatment model is being evaluated and adjusted according to the findings (*Genefke & Aalund* 1983).

Research of the applied clinical model and the results achieved by the treatment are however confronted by some major problems:

It has not been feasible to make a prospective controlled randomized study of a treatment and a control group, mainly because it is considered unethical only to examine and not treat a control group. In addition, however, there are other factors which make research studies of the treatment of torture victims very difficult. Torture victims come from countries where there is very little tradition for controlled randomized studies, and from a foreign culture. Torture victims who are in need of treatment are generally speaking very shy and mistrustful, wanting to isolate themselves. The treatment model in RCT is based on mutual trust, and any kind of research which gives the torture victims the feeling of being used as guinea-pigs will automatically ruin the contact and confidence which is the prerequisite for successful treatment. Treatment of torture victims, as of other patients, is based on knowledge. Research into treatment models is therefore in the interest of the torture victims, and the terrible experiences the torture victims have suffered do not legitimize any low methodological standard (*Boysen* 1984, *Riis* 1987, *Thorvaldsen* 1987). Research is carried out at the RCT (*Lunde et al* 1987), using "a prospective, descriptive method based on self-reported description of health – by interview – the examiner's assessment at entrance, open intervention (treatment) and open evaluation of treatment – by the torture survivor and by the examiners".

UNITED NATIONS (UN)

There was a recommendation in 1978 (*AI* 1978 (Violations of human rights)) that the UN should set up a special United Nations fund to guarantee free and adequate medical treatment for torture victims, whether refugees or residents in their own countries. The United Nations Voluntary Fund for Victims of Torture was established by General Assembly resolution 36/151 of December 1981, for the purpose of receiving voluntary contributions for distribution, through established channels of assistance, as humanitarian, legal and financial aid to individuals who have been tortured and to their relatives. The Fund has since its establishment played an important role in supporting many therapy and rehabilitation programmes in several countries in different parts of the world. The Voluntary Fund has also supported the training of medical professionals in the treatment of torture victims (*Danelius* 1986, *Rodley* 1987).

2) PREVENTION OF TORTURE

Since the beginning of the 1970s an increasing interest has been shown in how the medical profession can assist in the preventive work against torture (*Baker et al* 1973, *Bowden* 1976, *Riis* 1977, 1978, 1980, *Danish Medical Bulletin* 1979, 1987, *Burges* 1980, *Anonymous* 1980, 1981, 1982a, 1982b, 1985, *Berger* 1981, *Berro et al* 1986, *Bankowski* 1982, *Council for International Organizations of Medical Sciences* 1984, *Kosteljanetz & Aalund* 1983, *Marcussen et al* 1983, *Leon* 1983, *Wilson* 1983, *Payne & Russell* 1984, *Gaylin et al* 1985, *Goldman* 1985, *Stover & Nightingale* 1985a,b, *Bendfeldt-Zachrisson* 1985, *Knoll & Lundberg* 1986, *Bloche* 1986, *Beardsley* 1986, *Nightingale & Stover* 1986, *Rasmussen* 1986, *Genefke* 1986a,b, *Hanauske-Abel* 1986). *Lery & Labarthe* (1984) have published an extensive bibliography on torture of special interest for the medical profession.

PREVENTION ON A NATIONAL LEVEL

The individual doctor

Doctors who work against torture and for fundamental human rights are often at great risk of becomming themselves victims of the repression they try to prevent.

Many doctors have been arrested and tortured, accused of subversive activities because they have treated torture victims, denounced torture, or in other ways worked actively against the practice of torture (*AI* 1976 (Medical personnel in prison), *Meltzer* 1979, *Jadresic* 1980, *Onaindio* 1980, *AI* 1986 (*Olivares*), 1987 (*Macaya*), 1987 (*Gomez & Taborda*)). Doctors, themselves imprisoned, have assisted and treated fellow prisoners and helped to understand the horrors which take place behind the barbed wire (*Thygesen* 1945, *Engzell* 1981, *Koskela* 1981, *Laino* 1983). In spite of the notorious danger, doctors continue to use their medical skills against torture, and they should receive all possible international support and protection in their activities. The medical profession is probably the one which is most likely to be confronted with torture victims. It might be as a general practitioner when one of the patients complains of symptoms following torture. Torture victims are brought to the first-aid department or intensive care unit of a hospital, and hospital doctors are in charge of the treatment. Forensic doctors see torture victims when a medical certificate is required by the police or at the autopsy of dead torture victims. Prison doctors, police doctors or military doctors who work in close contact with the institutions responsible for the torture are more than likely to see torture victims or even to collaborate with the torturers.

A doctor who sees a torture victim should be obliged by law to report the case to the authorities for further investigation by the police, as for instance in the case of a suspected battered child syndrome. The problem with reporting torture cases to the authorities is that the authorities who will be in charge of the investigation are probably those responsible for the torture, and this would be like asking a murderer to investigate his own crime. At best, the notifying doctor will be told that the case will be investigated – but nothing is actually done. Another possibility is that the torture victim or his family will be subject to threats, harassments, rearrest, or even torture. Finally, the doctor who has complained to the authorities is at risk of being arrested and tortured, charged with subversive activities.

National medical organizations

Doctors might turn to the National Medical Association, but this is likely to be controlled by the government. They might also turn to their national specialist association, such as general practitioner, forensic specialist, psychiatrist, etc. National associations, through international specialist contacts, can play an important role in creating an international awareness about human rights abuses (*Rafaelsen* 1987). These efforts, however, are still very few, and they depend on the initiative of local doctors who run a big risk themselves. An International Medical Body outside the control of the local authorities is called for, which could receive allegations of torture and take appropriate action.

PREVENTION ON AN INTERNATIONAL LEVEL

Non-governmental organizations

The proposed International Medical Body (IMB) could be a non-governmental organization, with the advantage of independence from national interests. Several such organizations actually exist, but have still not proved to be very powerful.

Two main purposes would be achieved by establishing an IMB to receive medical evidence of torture:

1) The IMB would receive first-hand medical accounts of torture, on which they should take appropriate action (see later).
2) The individual doctor who gives the evidence shows in this way that he or she does not approve of torture. This might be helpful if legal prosecution for being involved in torture at a later stage should take place.

Governmental organizations

There is a need for a powerful International Medical Governmental Organization. The World Health Organization (WHO) is probably the best existing organization to incorporate a programme on the prevention of torture in its activities. WHO has contributed to important meetings on health hazards of organized violence (*World Health Organization* 1983, 1987), dealing with the curative aspects, but has as yet abstained from active involvement in preventive and monitoring work. If WHO was to create a committee to receive medical evidence of torture, a system of reporting to the UN Committee against torture could be established. The UN Committee could also take action from the received information, because, according to Article 22 in the Convention against torture (1984), States that are parties to the Convention may declare that they: "recognize the competence of the Committee to receive and consider communications from or on behalf of individual subjects to its jurisdiction who claim to be victims of a violation by a State party of the provisions of the Convention".

According to Article 20 of the same Convention, the Committee can on its own initiative, with the consent of the State in question, decide to perform a fact-finding mission: "If the Committee receives reliable information which appears to it to contain well-founded indications that torture is being systematically practised in the territory of a State Party, the Committee shall invite that State Party to co-operate in the examination of the information and to this end to submit observations with regard to the information concerned".

WHO has created the International Classification of Diseases, and this has been adjusted at regular intervals (*World Health Organisation* 1977). Torture is not specifically mentioned among the non-accidental causes of violence. If WHO were to include torture as a specific cause with a specific number, it would be feasible to receive information from different countries with the number of cases under treatment for sequels of torture. The proposed committee in WHO could be responsible for obtaining these diagnoses and publishing the results at regular intervals, in the same way as malaria is handled for example. These reports could serve as important indicators of the spread of torture and the need for treatment, provided the reporting system was reliable.

Doctors to protect detainees from torture

If a government so wishes, the medical profession can be used very effectively in the prevention of the torture of detainees (*AI* 1978 (Northern Ireland), 1980 (Spain), 1983 (Chile), *Kelstrup* 1986). All arrested persons, and especially those accused of anti-state activities, should be offered a medical examination by an independent doctor prior to interrogation. A detainee should at any time have the right to independent medical assistance, and an independent medical examination should be offered to all prisoners before transfer from police custody to prison or release. The findings of all medical examinations and details of any medical treatment must be recorded in detail and made available on demand to any parties in case of allegations of torture.

Although the following legal instruments (1-4) all serve as very important stimuli to avoid torture and perform investigations of torture allegations, there are no recommendations for suggestions of specific, detailed, practical preventive safeguards in the text: 1) UN Declaration on the protection of all persons from being subjected to torture and other cruel, inhuman or degrading treatment or punishment (1975), 2) UN Convention against torture and other cruel, inhuman or degrading treatment or punishment (1984), 3) UN standard minimum rules for the treatment of prisoners (1977), and 4) UN Code of Conduct for law enforcement officials (1979). But it is known that simple measures like closed-circuit television monitoring of interrogations by senior officers, detailed record-keeping of detainees, the offer of a medical examination every 24 hours, and access to a lawyer after each 48 hours in custody proved to be an effective way of decreasing the complaints of torture in Northern Ireland (*AI* 1984 (Torture in the eighties)). The Human Rights Committee in 1982 adopted a general comment that states should take additional preventive and remedial steps to ensure effective control of the prohibition of torture, as stated in the International Covenant on Civil and Political Rights (*AI* 1984 (Torture in the eighties)). *AI* (1984 (Torture in the eighties), 1984 (Against torture)) and the *Swiss Committee against torture* (1983) have examined the preventive safeguards that governments should implement if they wish to stop torture. It is the belief of AI that a government, using these guidelines, can stop torture if the political will exists, and AI offers specific guidelines to individual governments in its reports (1980 (Israel), 1984 (China, Iran), 1985 (Iraq, Mozambique, Spain, Turkey), 1986 (Afghanistan), 1987 (Iran, Guatemala, Kampuchea, Kenya, China)).

Protection of interrogators from becoming torturers

During peace as well as war, interrogation of criminals and prisoners of war, respectively, is necessary and unavoidable. However, it is essential that the interrogator abstains from the use of torture during the interrogation in order to extract information. Medical investigation of former torturers has increased our understanding of how torturers are created (*Christie* 1972, *Gibson & Haritos-Fatouros* 1986, *Haney et al* 1973, *Haritos-Fatouros* 1981, *Wagner & Rasmussen* 1983a,b).

Such investigations should continue and are the prerequisite for active prophylactic work within the military and police forces (*Rasmussen* 1987).

Medical delegates on "fact-finding missions"

Fact-finding missions are used in order to perform on-the-spot investigations of alleged human rights violations. The delegates usually have a legal or political background (*Studie- en Informatiecentrum Mensenrechten* 1983). The organizations which use fact-finding missions vary from a non-govern mental human rights organization such as the International Committee of the Red Cross (*International Committee of the Red Cross* 1976), Amnesty International (*AI* 1984 (Torture in the eighties)), and other organizations (*American Associations for the Advancement of Science* 1983, *Sagan & Denney* 1983, *Gellhorn* 1983, *Breslin et al* 1985, *Goldstein & Breslin* 1986, *International Human Rights Law Group* 1987). International Governmental organizations such as the United Nations, and nations such as the United States of America also use fact-finding missions increasingly to investigate human rights abuses.

The Belgrade Minimal Rules of Procedure for International Human Rights Fact-finding Missions, approved by the International Law Association in 1980 (*Franck* 1981), recommended that fact-finding missions should be composed of "persons who are respected for their integrity, impartiality, competence and objectivity and who are serving in their own capacity".

Fact-finding missions by International Non-governmental Human Rights Organizations have been studied in detail by two American lawyers (*Weissbrodt & McCarthy* 1981, *Weissbrodt* 1985). They observe that some organizations have recognized that a mis-

sion can be assisted in its fact-finding by a doctor as long as he is given evidence about physical abuse. Amnesty International first included doctors in its mission in 1974 (*AI* 1975 (Israel and the Syrian Arab Republic)). Medical doctors have since been included in several AI fact-finding missions (*AI* 1977 (Korea), 1978 (Northern Ireland), 1980 (Spain, Argentina, Colombia), 1981 (Iraq), 1983 (Chile, Canada), 1984 (El Salvador), 1985 (Congo, Uganda, Caruana), 1986 (Thailand)).

The medical delegates can mainly offer expertise in examination of persons who allege torture. But also aspects like medical neglect of prisoners, prison conditions, and the participation of doctors in torture can be included (*AI* 1983 (Chile)). If the mission includes the medical examination of a dead person suspected of being tortured, a forensic medical specialist should be included (*Albrectsen* 1982).

Forensic pathologists work routinely with descriptions of physical injuries for possible criminal proceedings. It would therefore seem logical for forensic experts to participate in fact-finding missions with respect to torture victims (*Levine* 1984, *Lonardo et al* 1984, *Tedeschi* 1984a,b). Amnesty International has used forensic experts on a number of medical missions (*AI* 1984 (El Salvador), *AI* 1985 (Uganda)). The different aspects of the forensic work in Amnesty International have been covered by *Thomsen et al* (1984).

During the last 5 years, forensic pathologists have increasingly been involved in human rights work. In 1984 the "Committee of Concerned Forensic Scientists and physicians for the documentation of human rights abuses" (CCFS) was formed. One of its main purposes was to support doctors who, due to their work for the authorities, were at risk of participating in torture.

The members of the committee are available for organizations who want to send a fact-finding mission to investigate allegations of torture. The members of the committee should also support each other if a pathologist is in danger of imprisonment and torture because of human rights activities.

Human rights sessions have been included in the scientific programmes of the last three meetings of the International Association of Forensic Science (Bergen 1981, Oxford 1984, Vancouver 1987). Several sessions at the 2nd Indo-Pacific congress on legal medicine and forensic sciences (Columbo 1986) included human rights questions (*Thomsen et al* 1986).

The American Association for the Advancement of Science (AAAS) has used forensic experts in missions to Argentina in order to examine skeletal remains of possible "disappeared persons" during the junta period (*Snow et al* 1984). AAAS in 1986 organized a teaching mission to the Philippines in order that forensic experts from Denmark, USA, and Argentina could teach Filipino forensic experts the technique of identification of skeletal remains, possibly the remains of "disappeared persons" (*Hannibal* 1987). The Minnesota Lawyers International Human Rights Committee has published guidelines for the investigation of dead persons (*Minnesota Lawyers International Human Rights Committee* 1986). International rules for the completion of death certificates are missing, but such guidelines might become a valuable tool in order to improve the standards in some countries where the procedures are primitive. In December 1985, the United Nations adopted a resolution recognizing and encouraging the efforts to establish international minimum standards for autopsies and investigations.

Members of the Danish Parliament have brought the issue up in the Council of Europe after notification of examples of extremely primitive autopsy performance in some parts of Europe. The Council of Europe should ensure that all medico-legal procedures in Europe are conducted to the highest possible scientific standards.

SUMMARY IN ENGLISH

The horror of torture is so coupled with madness, pain, suffering, and nightmares that it can never be fully understood by those who have not experienced it on their own body.

CHAPTER I. INTRODUCTION AND AIM OF THE PRESENT STUDY

The historical aspect of torture is briefly presented, and the main differences between ancient torture, e.g. The Inquisiton, and today's torture is emphasized:

1. Ancient torture was accepted, to-day's is not.
2. Ancient torture was executed in public, today it is in secret.
3. Ancient torture was carried out after "legal" proceedings, today it is arbitrary.

Definitions of torture have been offered by The United Nations and The World Medical Association, among others. These definitions are discussed, and it is argued that the WMA's definition is the most relevant for the medical profession, and thus the one which will be applied in the present survey.

The medical work against torture in Amnesty International was initiated in 1973 and the first Medical Group in the organization was created in Denmark in 1974. A brief outline of the different studies published by the medical group is presented.

The author of the present survey has been active in the medical work against torture since 1974, and this book has been written in order to fulfil an increasing desire to gather the accumulated knowledge and recommendations on the subject in one book. The views and conclusions expressed are mine and do not necessarily represent those of the organizations I have worked for.

The purpose of the present study included four specific items:

1. Based on the medical records from the examinations of 200 persons who alleged having been tortured, to describe different types of torture and resulting symptoms and lesions, and to evaluate their consequences with regard to diagnostic significance and the person's health, and to relate the results to today's accumulated knowledge on the subject.
2. To evaluate the influence of exile on health complaints in torture victims.
3. To describe the kind and frequency of medical involvement in torture, using the data from the present study.
4. To describe the existing relationship between the medical profession and torture, and to make proposals as to how the medical profession can be used in the prevention of torture.

CHAPTER II. METHODS

The procedure for the examination of the torture victims is described. The interview technique and reporting system have constantly been improved as the Danish medical group gained more experience. The group consisted of 25 Danish doctors with different specialities and background. When enrolled in the medical examination team, new doctors had to go through a training period during which they examined a number of torture victims together with an experienced investigator from the team.

Except for a few cases, all the examinations were performed by two doctors from the group, in most of the cases with the help of an interpreter.

82 examinations were carried out in Denmark, and the rest during missions to other countries.

Data from the 200 examined torture victims was filed on an electronic data base. A description is given of the handling of missing data.

If the reply frequency was less than 75% no further statistical evaluation was performed.

Other existing ways of examining torture victims are also described. Examples are presented of a self-reporting questionnaire

and a data collecting protocol for use by local doctors in countries where torture takes place.

A Mantel-Haenszel test was used in the statistical evaluation after stratification for possible confounders, and a Wilcoxon's rank sum test for paired data (SAS statistical library, NEUCC) to evaluate age distribution.

CHAPTER III. MATERIAL

All 219 persons examined by the Danish medical group from its formation up to May 1982 entered the study. 19 persons were excluded, 12 because their treatment did not fulfil the criteria of torture and 7 because their report was insufficient. The remaining 200 persons, 39 women and 161 men, comprise the present study.

19 nationalities were represented, and the alleged torture took place in 18 countries. The three largest groups of persons said that they had been tortured in Chile, Greece or Spain.

In general the examined persons were young (median age at the time of examination 30 years) and they were well educated (about ⅔ had vocational/technical or college/university degrees at the time of arrest) and only 4% were unemployed. About half were single at the time of arrest and the others engaged or married.

The examination took place at varying periods after the alleged torture (median 2 years, range 3 days to 12 years).

The reported state of health before the arrest was good, and 86% did not make complaints of any serious diseases. Mental complaints before the arrest were only mentioned by 2 persons.

CHAPTER IV. TYPES OF ALLEGED TORTURE

Types of Torture are presented according to the allegations made by the examined persons.

The torture and maltreatment mainly took place during the early period of captivity. The medium number of days of torture per person was five (range 1-250 days).

The reported types of torture have been classified into physical and mental, but there was considerable overlapping.

Beating was by far the most commonly applied type of physical torture. 99% of the examined persons reported having been beaten, and 95% said that the beating had included severe beating with fists or an instrument, or by kicking. 73% had been severely beaten on the head. Severe beating on the soles of the feet (falanga) was reported by 29%, particularly in Greece and Iraq. Simultaneous beating of both ears with the palms of the hands (teléfono torture) was experienced by 9%.

54% had been subjected to electric torture, particularly in Chile and Uruguay. Electric torture was very often applied to sensitive parts of the body, and 50% of it included the genital region.

Suspension was reported by 50 persons. A special form, called "la barra" or "the parrot perch", was experienced by 20 persons. The wrists are tied together and lowered in front of the knees before a bar is pushed behind the knees and in front of the elbows. The bar is lifted and the victim, with the head hanging downwards, is often tortured in other ways, e.g. electric torture, beating, and falanga.

Water torture ("la bañera" or "wet submarino") was described as the forcing of the head into a bathtub filled with filthy water and keeping the victim there until nearly suffocated. Dry submarino consisted of having a plastic bag forced over the head, and kept there again until the victim was nearly suffocated.

Sexual violation was reported by 2 men and 5 women. 2 of the women had been raped by several of their interrogators. 8 women and 12 men reported sexual violation by means of an instrument.

Other types of physical torture included forcing the victim to mantain an abnormal body position for long periods, forced gymnastics, climatic stress, burning with cigarettes, tearing off nails, etc.

Mental types of torture usually included threats of, for example, further torture, execution, and the arrest and torture of the family, including the children. Threats of execution were experienced by 60%, and against family or friends by 43%.

Sham execution was reported by nearly one-third of the examined persons.

Deprivation techniques such as interrogation for long periods, deprivation of sleep, and deprivation of water and food were very common allegations.

Humiliations in the form of sexual verbal assaults were reported by 20%, and 45% had been stripped naked during the interrogation.

Non-therapeutic administration of drugs occurred in 9 cases and a detailed account is given.

13% said that the interrogation used changing attitudes, including a friendly interrogator (the good man), in between the torture.

75% had been kept in solitary confinement for a median length of 2 weeks (range 1-274 days).

CHAPTER V. SYMPTOMS AND SIGNS

Immediate symptoms after the alleged torture, symptoms at the time of examination, and the results of the medical examination are presented. An analysis was made of the different types of alleged torture and their relation to symptoms and lesions in the victims. The diagnostic significance of the sequelae and their influence on the person's heath are evaluated and related to the present accumulated knowledge on the subject. The presentation is made according to organs:

A: Dermatological

70% of the examined torture victims reported that acute skin lesions had been present immediately after torture. In particulalar, torture forms such as beating, burning and electrical torture left acute skin lesions. The main significance of the skin changes is that they may support allegations of torture, and medical examinations of the acute lesions presumably yield better evidence than examinations performed several years later. The characteristic acute and late changes after electrical torture are presented and compared with experimental studies on fully anaesthetized pigs.

The most characteristic lesions followed burning and electrical torture, the former leaving permanent lesions more often then the latter.

B: Cardiopulmonary

The most common torture form against the chest was blunt trauma. Fractures of the chest were reported by 10 victims, while 2 men reported haemothorax and one man pneumothorax. "Wet submarino" caused acute lung symptoms in a number of persons.

At the time of examination, 42 persons complained of cardiopulmonary symptoms, most often chest pain, which in about half the cases could be related to the reported torture. In 15 persons no obvious organic causes could be found and the symptoms were classified as vegetative.

Bad prison conditions were incriminated in acute lung infections and tuberculosis in some of the victims.

C: Gastrointestinal

Fatal intra-abdominal lesions following torture have been reported at autopsies. Severe intra-abdominal traumatic injuries were not recorded in the present study.

Abdominal traumas were of a blunt nature and the immediate symptoms were located to the abdominal wall.

Weight loss was reported by rather more than half of the examined persons, with a mean value of 10 kg (range 2-36kg).

6 persons reported haematemesis in connection with the torture.

Alteration in defecation was reported by 59 persons, and 41 persons reported vomiting during detention.

15 persons complained of pain or bleeding, or both, after torture of the perineal region.

Gastrointestinal symptoms at the time of examination were comparable with those of a normal population.

D: Musculoskeletal

Acute symptoms from the locomotor system were reported with a high frequency (81%) following torture, particularly severe beating. 26 persons reported fractures and 15 persons were admitted to hospital.

Special torture procedures resulted in rather specific acute symptoms. These are described for different forms of suspension, e.g. the "parrot perch", and for torture forms like "the motorcycle", "the operating table", and falanga.

Falanga torture produced acute as well as long lasting symptoms. The development of an acute closed compartment syndrome in the foot due to falanga torture is explained on a pathophysiological basis.

Apart from falanga torture sequels, only a few cases of persistent changes could specifically be related to torture, since most symptoms and abnormalities were unspecific and did not occur with a higher frequency in torture victims than in the normal Danish population.

X-ray examination for the documentation of fractures is a valuable contribution in supporting the allegation of torture, most often independent of the time of examination.

E: Neurological

Neurological symptoms at the time of torture were reported by 75% of the examined persons. The most frequently reported symptom was headache.

Loss of consciousness occurred in nearly 20% of the victims who sustained head trauma. Loss of consciousness unrelated to head trauma but due to the inflicted pain, exhaustion, or for other reasons was frequent (31%).

Head injuries leading to skull fractures, intracranial haemorrhage, and brain laceration were reported in a few cases.

23% complained of acute peripheral nerve symptoms. In the majority the symptoms were related to pressure at the wrists from handcuffing or tight binding with ropes. Peripheral nerve symptoms after electric and falanga torture were also reported.

12% complained of persistent peripheral nerve symptoms.

At the time of examination 64% complained of neurological symptoms. Headaches, loss of concentration or attention, and memory disturbances were the most frequently reported neurological symptoms. A relationship was demonstrated between severe head traumas with loss of consciousness and impaired memory and headache at the time of examination. Some of the victims who were complaining of neurological symptoms were thought to have a postconcussion syndrome due to organic brain damage, but in the majority the inflicted head trauma had not been so severe that a postconcussion syndrome was likely to develop.

The neurological symptoms in the present survey are compared with sequelae of other severe stress events.

It is suggested that factors other than trauma of the head may play an important role in the development of acute and long-lasting neurological symptoms. Excessive fear and anxiety normally trigger a stage of alertness in man, and it is suggested that this trigger mechanism has been altered in such a way in torture victims that small amounts of fear induce overreaction.

F: Psychiatric

The horror of torture is so coupled with madness, pain, suffering, and nightmares that it can never be fully understood by those who have not experienced it on their own body. Alternative "languages" like films, poems, paintings, etc. have helped us to increase the understanding and perception of torture. The presentation of the mental symptoms at the time of torture should be seen in this light.

In addition to fear due to the arrest and torture, mental symptoms and mental complaints at the time of torture were reported by 68%. Sleep disturbances, nightmares and severe anxiety were the most frequent symptoms.

Hallucinations were described by 14 persons, and a detailed account is given for each case. Of 6 persons admitted to psychiatric hospital, 4 complained of hallucinations. A total of 21 persons received psychiatric or psychological treatment immediately after their release.

At the time of examination, 68% complained of mental symptoms. Sleep disturbance was the most frequently recorded symptom, but nightmares, irritability, and a change in mood were also frequent. 24 persons complained of sexual problems.

The frequency of mental symptoms could not be related to the age of the victims or special types of torture, but threats and sham execution had often been experienced by those complaining of mental symptoms at the time of examination.

At the medical examination, 28 persons were found to be depressed, while 13 were passive with lack of response. Only one person was aggressive, and 8 were abnormally labile.

The mental symptoms in the present survey were similar in many respects to those in other studies of torture victims, and in victims of severe stress, e.g. war sailors, concentration camp victims, etc.

G: Urological and genital

25% complained of symptoms from the kidney or bladder, or both, at the time of torture. The two most common complaints were haematuria and dysuria. Haematuria could be explained by direct trauma to the genital region and by renal trauma. Some cases of "haematuria" were probably haemoglobinuria caused by the beatings by a mechanism similar to "footstrike haemolysis" in runners. Dysuria was probably caused by torture instruments in some cases, and by cold plus poor hygienic standards in the others.

At the time of examination, bladder or kidney complaints were not more frequent than in control groups from other studies of torture victims.

H: Gynaecological

24 (61%) of the 39 women in the present study complained of symptoms from the genital tract arising at the time of torture. The most frequent symptom was a change in uterine bleeding, e.g. amenorrhoea in more than 25% of the female torture victims. Fear-induced amenorrrhoea is known to be the result of a hypothalamic-pituitary failure disorder with decreased secretion of gonadotrophic hormones. The same mechanism probably lies behind the bleeding disturbances in female torture victims.

2 women were pregnant when arrested and they both began to bleed after severe torture. One of them had a spontaneous abortion while still imprisoned, and the other gave birth in prison.

5 women complained of inflammatory symptoms from the genital tract, and 2 of them had been raped.

31% of the women complained of genital tract symptoms at the time of examination, particularly menstruation irregularities. No hormonal analysis of female torture victims has been found in the literature.

I: Otorhinolaryngological

Otorhinolaryngological sequels of torture were mainly associated with the hearing function. The torture form "teléfono" in particular caused immediate and long-lasting symptoms. It was suggested that the mechanism was similar to that after blast injuries.

J: Ophthalmological

10% complained of ocular symptoms at the time of torture. They usually consisted of short-lived visual disturbances. Filthy cloths used for blindfolding and the torture form "banera" were said to have produced conjunctivitis in a few cases.

Only very few ocular symptoms which could possibly be related to torture or detention were found at the time of examination.

K: Dental

Acute dental symptoms in torture victims were caused by traumatic injuries causing fractures (13%) or loss of teeth (9%).

Dental treatment during detention was often lacking or only consisted of extraction of damaged teeth.

Poor oral hygienic conditions during detention, with lack of optimal dental cleaning, could cause a deterioration in the dental state.

Long lasting symptoms were mainly due to affection of the gingiva.

Examination of the masticatory muscles is recommended in the medical examination of torture victims since fibrositis has been described at a high frequency.

CHAPTER VI. EXILE

In order to study the possible influence of exile on torture victims, the present material was divided into those who were examined when living in exile (n=111) and those who lived in their country of origin at the time of examination (n=89).

The two groups were comparable with respect to age and sex, but were very different concerning country of origin. Some differences were found in exposure to certain special types of torture, e.g falanga. It was found that impaired memory, impaired concentration, nightmares, and depression were significantly more frequent in victims living in exile.

Chileans living and examined in Chile (n=18) were compared with Chileans living and examined in Denmark (n=54). Those examined in Chile were younger and had a higher percentage of females. The exposure to torture was very similar in the two groups, except that the Chileans who were examined in Denmark had undergone forms of suspension more frequently, and the length of their registered torture was longer. The symptomatology in the two groups was very similar, except that "general tiredness" was more frequent in Chileans living in Chile.

The findings should be interpreted with great care since quite a number of variables might have influenced the results. However, considering the few differences in symptomatology in the two groups, torture sequels in refugee victims might not be very different from torture sequels among victims living in their own country where torture is still practised.

CHAPTER VII. TORTURE SYNDROME?

Some types of torture caused rather specific sequels which it is suggested might be called "specific torture syndromes":

Severe beating on the head could result in a postconcussion syndrome.

Teléfono torture could lead to lesions of the tympanic membrane similar to those resulting from blast injuries.

Beating could damage the red blood cells and thereby produce haemoglobinuria similar to footstrike haemolysis.

Tight binding with ropes around the wrists, handcuffing, or suspension by the wrists might damage peripheral nerves to the hand in a similar way to handcuff neuropathy.

Electric torture might leave diagnostically significant changes in the skin similar to those demonstrated in experimental animal studies.

Other skin lesions, e.g. cigarette burns, leave very characteristic changes.

The constitution of a possible mental and neurological torture syndrome, caused by either physical or mental torture or a combination of the two, is examined. The most often recorded mental and neurological symptoms were 1) sleep disturbances with or without nightmares, 2) irritability, change in mood and/or anxiety, 3) impaired concentration, 4) headache, and 5) impaired memory. It was found that 40% of all the persons in the present survey complained of more than three of the 5 mentioned symptoms.

Both mental and neurological complaints were common in the examined torture victims.

It is concluded that further studies are needed to clarify whether the symptoms shown by torture victims constitute a specific torture syndrome, different from other syndromes after stressful events. A clarification of terminology and definitions is stressed, particularly concerning the victim's description of symptoms.

The creation of a well-defined torture syndrome is not only of academic interest, but might be of benefit to the torture victim, for example facilitating the granting of compensation for damage in the same way as has been instituted for concentration camp victims.

CHAPTER VIII. MEDICAL INVOLVEMENT IN THE PRACTICE OF TORTURE

The medical profession's participation in torture is well-documented. In the present study 41 of the 200 examined torture victims reported that medical personnel were involved in their torture. Varying degrees of this involvement took place: 15 persons stated that they were examined by a doctor prior to their torture, 9 said that non-therapeutic administration of drugs was used against them, 10 that a doctor was present during the torture, and 15 that they received medical resuscitation because they lost consciousness during torture.

The ways in which a doctor can participate or be involved in torture may be classified as follows:

1. To make a diagnosis.
2. To treat the victim.
3. The opposite of prophylactic work.

Examples of the third group include doctors' participation in creating and inventing new sophisticated types of torture, in punitive amputations, in carrying out the death penalty, and in abuse of psychiatry.

In spite of numerous testimonies in which torture victims identify the doctor, very few legal prosecutions have been organized.

The national medical associations are responsible for the ethical conduct of their members, and vey clear declarations, such as the Tokyo Declaration, serve as unambiguous guidance. The national medical associations should be encouraged by all national as well as international means to live up to these expectations.

It is recommended that doctors who are found guilty of torture should not be allowed to practice as a doctor in any country of the world.

Both governmental and nongovernmental International Medical Bodies should be encouraged to incorporate the prevention of torture into their programmes. It is particularly recommended that WHO should include these items in its health activities.

CHAPTER IX. THE MEDICAL PROFESSION AGAINST TORTURE

The role of the medical profession in relation to torture mainly falls into three parts:

1. Treatment and rehabilitation of torture victims.
2. Prevention of torture and
3. work against the medical participation in torture (this last item has been delt with in chapter VIII).

Although treatment of torture victims is outside the scope of the present survey, a short presentation of the different "schools" is given. Rehabilitation and treatment of torture victims was initiated in 1973 in Chile. Treatment includes the whole family, and special centres for treatment of children have been created. The treatment includes political solidarity, and treatment centres inspired by the "Chilean School" have been set up in different places in Europe, particularly for the treatment of Latin American refugees.

On the initiative of AI, an independent Danish centre for the treatment and rehabilitation of torture victims (RCT) was founded in 1982. The treatment was based on individual psychotherapy. Standard medical research of the treatment has however been hampered by many cultural and ethical problems. It is stressed that, in the interest of the victims themselves (past, present and future), research into the treatment of torture victims should apply the highest possible methodological standards.

Interest has been growing since the early 1970s in ways by which the medical profession can assist in the prevention of torture. The profession can play a central role, and different aspects of the work at a national level are presented. When they participate in the fight against torture, doctors and national medical organizations often place themselves at great risk. All possible international support and protection are needed in order that this important work can continue.

At an international level a powerful International Medical Organization is called for to work for the prevention of torture and to organize and coordinate activities throughout the world. Of the existing organizations, WHO is probably the best placed for incorporation of such activities into its programme.

The medical profession can play an important role in reporting cases of torture, but more important it can be a very effective instrument in the protection of detainees from torture.

Psychologists and doctors have studied the entire educational system that is needed to create a torturer.

Such studies are important in the elucidation of the different mechanisms behind state repression techniques, and they deserve to be intensified in order to institute active prophylactic work within the military and police forces responsible for the torture.

The use of the medical profession to document torture on fact finding missions is recommended.

RESUME PÅ DANSK

Torturens rædsler er så fyldte med vanvid, smerte, lidelse og mareridt, at det formentlig aldrig fuldtud vil kunne forstås, såfremt man ikke selv har oplevet det på egen krop.

KAPITEL I. INTRODUKTION OG FORMÅL MED NÆRVÆRENDE UNDERSØGELSE

I en kort historisk redegørelse for anvendelse af tortur skelnes mellem tidligere tiders tortur, som den fx blev anvendt under inkvisitionen, og tortur som den udøves i dag:

1. Tortur var tidligere accepteret, idag er tortur ikke accepteret.
2. Tidligere blev tortur udøvet åbent og offentligt, idag udøves tortur i hemmelighed.
3. Tidligere blev tortur udøvet efter en »retslig« handling idag udøves tortur vilkårligt.

Der eksisterer flere, forskellige definitioner af tortur. De Forenede Nationer's (UN) og Verdens Lægelige Organisation's (WMA) definitioner diskuteres. WMA's definition fremhæves som den mest relevante til brug for den medicinske profession og anvendes derfor i nærværende arbejde.

Det lægelige arbejde mod tortur i organisationen Amnesty International (AI), påbegyndtes i 1973, og den første lægegruppe blev oprettet i Danmark i 1974. Der gives en oversigt over undersøgelser, som lægegruppen har udført vedrørende torturofre. Idet forfatteren til denne bog har deltaget i det medicinske arbejde mod tortur siden 1974, har der udviklet sig et ønske om at samle og objektivisere den indhentede viden. Oplysninger og synspunkter er forfatterens egne og foregiver ikke nødvendigvis de organisationer som jeg har arbejdet for.

Mere specifikt kan hovedformålet med nærværende arbejde beskrives i følgende punkter:

1. Via registrerede data i lægelige rapporter af 200 undersøgte torturofre at analysere de torturformer, symptomer og læsioner torturofret påføres; vurdere følgernes diagnostiske signifikans og betydning for personens helbred, samt sammenholde dette, med den nuværende viden på området.
2. At vurdere eksilets indflydelse på sygdomsklager hos de undersøgte torturofre.
3. At beskrive med hvilken hyppighed og på hvilken måde den lægelige profession bliver indblandet i tortur via ovennævnte registrerede data.
4. At beskrive den lægelige professions relation til tortur og fremsætte forslag til forbedringer i retning af en bedre udnyttelse af professionen i arbejdet på forebyggelse af tortur.

KAPITEL II. METODE

Der redegøres for undersøgelsesproceduren af torturofrene. I undersøgelsesperioden har den danske lægegruppe i takt med indhøstet erfaring forbedret interview- og rapportsystemet. Den lægelige undersøgelse af torturofrene blev udført af i alt 25 danske læger med forskellig uddannelse og baggrund. Når en ny læge blev medlem af lægegruppen gennemgik vedkommende et uddannelsesforløb, og de første undersøgelser foregik altid sammen med en erfaren undersøger. Undersøgelsen blev i næsten alle tilfælde udført af to læger, og i de fleste tilfælde med brug af en tolk.

82 undersøgelser blev udført i Danmark og resten (118) blev udført under missioner til andre lande.

I nærværende undersøgelse blev et EDB-system anvendt til at indkode undersøgelsesresultaterne fra de 200 undersøgte personer. Der gøres rede for, hvordan manglende oplysninger er blevet behandlet i den statistiske analyse. Såfremt besvarelsesprocenten lå under 75, blev den pågældende variabel anset for invalid til dybderegående analyse.

Materialet er statistisk behandlet ved hjælp af en Mantel-Haenszel test efter stratificering af formodede confounders. Til statisisk behandling af aldersfordelingen er anvendt Wilcoxon's rangsumtest for parrede data (SAS statistical library, NEUCC).

Sluttelig redegøres for andre undersøgelsesmetoder af torturofre. Der gives eksempel på et selvadministrerende spørgeskema samt et dataregistrerings skema til brug for lokale læger i et land hvor tortur foregår.

KAPITEL III. MATERIALE

Alle 219 personer undersøgt af den danske lægegruppe fra oprettelsen og frem til maj 1982 indgik i undersøgelsen. 19 personer måtte udgå, 12 fordi de ikke opfyldte torturkriteriet og 7 personer fordi rapporten var for mangelfuld. Tilbage blev 200 personer, 39 kvinder og 161 mænd, der anvendtes i analysen.

19 nationaliteter var repræsenteret, og den anførte tortur fandt sted i 18 forskellige lande. De 3 største grupper angav at have været torteret i Chile, Grækenland eller Spanien.

De undersøgte personer var unge (medianalderen på undersøgelsestidspunktet var 30 år), veluddannede (omkring 2/3 havde erhvervs/teknisk eller studenter/universitets eksamen på arrestationstidspunktet), og kun 4% var uden arbejde.

Omkring halvdelen var enlige på arrestationstidspunktet, og den anden halvdel var gift, forlovede eller havde fast partner.

Den mediane tid efter den anførte tortur frem til undersøgelsen var 2 år (spredning 3 dage til 12 år).

Helbredstilstanden før arrestation blev anført som god, og 86% havde ingen helbredsklager af alvorlig art. Kun 2 personer angav lettere psykiske klager.

KAPITEL IV. DE ANGIVNE FORMER FOR TORTUR

Torturformerne fremlægges, som de er angivet af de undersøgte personer.

Torturen og mishandlingen fandt hovedsagelig sted i den første periode af tilbageholdelsen. Det mediane antal dage en person var torteret var 5 dage (spredning 1-250 dage).

Torturformerne blev inddelt i psykiske og fysiske, vel vidende at en betydelig overlapning eksisterer.

Slag var den altdominerende form for fysisk tortur. 99% af de undersøgte var blevet slået og 95% kraftigt med anvendelse af et instrument, knytnæver eller spark. 73% var blevet slået kraftigt mod hovedet. Kraftige slag rettet mod fodsålerne (falanga) blev anvendt

mod 29%. Specielt personer fra Grækenland og Irak havde været udsat for falanga. 9% havde været udsat for telefontortur som består i slag med flad hånd samtidig mod begge ører.

54% angav at have været udsat for elektrisk tortur. Over for chilenere og uruguanere var denne torturform specielt meget hyppig anvendt (87%). Den elektriske tortur blev ofte udført på meget følsomme steder af kroppen og således havde den elektriske tortur i 50% indbefattet kønsorganerne.

50 personer havde været udsat for ophængning. En speciel form for ophængning kaldet »la barra« eller »papegøjepinden« blev anvendt over for 20 personer: idet personen er bundet om håndleddene, føres hænderne frem over knæene, og en stav føres ind under knæhaserne foran albuerne. Staven løftes og ofret hænger herefter med hovedet nedad. I denne stilling torteres ofte med anden tortur såsom elektrisk tortur, slag eller falanga.

Vandtortur, »la bañera« eller »våd submarino« består i, at ofret får hovedet tvunget ned i et badekar fyldt med snavset vand, og hovedet fastholdes under vand, indtil ofret er ved at kvæles. »Tør submarino« består i fx at få en plastikpose tvunget over hovedet og først få den fjernet, når ofret er ved at blive kvalt.

5 kvinder og 2 mænd angav at være blevet voldtaget. 2 af kvinderne var blevet voldtaget flere gange af forskellige torturudøvere. 8 kvinder og 12 mænd berettede om seksuel vold med anvendelse af et instrument.

Anden fysisk tortur indbefattede, at ofret skulle indtage en bestemt stilling i længere tid, skulle udføre bestemte gymnastiske øvelser, anbringelse i ekstrem varme eller kulde, brænding med fx cigaretter, udrivning af negle osv.

Den hyppigste form for psykisk tortur var trusler. Der blev oftest truet med yderligere tortur eller drab (50%) og trusler om arrestation og tortur af familien indbefattet børnene (43%).

Skinhenrettelse oplevede næsten en trediedel af de undersøgte.

Deprivationsteknikker såsom forhør i meget lang tid, berøvelse af søvn, mangel på vand eller føde var hyppige klager.

Ydmygelser i form af verbale seksuelle grovheder blev anvendt over for 20%, og 45% havde været afklædt under forhørene.

Indgift af medicin i ikke-terapeutisk øjemed skete i 9 tilfælde, og der gøres udførligt rede for hver enkelt.

13% sagde, at der ved forhøret blev anvendt en skiftende attitude med brug af den såkaldte venlige fohørsleder imellem tortursessionerne.

73% havde været holdt i isolation. Den mediane længde af isolationen var 2 uger (spredning 1-274 dage).

KAPITEL V. SYMPTOMER OG OBJEKTIVE FUND

Umiddelbare symptomer efter den påståede tortur, symptomer på undersøgelsestidspunktet, samt de objektive fund ved den lægelige undersøgelse fremlægges. Der foretages en analyse af den påståede tortur og dennes relation til symptomer og læsioner hos de undersøgte torturofre. Følgernes diagnostiske signifikans og betydning for personens helbred vurderes og sammenholdes med den nuværende viden på området. Der redegøres for hvert enkelt organsystem for sig:

A: Dermatologisk

70% af de undersøgte torturofre kunne fortælle om akutte hudlæsioner opstået i forbindelse med torturen. Specielt torturformer som slag, brænding og elektrisk tortur efterlod akutte hudlæsioner. Betydningen af hudlæsioner er først og fremmest, at de kan støtte anklagerne om tortur, og lægelig undersøgelse af akutte læsioner giver formentlig bedre beviser end undersøgelser, der foretages mange år efter. De karakteristiske akutte og sene følger efter elektrisk tortur præsenteres og sammenlignes med eksperimentelle studier på fuldt bedøvede grise.

De mest karakteristiske læsioner fandtes efter brænding og elektrisk tortur, idet brænding hyppigere efterlader permanente læsioner end elektrisk tortur.

B: Kardio-pulmonalt

Den oftest anvendte torturform mod thorax var stumpe traumer. Frakturer af thorax blev rapporteret i 10 tilfælde. 2 mænd udviklede hæmothorax og een mand pneumothorax som et resultat af torturen. »Våd submarino« resulterede i en del tilfælde i akutte lungesymptomer.

På undersøgelsestidspunktet klagede 42 personer over kardiopulmonale symptomer, og oftest drejede det sig om smerter i brystet, som i omkring halvdelen af tilfældene kunne relateres til torturen. I 15 tilfælde var der ikke nogen åbenbare organiske forklaringer, og symptomerne blev klassificeret som vegetative.

Dårlige fængselsforhold førte til akutte lungeinfektioner og tuberkulose hos nogle af ofrene.

C: Gastrointestinalt

Dødelige intraabdominale læsioner efter tortur er rapporteret ved obduktioner. I det undersøgte materiale af overlevende torturofre blev svære intra-abdominale traumatiske skader ikke fundet. Abdominaltraumerne var af stump karakter, og de umiddelbare symptomer var hyppigst lokaliseret til abdominalvæggen.

Omkring halvdelen af de undersøgte personer angav vægttab med en middelværdi på 10 kg (spredning 2-36 kg).

6 personer fik hæmatemese i forbindelse torturen. 41 klagede over opkastning i løbet af tilbageholdelsen. Afføringsændring anførtes af 59 personer.

15 personer havde smerte og/eller blødning i perinealregionen efter tortur.

Gastrointestinale symptomer på undersøgelsestidspunktet var sammenlignelige med, hvad der er fundet i normalbefolkningen.

D: Bevægeapparat

Akutte symptomer fra bevægeapparatet fandtes med stor hyppighed efter tortur (81%). Kraftige slag var årsag til de fleste af symptomerne. 26 personer havde frakturer som følge af torturen, og 15 af disse blev indlagt på hospital.

Specielle torturformer resulterede i ret specifikke akutte symptomer. Der gives en beskrivelse af symptomerne efter forskellige former for ophængning som fx »papegøjepinden«, samt efter torturformer som »motorcyklen«, »operationsbordet« og falangatortur.

Falangatortur forårsagede såvel akutte som længerevarende symptomer hos torturofrene. Udvikling af akut »closed compartment syndrome« i foden efter falangatortur gav en patofysiologisk forklaring på symptomer og objektive fund.

Udover følgerne efter falangatortur var der få tilfælde, hvor de persisterende forandringer specifikt kunne relateres til en bestemt torturform. De fleste af symptomerne og de abnorme fund var uspecifikke og forekom ikke med en højere frekvens end i den danske normalbefolkning.

Røntgenundersøgelser til dokumentation for frakturer fremhæves som en god undersøgelse til underbyggelse af torturanklager, idet denne undersøgelse ofte er ret uafhængig af den tid, der er forløbet efter torturen.

E: Neurologisk

Neurologiske symptomer omkring torturtidspunktet blev angivet af 75%. Den hyppigste klage var hovedpine (54%). Bevidstløshed forekom hos næsten 20% of de personer, som havde pådraget sig hovedtraume. Bevidstløshed uden relation til hovedtraume men pga. den påførte smerte, udmattelse eller af andre årsager var ret hyppige (31%).

Hovedtraume medførende kraniefraktur, intrakraniel blødning eller hjernedilaceration blev meddelt i nogle få tilfælde.

23% klagede over akutte symptomer fra de perifere nerver. Der var overvejende tale om symptomer, der kunne relateres til tryk ved håndleddet efter håndjern eller stramme reb. Symptomer fra de perifere nerver blev også angivet efter elektrisk tortur og falanga.

12% klagede over vedvarende symptomer fra de perifere nerver.

På undersøgelsestidspunktet klagede 64% over neurologiske symptomer. Hovedpine, koncentrations- og hukommelsesbesvær var de hyppigst forekommende neurologiske symptomer. Der blev demonstreret en sammenhæng mellem svære hovedtraumer medførende bevidstløshed og symptomerne nedsat hukommelse og hovedpine på undersøgelsestidspunktet. Nogle af ofrene med klager over neurologiske symptomer mistænktes at lide af et »post-concussion« syndrom forårsaget af en organisk hjerneskade, men hos hovedparten af torturofrene havde det påførte hovedtraume ikke været af en sådan styrke, at udviklingen af et »post-concussion« syndrom var sandsynligt.

De neurologiske symptomer i nærværende arbejde er sammenlignelige med følger efter andre svære belastningstilstande.

Andre faktorer end hovedtraume synes at spille en rolle i udviklingen af akutte og længerevarende neurologiske symptomer. Svær frygt og angst udløser normalt en tilstand af årvågenhed, og hypotetisk kunne det tænkes, at denne udløsningsmekanisme hos torturofre er blevet ændret på en sådan måde, at selv små mængder angst inducerer en overreaktion.

F: Psykisk

Torturens rædsler er så fyldte med vanvid, smerte, lidelse og mareridt, at det formentlig aldrig fuldtud vil kunne forstås, såfremt man ikke selv har oplevet det på egen krop. Alternativt »sprog« som film, digte, malerier osv. kan hjælpe os til en øget forståelse og bedre opfattelse af torturen. Præsentationen af de psykiske symptomer omkring torturtidspunktet vurderes med dette forbehold.

I tillæg til frygt pga. arrestation og tortur klagede 68% over mentale symptomer omkring torturtidspunktet. Søvnforstyrrelser, mareridt og svær angst var de hyppigst forekommende symptomer.

Hallucinationer blev beskrevet af 14 personer, og en detaljeret redegørelse gives for hvert enkelt tilfælde. 6 personer blev indlagt på psykiatrisk afdeling, og 4 af disse klagede over hallucinationer. I alt fik 21 personer psykiatrisk og/eller psykologisk behandling umiddelbart efter løsladelsen.

På undersøgelsestidspunktet klagede 68% over psykiske symptomer. Søvnforstyrrelser var det hyppigst forekommende symptom. Mareridt, irritabilitet og ændret stemningsleje var de hyppigste klager. 24 personer klagede over seksuelle problemer.

Frekvensen af psykiske symptomer var uafhængig af ofrets alder. Personer, der klagede over psykiske symptomer på undersøgelsestidspunktet, havde med meget stor hyppighed været udsat for trusler og skinhenrettelse.

28 personer blev ved undersøgelsen fundet deprimeret, medens 13 personer var passive med manglende respons. Kun een person blev fundet aggressiv, og 8 personer blev karakteriseret som abnormt labile.

Der fandtes ligheder med de psykiske symptomer, der beskrives i nærværende arbejde, sammenlignet med andre undersøgelser af torturofre samt ofre for svære belastninger som fx krigssejlere, koncentrationslejrfanger mv.

G: Urologisk

25% klagede på torturtidspunktet over symptomer fra nyrerne eller blæren. De to hyppigst forekommende symptomer var hæmaturi og dysuri. Hæmaturien kunne oftest forklares ved et direkte traume mod genitalregionen eller ved et traume mod nyreregionen. Nogle tilfælde af »hæmaturi« var formentlig forklaret ved hæmoglobinuri forårsaget af slag, i lighed med, hvad der ses efter »footstrike« hæmolyse hos løbere. Dysuri kunne forklares ved slimhindeirritation forårsaget af tortur i nogle tilfælde, kuldeeksposition samt dårlig hygiejnisk standard hos resten.

På undersøgelsestidspunktet fandtes imidlertid ikke højere frekvens af urologiske symptomer, end hvad der svarer til fund hos kontrolpersoner i andre studier af torturofre.

H: Gynækologisk

24 kvinder (61%) af de 39 kvinder i nærværende undersøgelse klagede over symptomer fra underlivet, opstået efter tortur. Det hyppigste symptom var blødningsændring. Amenorre optrådte hos mere end 25% af de kvindelige torturofre. Angst induceret amenorre forårsages af svigtende hypothalamisk-hypofysær funktion med nedsat produktion af gonadotrope hormoner. Samme mekanisme ligger formentlig bag blødningsforstyrrelserne hos de kvindelige torturofre.

2 kvinder var gravide på arrestationstidspunktet, og begge begyndte at bløde efter svær tortur. En af kvinderne aborterede spontant, medens hun stadig var tilbageholdt, og den anden fødte barnet under indespærringen.

5 kvinder klagede over underlivsbetændelse, og 2 af disse kvinder var blevet voldtaget.

31% af kvinderne klagede over underlivssymptomer på undersøgelsestidspunktet, hyppigst beskrevet som menstruationsforstyrrelser. Hormonanalyser af kvindelige torturofre er ikke beskrevet i litteraturen.

I: Otorinolaryngologisk

Øre-næse-hals symptomer efter tortur påvistes hovedsagelig som høreforstyrrelser. Specielt torturformen »teléfono« synes at give akutte såvel som længerevarende symptomer. Patomekanismen ved læsionen er formentlig identisk med eksplosionsulykkesskader.

J: Oftalmologisk

10% klagede over øjensymptomer på torturtidspunktet.

Hyppigst var synsforstyrrelser af kortere varighed.

Øjenkatarsymptomer blev angivet i nogle tilfælde tilfælde og mentes at være forårsaget af »bañera« eller snavset stof, der blev brugt til blænding.

På undersøgelsestidspunktet påvistes få øjensymptomer der skønnedes at kunne relateres til tortur og fængslings perioder.

K: Stomatologisk

Akutte tandsymptomer bestod hovedsagelig af følgetilstande efter traumatiske tandfrakturer (13%) eller tandtab (9%).

Tandbehandling under tilbageholdelsen manglede oftest eller bestod udelukkende i ekstraktion af beskadigede tænder.

Dårlig mundhygiejne under tilbageholdelsen, uden mulighed for optimal tandpleje, kan forårsage en forværring af tandstatus.

Længerevarende symptomer drejede sig hovedsagelig om affektion af gingiva.

Undersøgelse af tyggemusklerne anbefales inkluderet i lægeundersøgelse af torturofre, idet andre har beskrevet fibrositis hos torturofre med stor frekvens.

KAPITEL VI. EXIL

Med henblik på exilets mulige indflydelse på torturofre, blev nærværende materiale inddelt i personer, som var undersøgt medens de boede i exil (n=111) og personer boende i deres hjemland på undersøgelsestidspunktet (n=89).

De to grupper kunne sammenlignes med alder og køn, men ikke hvad nationalitet angik. Den angivne tortur var ens i de to grupper fraset udsættelse for visse specielle torturformer som fx falanga. Symptomerne hukommelses-, koncentrationsnedsættelse, mareridt og depression fandtes signifikant hyppigere blandt de torturofre der levede i exil.

Forskellen i nationalitet søgtes mindsket ved at sammenholde chilenerne, der var undersøgt i Chile (n=18) med chilenere, der boede og var undersøgt i Danmark (n=54). De to grupper var ikke sammenlignelige med henblik på køn og alder, idet gruppen undersøgt i Chile var yngre og bestod af flere kvinder. Udsættelsen for tortur skønnedes ens i de to grupper, fraset at chilenerne undersøgt i Danmark hyppigere havde været udsat for ophængning såvel som længere varighed af den registrerede tortur. Symptomatologien i de to grupper var næsten sammenlignelige. Symptomet »generel træthed« blev imidlertid registreret hyppigere blandt chilenerne der boede i Chile. Fundene bør imidlertid fortolkes med forsigtighed,

da en del andre forskelle end exilet kan have påvirket resultatet. Den fundne lighed kunne imidlertid med de anførte forbehold antyde at torturfølgerne blandt flygtninge ikke er væsentlig forskellig fra torturfølgerne hos ofre, der ikke bor i eksil, men i et land, hvor tortur fortsat praktiseres.

KAPITEL VII. TORTURSYNDROM?

Visse torturformer medfører ret »specifikke torturrelaterede syndromer«:

Voldsomme slag mod hovedet kan resultere i »post-concussion« syndromet.

»Telefontortur« kan føre til læsioner af trommehinden på samme måde som efter eksplosionsulykker.

Slag kan forårsage hæmolyse og derved give hæmoglobinuri.

Stramme reb omkring håndleddene eller ophængning ved håndleddene kan beskadige de perifere nerver til hånden analogt til håndjernsneuropati.

Elektrisk tortur kan efterlade diagnostisk signifikante ændringer i huden som påvist i eksperimentelle dyrestudier, og cigaretbrænding efterlader karakteristiske hudforandringer.

Det er vurderet, hvorvidt der på baggrund af nærværende undersøgelse af torturofre kan eftervises forekomsten af et psykisk og neurologisk tortursyndrom forårsaget af den beskrevne henholdsvise psykiske og fysiske tortur. De hyppigst forekommende psykiske og neurologiske symptomer var 1. søvnforstyrrelser med eller uden mareridt, 2. irritabilitet, ændret stemningsleje og/eller angst, 3. nedsat koncentration, 4. hovedpine og 5. nedsat hukommelse. 40% fandtes i nærværende undersøgelse at klage over mere end 3 af ovennævnte 5 symptomer.

Der er fundet en høj incidens af både psykiske og neurologiske klager blandt de undersøgte torturofre. Uden en kontrolgruppe, er det imidlertid ikke muligt at afgøre, om symptomkonstellationen kan betegnes som et specifikt tortursyndrom. Yderligere undersøgelser er nødvendige for at klarlægge, hvorvidt symptomfundene hos torturofrene kan betegnes som et »tortursyndrom«, der specifikt adskiller sig fra andre belastningssyndromer.

En afklaring af terminologi og definitioner, specielt vedrørende torturofrenes symptombeskrivelse understreges.

Oprettelsen af et veldefineret tortursyndrom er ikke udelukkende af akademisk interesse. Dette kan meget vel være i torturofrets interesse, ved fx at lette opnåelse af skadeserstatning sådan som det er gældende ret for koncentrationslejrofre.

KAPITEL VIII. LÆGERS DELTAGELSE I TORTUR

Den lægelige professions deltagelse i tortur er veldokumenteret. I nærværende arbejde fortalte 41 ud af de 200 undersøgte torturofre, at læger var involveret i torturen. Forskellige grader af den lægelige medvirken fandt sted: 15 personer fortalte, at de var blevet undersøgt af en læge forud for torturen, 9 personer sagde, at medicin i ikke-terapeutisk øjemed var blevet anvendt imod dem, 10 personer sagde, at en læge havde været til stede under torturen, og 15 personer fortalte at de blev akut lægebehandlet pga. indtrådt bevidstløshed i forbindelse med torturen.

En klassifikation af lægelig medvirken i tortur kan inddeles i 3 grupper:

1. det at stille en diagnose
2. det at behandle ofret
3. det modsatte af profylaktisk arbejde samt direkte destruktiv virksomhed.

Eksempler på den 3. gruppe omfatter lægers udvikling af nye sofistikerede torturformer, udførelse af amputationer i straffeøjemed, medvirken ved dødsstraf og misbrug af psykiatri.

På trods af adskillige vidnesbyrd, hvorunder torturofre har kunnet identificere lægen, har der kun været meget få retslige opgør mod læger, der mistænkes for deltagelse i tortur.

De nationale lægeforeninger er ansvarlig for at sikre medlemmernes overholdelse af de etiske regler, og klare retningslinjer som fx Tokyo-deklarationen fungerer her som en utvetydig retningslinje. De nationale lægeforeninger bør imidlertid både nationalt og internationalt opfordres til at leve op til disse forventninger.

Læger, der findes skyldige i tortur, bør udelukkes fra at fungere som læge i noget land i verden.

Både internationale medicinske regerings- og ikke-regerings sammenslutninger foreslås at inkludere forebyggelse af tortur i deres handlingsprogrammer.

Specielt burde det påhvile WHO at medtage disse områder i sit sundhedsprogram.

KAPITEL IX. DEN LÆGELIGE PROFESSION MOD TORTUR

Relationen mellem den lægelige profession og tortur fremstår hovedsagelig i 3 former:

1. Rehabilitering og behandling af torturofre.
2. Forebyggelse af tortur.
3. Den lægelige deltagelse i udøvelse af tortur (behandlet i kapitel VIII).

Skønt rehabilitering og behandling af torturofre ligger uden for formålet med nærværende arbejde fremlægges en kort beskrivelse af de forskellige behandlingsskoler. I Chile påbegyndtes dette arbejde i 1973. Behandlingen omfattede hele familien, og specielle institutioner til behandling af børn blev oprettet. Politisk solidaritet blev anset for en væsentlig del af terapien.

Behandlingscentre inspireret af »den chilenske skole« er siden blevet oprettet forskellige steder i Europa, især med henblik på latinamerikanske flygtninge.

På AI's initiativ blev det uafhængige danske Rehabiliterings Center for Torturofre (RCT) dannet i 1982. Behandlingen blev baseret på individuel psykoterapi. Traditionel medicinsk forskning af behandlingsmodellen frembyder imidlertid mange både kulturelle og etiske problemer. Det fremhæves, at det er i både tidligere og kommende torturofres interesse, at fremtidig forskning af behandlingseffekten baseres på anvendelse af den højest mulige metodologiske standard.

Siden begyndelsen af 70'erne er der blevet udvist en stigende interesse for, hvordan den lægelige profession kan inddrages i arbejdet til forebyggelse af tortur. Den lægelige professions muligheder for at forebygge tortur på nationalt plan diskuteres. Både Læger og nationale lægeforeninger, som deltager i kampen mod tortur, løber imidlertid en stor risiko for selv at blive ofre for repression og tortur. International hjælp og beskyttelse er nødvendig til bevarelse af dette vigtige arbejde.

Der efterlyses en kraftfuld international lægelig organisation i arbejdet for forebyggelse af tortur, til at påtage sig opgaven at organisere og koordinere de forebyggende bestræbelser på globalt plan.

Verdenssundhedsorganisationen (WHO) fremhæves som den eksisterende organisation, der formentlig er bedst til at inkludere sådanne aktiviter i sit sundhedsprogram.

Vigtigheden af, at den lægelige profession sikres mulighed for at indberette de tilfælde af tortur, som den kommer i kontakt med, fremhæves som et vigtigt redskab i beskyttelsen af arresterede personer mod tortur.

Psykologer og læger har studeret uddannelsen til oplæring af torturudøvere. Sådanne studier er væsentlige til belysning af en regerings repressionsteknik. Studier af denne art anbefales intensiveret med det formål at påbegynde aktivt profylaktisk arbejde inden for militærets og politiets egne rækker.

Udnyttelsen af den lægelige profession i undersøgelsesrejser for at dokumentere torturovergreb anbefales.

RESUMEN EN ESPAÑOL

El horror de la tortura está tan vinculado a la locura, al dolor, al sufrimiento y a las pesadillas, que aquellos que no la han experimentado en su propio cuerpo, nunca llegaran a comprenderla cabalmente.

CAPITULO I: INTRODUCCION Y OBJETIVOS

En el presente estudio, se presenta brevemente el aspecto histórico de la tortura y se enfatizan las principales diferencias entre la práctica de la tortura antigua (Ej.: la Inquisición) y la práctica actual:

1. Antiguamente la tortura era aceptada, hoy en día no.
2. Antiguamente se llevaba a cabo en público, hoy en secreto.
3. Antiguamente se efectuaba después de un procedimiento "legal", hoy en día es arbitraria.

Se han utilizado, entre otras, las definiciones de tortura de las Naciones Unidas y de la Asociación Médica Mundial. Estas se discuten, argumentandose que la definición de la Asociación Médica Mundial es la más relevante para la profesión médica y por ende, la que se aplicará en la presente investigación.

En 1973 se inició el trabajo médico contra la tortura en Amnistía Internacional y en 1974, se creó el primer Grupo Médico de la organización en Dinamarca. Se presenta un breve esbozo de los diferentes estudios publicados por este grupo.

El autor de la presente investigación ha participado activamente en el trabajo médico contra la tortura desde 1974, y este libro fue escrito para satisfacer el creciente deseo de compilar el conocimiento acumulado y las recomendaciones sobre la materia. Tanto los puntos de vista como las conclusiones expresadas son del autor, y no representan necesariamente los de la organización para la cual ha trabajado.

El objetivo de este estudio incluye cuatro temas específicos:

1. Describir diferentes tipos de tortura y los síntomas y lesiones resultantes, en base a fichas médicas provenientes de exámenes efectuados a 200 personas que manifestaron haber sido torturadas. Evaluar las consecuencias de la tortura, teniendo en cuenta el significado del diagnóstico y la salud de la persona, y relacionar los resultados con el conocimiento acumulado hasta hoy sobre el tema.
2. Evaluar la influencia del exilio en los problemas de salud de las víctimas de la tortura.
3. Describir el grado y frecuencia de participación de los médicos en la tortura, utilizando los datos de este estudio.
4. Describir la relación existente entre la profesión médica y la tortura, y proponer formas adicionales mediante las cuales los médicos puedan contribuir a la prevención de la tortura.

CAPITULO II: METODO

Se describe el procedimiento para examinar a víctimas de la tortura. Los exámenes médicos fueron efectuados por 25 médicos daneses de diferentes especialidades y antecedentes. Dos médicos del grupo realizaban el examen, excepto en contadas oportunidades, y en la mayoría de los casos, lo hacían con la ayuda de un intérprete. En Dinamarca se llevaron a cabo 82 exámenes, y el resto durante misiones a otros países.

A medida que el Grupo Médico adquiría mayor experiencia, las técnicas de entrevista y el sistema de información se perfeccionaba constantemente. Por otra parte, los nuevos médicos que ingresaban al equipo, pasaban por un período de entrenamiento durante el cual examinaban a víctimas de la tortura junto con un investigador experimentado.

Los datos de las 200 víctimas de la tortura examinadas se archivaron en una base de datos electrónica. Se describe el manejo de los datos faltantes. Si la frecuencia de respuesta era menor que un 75%, no se realizaba una evaluación estadística adicional.

El test de Mantel-Haenszel se utilizó para la evaluación estadística una vez efectuada la estratificación, con la finalidad de evitar posibles confusiones. Se aplicó además, el test de sumatoria de rangos de Wilcoxon, para parear los datos y evaluar la distribución de edad (SAS Statistical Library, NEUCC).

En este capítulo se mencionan también, otras formas existentes para examinar a víctimas de la tortura. Se presentan ejemplos de un cuestionario de auto-información y un protocolo de recolección de datos para ser utilizados por médicos locales en países en los que se practica la tortura.

CAPITULO III: MATERIAL

De este estudio se excluyeron 19 personas de las 219 examinadas por el Grupo Médico danés desde su formación hasta mayo de 1982: 12 debido a que su tratamiento no correspondía al criterio de tortura y 7 porque la información era insuficiente. Las 200 personas incluídas, 39 mujeres y 161 hombres, pertenecían a 19 nacionalidades y fueron torturadas en 18 países. Los grupos más numerosos habían sido torturados en Chile, Grecia y España. En general, las personas examinadas eran jóvenes (un promedio de 30 años en el momento del examen médico), y tenían un buen nivel educacional cuando fueron detenidos (cerca de 2/3 con estudios técnico-profesional o secundario-universitario). Solo un 4% eran ì cesantes. La mitad de ellos eran solteros y los otros comprometidos o casados.

Los exámenes se efectuaron en diversos períodos, después de la denuncia de tortura (media = 2 años; rango = 3 días a 12 años).

El estado de salud antes del arresto era bueno. Un 86% manifestó no haber tenido ninguna enfermedad grave. Solo 2 personas mencionaron haber tenido algún tipo de trastorno psíquico antes del arresto.

CAPITULO IV: TIPOS DE TORTURA DECLARADAS

Se presentan los tipos de tortura a las que fueron sometidas las personas mencionadas según sus declaraciones. Estos han sido clasificados en métodos de tortura física y psíquica, sin embargo, encontramos una considerable superposición.

La tortura y los malos tratos ocurrieron principalmente durante los primeros días de cautiverio. La media, en cuanto a días de tortura por persona, era de cinco (rango = 1 a 250 días).

Sin duda, el método de tortura física más comunmente aplicada, eran los golpes. El 99% de las personas examinadas informaron haber sido golpeadas. El 95% declaro que los golpes incluían severas golpizas con los puños, con algún instrumento, o patadas. El 73% recibió fuertes golpes en la cabeza y el 29% informó haber recibido severos golpes en las plantas de los pies (falanga), particularmente en Grecia e Irak. Golpes simultáneos en ambos oídos con las palmas de las manos (teléfono), fueron reportados por un 9% de los examinados.

El 54% fue sometido a torturas con electricidad, especialmente en Chile y Uruguay, la que a menudo se aplicaba a partes sensibles del cuerpo; un 50% incluía los genitales.

El colgamiento fue aplicado en 50 personas, de las cuales 20 experimentaron el tipo especial denominado "la barra" o "Pau de arara": las muñecas se atan juntas por debajo de las rodillas e introducen una barra detrás de las mismas y frente a los codos, la barra se levanta y la víctima, cuya cabeza queda colgando hacia abajo, es a menudo torturada de otra manera: con electricidad, golpes o falanga.

La tortura con agua (bañera o submarino húmedo) fue descrita de la siguiente forma: la persona es forzada a introducir la cabeza en una bañera que contiene agua inmunda y la dejan allí hasta cuando esta casi a punto de ahogarse. El submarino seco consiste en colocar una bolsa plástica en la cabeza de la víctima, hasta el punto de ser casi asfixiada.

El abuso sexual fue reportado por 2 hombres y 5 mujeres; 2 de ellas fueron violadas por varios de sus interrogadores. Ocho

mujeres y 12 hombres manifestaron haber sido violados mediante la introducción de un objeto.

Otros tipos de tortura física consistían en obligar a la víctima a tomar posiciones corporales incómodas durante largo tiempo, gimnasia forzada, sometimiento a temperaturas extremas, quemaduras con cigarrillos, extracción de las uñas, etc.

Los tipos de tortura psíquica más frecuentes incluían amenazas de, por ejemplo, continuar las torturas, de ejecución, y de arresto o tortura de la familia, incluyendo a los niños. El 60% de las víctimas sufrieron amenazas de ejecución, y el 43% de ellas contra su familia o amigos. Casi un tercio de las personas examinadas dijeron haber sido sometidas a simulacros de fusilamiento.

Muy frecuentes fueron las declaraciones sobre la utilización de técnicas de privación del sueño, interrogatorios por períodos prolongados y privación de agua y alimentos.

Un 20% manifestó haber soportado humillaciones mediante insultos con connotación sexual y un 45% habían sido desnudados durante el interrogatorio.

En 9 casos se reportó la administración de drogas no terapéuticas y se da un detalle al respecto. Un 13% manifestó que en los interrogatorios notaron cambios de actitud: aparente amabilidad (un hombre bueno), entre sesiones de tortura. El 75% fue sometido a confinamiento solitario por un período promedio de 2 semanas (rango = 1 a 274 días).

CAPITULO V: SINTOMAS Y SIGNOS

Se presentan los síntomas inmediatos posteriores a la tortura, los síntomas en el momento del examen médico y sus resultados. Se hace un análisis de los diferentes métodos de tortura infligidas y su relación con los síntomas y lesiones que presentaban las víctimas. Se evalúa la importancia del diagnóstico de acuerdo a las secuelas y su influencia en la salud de la persona, relacionandolo con el conocimiento acumulado sobre el individuo. Se hace esta presentación de acuerdo a los órganos afectados:

A: Dermatológicos

El 70% de las víctimas de la tortura examinadas informaron que se les produjeron lesiones agudas en la piel inmediatamente después de la tortura. En particular, el método de tortura que dejaba este tipo de lesiones eran los golpes, las quemaduras y la electricidad.

La importancia principal de los cambios en la piel es que pueden sustentar alegatos de tortura, y los exámenes médicos de estas lesiones agudas presumiblemente otorgan mejores evidencias que los exámenes realizados varios años más tarde. Se presentan los cambios tardíos y profundos característicos luego de la tortura con electricidad y se comparan con estudios experimentales realizados con cerdos totalmente anestesiados.

Las lesiones más características se producían luego de quemaduras y tortura con electricidad, de estos dos métodos, el primero deja lesiones permanentes con más frecuencia que el último.

B: Cardiopulmonares

La forma más común de tortura en relación al pecho era un traumatismo torácico. Diez víctimas informaron haber sufrido fracturas óseas, mientras dos hombres presentaban hemotórax y uno neumotórax.

Algunas personas se vieron afectadas por síntomas pulmonares agudos a causa del submarino húmedo. Durante el examen, 42 personas se quejaron de síntomas cardiopulmonares y con mayor frecuencia de dolores en el pecho, dolores que en aproximadamente la mitad de los casos pudieron corroborarse con las torturas denunciadas. En el caso de 15 personas, no pudieron detectarse causas orgánicas y los síntomas se clasificaron como vegetativos.

Las malas condiciones de prisión incrementaron las infecciones pulmonares agudas y la tuberculosis en algunas de las víctimas.

C: Gastrointestinales

En las autopsias se han encontrado lesiones intra-abdominales mortales luego de torturas. En el presente estudio no se registraron heridas intra-abdominales traumáticas graves. Los traumas abdominales severos y los síntomas inmediatos estaban localizados en la pared abdominal.

Poco más de la mitad de las personas examinadas manifestaron haber perdido peso, un promedio de 10 kilos (rango = 2 a 36). Seis personas declararon hematemesis en relación a la tortura. Durante la detención, 59 personas sufrieron alteraciones en el tránsito intestinal y 41, vómitos. Quince se quejaron de dolor o sangramiento, o ambos, en la región perineal, después de la tortura.

Los síntomas gastrointestinales en el momento del examen eran comparables a los de la población normal.

D: Músculo-esqueléticos

Se registraron síntomas agudos en el sistema locomotor después de la tortura con una alta frecuencia (81%), especialmente como consecuencia de golpes severos. 26 personas sufrieron fracturas y 15 fueron ingresadas a un hospital.

Los métodos de tortura especiales dieron como resultado síntomas específicos más bien agudos. Estos se describen considerando diferentes formas de suspensión o colgamiento, como: el "Pau de arara", la "motocicleta", el "quirófano", y la falanga. La tortura descrita como falanga producía tanto síntomas agudos como de prolongada duración. El desarrollo de un síndrome agudo en los pies debido a la falanga, se explica en base a la fisiopatología.

Aparte de las secuelas causadas por la falanga, solo unos pocos cambios persistentes podrían relacionarse específicamente con la tortura, ya que la mayoría de los síntomas y anomalías eran inespecíficos y no ocurrían con una frecuencia más alta en víctimas de la tortura que en la población danesa normal.

Los exámenes de rayos-x para documentar las fracturas constituyen un valioso aporte para sustentar los alegatos de tortura, a menudo independiente del período de examen.

E: Neurológicos

Los síntomas neurológicos en el momento de la tortura fueron descritos por el 75% de las personas examinadas, siendo la cefalea el más frecuente.

Cerca del 20% de las víctimas que manifestaron traumatismo encefalocraneano, perdieron el conocimiento. Esta pérdida de conciencia era frecuente encontrarla, aunque no relacionada con el trauma craneal, sino como consecuencia del dolor, del agotamiento, o debido a otras razones (31%).

Se detectaron pocos casos de heridas en la cabeza con fractura de craneo, hemorragias intra-craneales o laceración cerebral. Un 23% se quejó de síntomas agudos en el nervio periférico. En la mayoría de los casos estos síntomas se relacionaban con la presión ejercida por las esposas o sogas al atar las muñecas, o también, en otros casos, luego de tortura con electricidad o falanga. En un 12% de los casos estos síntomas eran persistentes.

En el momento del examen, un 64% padecía de síntomas neurológicos, entre los cuales los más frecuentes eran cefalea, pérdida de concentración o atención y alteraciones de la memoria.

Durante el examen, se pudo demostrar la relación existente entre lesiones severas en la cabeza y pérdida de conciencia y, entre alteraciones a la memoria y cefalea. En algunos casos se pensó que las personas que se quejaban de síntomas neurológicos podrían tener un síndrome postcontusión debido a un daño orgánico cerebral, pero en la mayoría de los casos, los golpes recibidos no eran de naturaleza tan severa como para que éste se desarrollara.

En esta investigación se comparan los síntomas neurológicos con las secuelas producidas por otras situaciones de mucha tensión. Se sugiere que otros factores, además de los golpes en la cabeza, pueden incidir en el desarrollo de síntomas neurológicos profundos y prolongados. El miedo excesivo y la ansiedad normalmente producen un estado de alerta en el hombre. Se plantea que este mecanismo de alerta ha sido alterado de tal forma en las víctimas de la tortura, que una pequeña dosis de miedo produce una hiper- reacción.

F: Psiquiátricos

El horror de la tortura está tan vinculado a la locura, al dolor, al sufrimiento y a las pesadillas, que aquellos que no la han experimentado en su propio cuerpo, nunca llegaran a comprenderla cabalmente. Existen algunos "lenguajes" alternativos como películas, poemas, pinturas, etc., que nos han ayudado a incrementar la comprensión y percepción de la tortura. Sobre esta base, se presentan los síntomas psíquicos en el momento de la tortura.

Además del miedo que produce el arresto y la tortura, el 68% de las personas examinadas, relataron haber padecido síntomas psíquicos al ser torturadas, entre los más frecuentes encontramos alteraciones del sueño, pesadillas y una profunda ansiedad.

Se da un detallado recuento de alucinaciones descritas por 14 personas. De 6 personas ingresadas a hospitales psiquiátricos, 4 padecían de alucinaciones, y un total de 21 recibieron tratamiento psiquiátrico inmediatamente después de ser liberadas.

Como se ha mencionado, en el momento del examen, el 68% se quejó de padecer síntomas psíquicos, siendo los más frecuentes las alteraciones del sueño, sin embargo, también eran frecuentes las pesadillas, la irritabilidad y los cambios en el estado de ánimo. De éstas, 24 personas tenían problemas sexuales, 28 estaban deprimidas, mientras que 13, tenían un comportamiento pasivo y no respondían. Solo una persona fue agresiva y 8 mostraban una inestabilidad fuera de lo normal.

La frecuencia de estos síntomas no puede relacionarse con la edad de las víctimas o con el hecho de haber experimentado torturas especiales, pero aquellos que en el momento del examen manifestaron estos síntomas, eran los que a menudo habían sufrido amenazas y simulacros de fusilamiento.

Los síntomas psíquicos descritos en esta investigación son similares en muchos aspectos a otros estudios sobre víctimas de la tortura, o a los de aquellas personas que padecieron profundas alteraciones, tales como marinos de guerra, víctimas de campos de concentración, etc.

G: Urológicos y genitales

Un 25% acusó síntomas renales o vesicales, o ambos, en el momento de la tortura. Lo más común era hematuria y disuria. La hematuria podría explicarse por las lesiones directas en la región genital y renal. Algunos casos de "hematuria" probablemente eran de hemoglobinuria causada por los golpes, un mecanismo similar al de la "hemolisis de los corredores". La causa de la disuria pudo ser la utilización de instrumentos de tortura en algunos casos, y en otros el frío, sumado a las malas condiciones higiénicas. En el momento del examen, los malestares de estas personas, a los riñones o a la vejiga, no eran más frecuentes que en otros grupos de control de víctimas de la tortura.

H: Ginecológicos

24 de las 39 mujeres examinadas en el presente estudio (61%), refirieron síntomas en el área genital producidos en el momento de la tortura. El síntoma más frecuente era una alteración del ciclo menstrual. La amenorrea se detectó en más del 25% de las víctimas. Se sabe que la amenorrea, inducida por el miedo, es causada por una falla en la pituitaria hipotalámica que disminuye la secreción de las hormonas gonadotrópicas. El mismo mecanismo tiene que ver probablemente con las alteraciones de la menstruación en las víctimas de la tortura.

Dos de estas mujeres estaban embarazadas cuando fueron arrestadas y ambas comenzaron a sangrar luego de ser brutalmente torturadas. Una de ellas tuvo un aborto espontáneo mientras estaba en prisión, y la otra dio a luz en las mismas condiciones.

Cinco mujeres presentaban inflamación en el área genital, y dos de ellas fueron violadas.

El 61% de las mujeres se quejaron de seguir padeciendo síntomas en el área genital en el momento del examen, especialmente alteraciones en la menstruación. No se han encontrado en la literatura análisis hormonales efectuados a mujeres víctimas de la tortura.

I: Otorrino-laringológicos

Las secuelas de la tortura están asociadas principalmente a la función auditiva. El "teléfono", en particular, produce síntomas inmediatos y prolongados en las víctimas, similares a nuestro entender, a aquellas heridas causadas por explosiones.

J: Oftalmológicos

Un 10% presentó síntomas oculares al ser torturados, los que generalmente consistían en alteraciones visuales de corta duración. En pocos casos se registró conjuntivitis, debido a la utilización de vendas sucias para tapar la vista y al tipo de tortura denominado "bañera". Se encontraron solo algunos casos de síntomas oculares relacionados a la tortura o detención, en el momento del examen.

K: Odontológicos

Los síntomas odontológicos agudos registrados, fueron causados por heridas traumáticas con resultado de fracturas (13%) o pérdida de piezas dentales (9%).

El tratamiento dental durante la detención era a menudo escaso o se limitaba a la extracción de piezas dentales dañadas. Las causas del deterioro dental, pudieron ser las malas condiciones de higiene oral y la falta de óptima limpieza durante la detención. Los síntomas prolongados se debían principalmente a afecciones a las encías (gengivitis).

Se recomienda examinar los músculos masticatorios en víctimas de la tortura, ya que se registró una alta frecuencia de fibrositis.

CAPITULO VI: EXILIO

Con el objeto de estudiar la posible influencia del exilio en víctimas de la tortura, se ha dividido el presente material en aquellas personas que fueron examinadas mientras vivían en el exilio (n = 111) y las que vivían en su país de origen al momento de ser examinadas (n = 89).

Ambos grupos eran comparables en cuanto a edad y sexo, pero muy disímiles en relación al país de origen. Se encontraron algunas diferencias en cuanto al hecho de ser expuestos a ciertos tipos especiales de tortura (ej.: falanga). Las alteraciones a la memoria, la falta de concentración y las pesadillas, tenían una frecuencia significativa en las víctimas que vivían en el exilio.

Se hizo una comparación entre chilenos que vivían y que fueron examinados en Chile (n = 18), con chilenos que vivían y fueron examinados en Dinamarca (n= 54). Los que fueron examinados en Chile eran más jóvenes y había un porcentaje mayor de mujeres, sin embargo, el tipo de torturas a las que habían sido sometidos, eran similares en ambos grupos. Por otra parte, los chilenos examinados en Dinamarca habían experimentado el tipo de tortura de suspensión o colgamiento con más frecuencia, y habían sido torturados por períodos más prolongados. La sintomatología de ambos grupos era también muy similar, excepto el "cansancio generalizado" que se daba más frecuentemente entre los que vivían en Chile.

Estos hallazgos deberían interpretarse con gran precaución, ya que una cantidad de variables pudieron haber influido en los resultados. Sin embargo, considerando la poca diferenciación en la sintomatología de los dos grupos, las secuelas de la tortura en los refugiados no debiera ser muy diferente a las que presentan las víctimas que viven en su propio país, en donde aún se practica la tortura.

CAPITULO VII: ¿SINDROME DE LA TORTURA?

Algunos métodos de tortura producen secuelas bastante específicas, por lo cual se sugiere que podrían denominarse "síndromes específicos de la tortura":

- Los golpes fuertes en la cabeza pueden producir un síndrome postconcusión.
- El "teléfono" puede causar lesiones en la membrana del tímpano, similares a aquellas provocadas por explosiones.

- Los golpes pueden dañar los glóbulos rojos y por lo tanto provocar hemoglobinuria, similar a la "hemolisis de los corredores".
- Atar con cuerdas, maniatar, o colgar de las muñecas, puede producir daños a los nervios periféricos de la mano, en una forma similar a la neuropatía causada por esposas.
- La tortura con electricidad puede dejar alteraciones significativas en la piel, similares a aquellas demostradas en estudios experimentales con animales.

Se examina el establecimiento de un posible síndrome de la tortura, mental y psicológico, causado ya sea por tortura física o psíquica, o por una combinación de ambas.

El padecimiento de síntomas mentales y neurológicos eran usuales en las víctimas de tortura examinadas, siendo los más comunes los siguientes:

1. alteraciones del sueño con o sin pesadillas,
2. irritabilidad, cambio de estados de ánimo y/o ansiedad,
3. problemas de concentración,
4. cefaleas, y
5. pérdida de la memoria.

De todas las personas que integraron este estudio, un 40% acusó más de tres de los cinco síntomas mencionados.

Se concluyó que se necesitan mayores estudios para clarificar si los síntomas que presentan las víctimas de la tortura constituyen un síndrome específico de la tortura, diferente de otros posteriores a situaciones de mucha tensión. Se enfatiza la necesidad de una clarificación de la terminología y de las definiciones, especialmente aquellas que se refieren a la descripción de los síntomas por parte de las víctimas.

La creación de un síndrome de la tortura bien definido no solo tiene un interés académico, sino que podría beneficiar a las víctimas de la tortura, al otorgarles por ejemplo, una compensación por daños, similar a la que se ha establecido para las víctimas de los campos de concentración.

CAPITULO VIII: PARTICIPACION MEDICA EN LA PRACTICA DE LA TORTURA

La participación de los profesionales médicos en la tortura está bien documentada. En el presente estudio, 41 de las 200 víctimas examinadas denunciaron la participación de personal médico en las torturas infligidas. Existían niveles variables de participación: 15 personas sostuvieron haber sido examinadas por un médico antes de ser torturadas, 9 dijeron que se les administraron drogas no terapéuticas, 10 manifestaron que un doctor estaba presente durante la tortura, y 15 recibieron atención médica debido a la pérdida de conciencia durante el proceso de tortura.

Las formas en que un médico puede participar o involucrarse en la práctica de la tortura, pueden clasificarse como sigue:

1. Hacer un diagnóstico.
2. Atender a la víctima.
3. Lo opuesto al trabajo profiláctico.

Este último grupo incluye a médicos que participan en la creación e invención de nuevos y sofisticados métodos de tortura: en amputaciones punitivas, en llevar a cabo la pena de muerte, y en el abuso de la psiquiatría.

A pesar de numerosos testimonios en los que víctimas de la tortura han identificado a los médicos participantes, se han realizado muy pocas acciones legales.

Las asociaciones médicas nacionales son responsables de la conducta ética de sus miembros, y declaraciones de mucha claridad, como la de Tokio, sirven de guía. Las asociaciones médicas nacionales deberían ser estimuladas por todos los medios, tanto nacionales como internacionales, para impulsar estas iniciativas.

Se recomienda que a los médicos que se les ha encontrado culpables de torturas, no se les permita ejercer su profesión, en ningún país del mundo.

Las organizaciones médicas internacionales gubernamentales y no gubernamentales deben ser alentadas para que incorporen la prevención de la tortura en sus programas. Se recomienda en forma especial que la Organización Mundial de la Salud (OMS) incluya este aspecto en sus programas de actividades.

CAPITULO IX: LA PROFESION MEDICA CONTRA LA TORTURA

El rol de los médicos en relación a la tortura, puede dividirse en tres categorías:

1. El tratamiento y rehabilitación de las víctimas de la tortura.
2. La prevención de la tortura.
3. Trabajar contra la participación médica en la tortura (este punto se trató en el capítulo VIII).

Aunque el tratamiento de las víctimas de la tortura está fuera de los parámetros de este estudio, se hace una breve presentación de las diferentes "escuelas".

La rehabilitación y tratamiento de víctimas de la tortura se inició en Chile en 1973. Toda la familia era incorporada al tratamiento y éste también incluía solidaridad política. Se crearon además, centros de tratamiento para niños.

En diferentes lugares de Europa se han establecido centros de tratamiento especialmente dirigidos a refugiados latinoamericanos, bajo la inspiración de la "Escuela Chilena".

En 1982, como iniciativa de Amnistía Internacional, se fundó un centro danés independiente para el tratamiento y rehabilitación de víctimas de la tortura. El tratamiento se basaba en psicoterapia individual, pero en las pautas para la investigación médica se enfrentaron algunos inconvenientes de tipo cultural y ético.

Por el interés en las víctimas (pasado, presente y futuro), es importante enfatizar que en la investigación del tratamiento de las víctimas de la tortura, deberán aplicarse pautas metodológicas al más alto nivel posible.

El interés ha ido incrementandose desde la década del setenta, de manera que los médicos pueden colaborar en la prevención de la tortura. La profesión puede jugar un rol protagónico y aquí se presenta este aspecto y otros aspectos diferentes del trabajo a nivel nacional. Cuando los médicos participan en la lucha contra la tortura, tanto ellos como las organizaciones médicas nacionales corren un gran riesgo. Es necesario todo el apoyo y la protección internacional para que esta importante labor pueda continuar.

Se hace un enérgico llamado a las organizaciones médicas internacionales para que trabajen en la prevención de la tortura y para que organicen y coordinen actividades en todo el mundo. De las organizaciones existentes, la Organización Mundial de la Salud (OMS), es probablemente la más idónea para incorporar tales actividades en su programa.

Por otra parte, la profesión médica puede jugar un importante rol denunciando casos de tortura, pero aún más importante, ésta podría ser un instrumento muy efectivo en la protección de los detenidos.

Psicólogos y médicos han estudiado los sistemas educacionales que crean torturadores. Tales estudios son importantes para dilucidar los diferentes mecanismos que actúan amparados por las técnicas de represión del estado, y merecen ser intensificados para implementar un trabajo profiláctico activo dentro de los organismos policiales y militares, responsables de la tortura.

En cuanto a la recolección de información, se recomienda enviar médicos a misiones para recaudar información en terreno.

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APPENDIX II. METHOD

DRAFT FOR TORTURE REPORT

(as used by the Danish Amnesty International medical group).

1. DATE OF EXAMINATION
Examiners:
Interpreter:
Report by:
Prisoner's name/No.:
Age: Sex:
Occupation:
Other present:

2. BRIEF PRESENTATION OF PRISONER
A very brief summary of the course of events to give an immediate impression of the case and the length of time the prisoner has spent in this country.

3. BACKGROUND
Including social conditions, family.

4. PREVIOUS DISEASES AND STATE OF HEALTH BEFORE THE ARREST
Ordinary history-taking as for a medical record.

5. ARREST AND ACCUSATION

6. CONDITIONS IN PRISON
In the event of different prisons or cell, describe each separately:
Size, number of prisoners, type of prisoners.
Conditions in cell:
Size
Number of prisoners in cell
Lighting
Temperature
Sanitation
Food
Furnishing
Sanitary conditions.
Access to medical aid, visiting, warders, informers.

7. INTERROGATION AND TORTURE
Itemized classification and detailed description of torture methods.

8. SYMPTOMS AFTER TORTURE
Detailed description of visible changes on the body as well as subjective sensations. State, if possible, the duration of each symptom.

9. KNOWLEDGE OF OTHER TORTURE METHODS

10. STATE OF HEALTH IN OTHER RESPECTS DURING STAY IN PRISON

11. FAMILY CONDITIONS

12. TRIAL, SENTENCE, FURTHER COURSE

13. PRESENT SYMPTOMS AND SIGNS

14. BRIEF SUMMARY AND CONCLUSION OF PHYSICAL EXAMINATION

CHECK-LIST FOR OBJECTIVE MEDICAL EXAMINATION

(used by the Danish Amnesty International medical group).

Name: _____
Profession: _____
Age: _____ Male/female _____
Pregnant: _____
Race: Cauc. /Mong. /Negr. /Other _____
Colour: _____
Height: _____ cm Weight: _____ kg
Bloodpressure: _____ / _____ mm Hg
Pulse: _____ /min

State of nutrition: much below average/below average/average/above average.
Febrile (if possible temp.) _____ C
Dehydration
Excessive exhaustion
Mobile/immobile (detailed description)
Influence of drugs

PSYCHE:

Neutral
Apathetic
Excited
Hallucinated (detailed description)
Anxiety

PHYSICAL EXAMINATION:

Skin of head.
Bruises
Excoriations
Wounds (possibly caused by burning with cigarettes)
Stings (possibly caused by injections)
Ulcerations
Scars
Characteristic marks left by electrodes
Hair growth (hair pigmentation, loss of hair)
Lice
Other lesions
Abnormal pigmentation of skin or hair

Skin of body.
Bruises
Excoriations
Wounds (possibly caused by burning with cigarettes)
Stings (possibly caused by injections)
Ulcerations
Abnormal pigmentation of skin or hair
Scars
Characteristic marks left by electrodes
Hair growth
Lice, scabies
Other lesions

Skin of extremities.
Bruises
Excoriations
Wounds (possibly caused by burning with cigarettes)
Stings (possibly caused by injections)
Ulcerations
Scars
Characteristic marks left by electrodes
Abnormal pigmentation of skin or hair
Nails
Scabies
Other lesions

Skull.
Soreness
Palpation of skull (possible contour discontinuity)
Dental alignment

Eyes.
Bilateral orbital effusion
Subconjunctival haemorrhages
Conjunctivitis
Pupils- size, form, reaction
Eye movements

Tongue, throat, teeth.
Mucous membrane (tongue bite)
State of teeth (number of teeth present)

Ears.
Discharge
Deformity of extermal ears
Otoscopy (hemorrhage/rupture, lesion of internal meatus)

Vertebral column.
Mobility
Direct soreness
Indirect soreness
Deformity

Thorax.
Mobility
Direct soreness
Indirect soreness
Subcutaneous emphysema
Ribs (fracture)
Clavicles

Breasts.

Ausculation of heart:

Abdomen. Soreness (especially renal regions)
Peritoneal reaction (defense)
Ascites
Organ swelling

External genital organs.
Scrotal swelling
Lesion of penis/vulva
Inguinal lymph node swelling
Urine sample

Gynaecological examination.
Lesion of mucous membrane
Signs of pregnancy

Proctoscopy
Lesion of mucous membrane

Extremities.
Mobility
Direct soreness
Indirect soreness (note soles of feet)
Oedema
Deformities

Neurological examination of extremities.
Finger-to-nose test
Heel-to-knee test
Biceps reflexes
Patellar reflexes
Achilles reflexes
Plantar reflexes
Diadochokinesia
Lasegue sign
Tremor
Gait
Muscular tonus, strength, fibrillations
Sensation

Additional or supplementory comments:

EXAMINING DOCTORS AND DENTISTS IN THE DANISH AMNESTY INTERNATIONAL MEDICAL GROUP IN THE PERIOD: APRIL 1975 TO MAY 1982:

DOCTORS:

Abildgaard U. Bech, Bro-Rasmussen F, Cohn J, Dam AM, Daugaard K, Genefke IK, Hyldebrand N, Jacobsen N, Jess P, Kelstrup J, Kjaersgaard AaR, Lindholm J, Kosteljanetz M, Marcussen H, Nielsen IL, Petersen EK, Petersen HD, Rabbe Å, Rasmussen OV, Severin B, Stadler H, Thorvaldsen P, Wallach M, Weile B.

DENTISTS:

Brandt H, Jacobsen G, Jerlang P, Marstrand P.

SELF REPORTING QUESTIONNAIRE USED BY ALLODI:

(reproduced by courtesy of Dr. Federico Allodi, Canada).

PART A:

1. Marital Status: 1. Married ( )
   2. Single ( )
   3. Divorced/Separated ( )
   4. Widow/er ( )
   5. Common law ( )
2. Sex: 1. Male ( )
   2. Female ( )
3. Age: _____ years
4. Country of origin: 1. Argentina ( )
   2. Colombia ( )
   3. Chile ( )
   4. Ecuador ( )
   5. Uruguay ( )
   6. El Salvador ( )
   7. Other country, specify: _____
5. Number of years of formal schooling (including college and university): _____ years
6. Type of diploma or degree: 1. Vocational or technical ( )
   2. Professional or academic ( )
   3. None ( )
7. Number of years of formal schooling (including college and university) for spouse: _____ years
8. Type of diploma or degree for spouse:
   1. Vocational or technical ( )
   2. Professional or academic ( )
   3. None ( )
9. Year of arrival in Canada: _____
10. Primary motive for immigration: 1. Political ( )
    2. Personal, family or other motive ( )
11. Current legal status in Canada: 1. Refugee Status ( )
    2. Landed Immigrant ( )
    3. Canadian Citizen ( )
    4. Minister Permit ( )
    5. Student Visa ( )
12. Respondent living with:
    1. Alone ( )
    2. Spouse and children, if any ( )
    3. Spouse and children, if any, and other relatives ( )
    4. Only with children ( )
    5. Only with other relatives ( )
    6. Other arrangement, specify: _____
13. Number of children: _____
14. Number of adults: _____
15. Occupation of respondent:
    1. Professional or managerial ( )
    2. Clerical, including some supervisory grades ( )
    3. Skilled manual ( )
    4. Semi-skilled or unskilled ( )
    5. Other, specify: _____
16. Occupation of spouse:
    1. Professional or managerial ( )
    2. Clerical, including some supervisory grades ( )
    3. Skilled manual ( )
    4. Semi-skilled or unskilled ( )
    5. Other, specify: _____
17. Please indicate if spouse: 1. Currently working ( )
    2. Currently unemployed ( )
    3. Other ( )
18. Highest occupational status in country of origin:
    1. Professional or managerial ( )
    2. Clerical, including some supervisory grades ( )
    3. Skilled manual ( )
    4. Semi-skilled or unskilled ( )
    5. Other, specify: _____
19. How do you consider your command of the English language:
    1. Speak fluently, write and read without difficulty ( )
    2. Speak, write and read with some difficulty ( )
    3. Speak with difficulty, almost do not read and do not write ( )
    4. Do not speak, read or write English ( )

PART B:

IN THIS SECTION WE ARE INTERESTED IN LEARNING ABOUT YOUR HEALTH AND CURRENT MOOD. PLEASE INDICATE WITH AN X THE ANSWER THAT BEST DESCRIBES YOUR SITUATION

20. Do you have headaches often? 1. Yes ( ) 2. No ( )
21. Is your appetite poor? 1. Yes ( ) 2. No ( )
22. Do you sleep badly? 1. Yes ( ) 2. No ( )
23. Are you easily frightened? 1. Yes ( ) 2. No ( )
24. Do your hands shake? 1. Yes ( ) 2. No ( )
25. Do you feel nervous, tense or worried? 1. Yes ( ), 2. No ( )
26. Is your digestion poor. 1. Yes ( ) 2. No ( )
27. Do you have trouble thinking clearly? 1. Yes ( ), 2. No ( )
28. Do you feel unhappy? 1. Yes ( ), 2. No ( )
29. Do you cry more than usual? 1. Yes ( ), 2. No ( )
30. Do you find it difficult to enjoy your daily activities? 1. Yes ( ), 2. No ( )
31. Do you find it difficult to make decisions? 1. Yes ( ), 2. No ( )
32. Is your daily work suffering? 1. Yes ( ), 2. No ( )
33. Are you unable to play a useful part in life? 1. Yes ( ), 2. No ( )
34. Have you lost interest in things? 1. Yes ( ), 2. No ( )
35. Do you feel that you are a worthless person? 1. Yes ( ), 2. No ( )
36. Has the thought of ending your life been in your mind? 1. Yes ( ), 2. No ( )
37. Do you feel tired all the time? 1. Yes ( ), 2. No ( )
38. Do you have uncomfortable feelings in your stomach? 1. Yes ( ), 2. No ( )
39. Are you easily tired? 1. Yes ( ), 2. No ( )

---

40. Do you feel that somebody has been trying to harm you in some way? 1. Yes ( ), 2. No ( )
41. Are you a much more important person than most people think? 1. Yes ( ), 2. No ( )
42. Have you noticed any interference or anything unusual with your thinking? 1. Yes ( ), 2. No ( )
43. Do you ever hear voices without knowing where they come from or which other people cannot hear? 1. Yes ( ), 2. No ( )

---

44. Are you currently suffering from any diagnosed illness, physical or psychological, or drug or alcohol addiction? 1. Yes ( ), 2. No ( )
45. If your answer to question 44 was 'yes', please indicate what illness/problem (s) you are currently suffering:
46. Were you hospitalized during the last year? 1. Yes ( ), 2. No ( )
47. Did you have any operation (s) during the last year? 1. Yes ( ), 2. No ( )
48. If your answer to either of the previous questions was 'yes', please indicate the reason for hospitalization or the kind of operation you had:

PART C:

IN THIS SECTION WE ARE PARTICULARLY INTERESTED IN FINDING OUT HOW YOU HAVE BEEN DOING IN THE LAST MONTH. WE WOULD LIKE YOU TO ANSWER SOME QUESTIONS ABOUT YOUR WORK, SPARE TIME AND FAMILY LIFE. THERE ARE NO RIGHT OR WRONG ANSWERS TO THE QUESTIONS. PLEASE CHECK THE SITUATION THAT BEST DESCRIBES YOU.

49. I am 1. A paid worker ( )
    2. A housewife ( )
    3. A student ( )
    4. Retired ( )
    5. Unemployed ( )

IF UNEMPLOYED, GO TO 55.

50. Do you usually work for pay more than 15 hours per week?
    1. Yes ( ) 2. No ( )

CHECK THE ANSWER THAT BEST DESCRIBES HOW YOU HAVE BEEN IN THE LAST MONTH.

51. How many days did you miss from your work in the last month?
    1. No days missed ( )
    2. Less than 10 days missed ( )
    3. More than 10 days ( )
    4. I did not work any day ( )

IF YOU HAVE NOT WORKED ANY DAYS IN THE LAST MONTH GO ON TO QUESTION 55.

52. Have you been able to do your work in the last month?
    1. I did my work very well ( )
    2. I needed help with work and did not do well about half of the time ( )
    3. I did my work poorly all the time ( )
53. Have you felt upset, worried or uncomfortable while doing your work during the last month?
    1. I never felt upset ( )
    2. Half of the time I felt upset ( )
    3. I felt upset most of the time ( )
54. Have you found your work interesting this last month?
    1. My work was almost always interesting ( )
    2. Most of the time my work was uninteresting ( )
55. How many times in the last month have you gone out socially with other people, outside your family? For example, visited friends, dated, gone to movies, dances, restaurants, clubs, etc.?
    1. 5 times or more ( )
    2. 2 to 4 times ( )
    3. Once or none ( )
56. How much free time have you spent on hobbies or spare time interests during the last month? For example, sports, reading, billiards, gardening, etc.?
    1. I spent most of my spare time on hobbies ( )
    2. I spent approximately half of my spare time on hobbies ( )
    3. I did not spend any spare time on hobbies ( )

ANSWER QUESTIONS 57 AND 58 ABOUT YOUR PARENTS, BROTHERS, SISTERS, IN-LAWS, AND CHILDREN NOT LIVING AT HOME. HAVE YOU BEEN IN CONTACT WITH ANY OF THESE RELATIVES IN THE PAST MONTH? IF NOT, GO ON TO QUESTION 62.

57. Have you been able to talk about your feelings and problems at least with one of your relatives in the last month?
    1. I can always talk about my feelings with a least one relative ( )
    2. About half of the time I felt able to talk about my feelings ( )
    3. I was never able to talk about my feelings ( )
58. Have you avoided contacts with your relatives during the last month?
    1. I have contacted relatives regularly ( )
    2. I have avoided or attempted to diminish my contacts with relatives but they have contacted me ( )
    3. I have had no contacts with any relatives ( )

IF YOU ARE LIVING WITH YOUR SPOUSE OR WITH SOMEONE AS A COUPLE, PLEASE ANSWER QUESTIONS 59 TO 61. IF NOT, GO ON TO QUESTION 62.

59. Have you been able to talk about your feelings and problems with your partner during the last month?
    1. I could usually or always talk freely about my feelings and problems ( )
    2. About half of the time I felt able to talk about my feelings and problems ( )
    3. I was not able to talk about my feelings and problems ( )
60. How many times have you and your partner had sexual relations during the last month?
    1. Once or more a week ( )
    2. Once every two weeks ( )
    3. Not at all in the last month ( )
61. How have you felt about sexual intercourse with your partner during the last month?
    1. I usually enjoyed it ( )
    2. About half of the time I enjoyed it ( )
    3. I never or almost never enjoyed it ( )

PLEASE ANSWER QUESTIONS 62 AND 63 IF YOU ARE LIVING WITH UNMARRIED CHILDREN, STEPCHILDREN OR FOSTER CHILDREN.

62. During the last month, have you been interested in what your children were doing, with friends, at school, in play?
    1. I was always or usually interested and actively involved ( )
    2. About half of the time, I was interested ( )
    3. I was always or usually disinterested ( )
63. How have you been getting along with the children during the past month?
    1. I had no arguments or only minor arguments and got along very well ( )
    2. I had more than one serious argument ( )
    3. I constantly had arguments ( )
64. Have you had enough money to take care of your own and your family's financial needs during the last month?
    1. I had enough money for needs ( )
    2. About half of the time I did not have enough money ( )
    3. I had great financial difficulty ( )

PLEASE INDICATE YOUR INCOME CATEGORY FOR THE PAST YEAR BY CHECKING ONE OF THE AMOUNTS IN EACH TYPE OF INCOME.

	Gross personal income	Gross household income
Under $ 10,000		
$ 10,000 to $ 14,999		
$ 15,000 to $ 19,000		
$ 20,000 to $ 29,999		
$ 30,000 and up		

IF YOU HAVE RECEIVED GOVERNMENT ASSISTANCE (WELFARE, UNEMPLOYMENT WORKMEN'S COMPENSATION), PLEASE INDICATE THE AMOUNT: $_____ MONTHLY, DURING_____ MONTHS.

PART D:

IN THIS SECTION WE ARE INTERESTED IN FINDING OUT YOUR OPINION ABOUT VARIOUS ISSUES. AS BEFORE, THERE ARE NO CORRECT OR INCORRECT ANSWERS. PLEASE GIVE US YOUR OPINIONS, FRANKLY. CHECK ON THE LINE GOING FROM "COMPLETELY AGREE" TO "COMPLETELY DISAGREE" THE ANSWER THAT BEST REPRESENTS YOUR OPINION. ANSWER ALL QUESTIONS. CIRCLE THE NUMBER REPRESENTING YOUR ANSWER.

1. Fundamentally, the world we live in is a pretty lonesome place.

COMPLETELY AGREE	AGREE MODERATELY	DISAGREE MODERATELY	COMPLETELY DISAGREE
1	2	3	4

2. It is often desirable to reserve judgment about what's going on until one has a chance to hear the opinions of those one respects.

COMPLETELY AGREE	AGREE MODERATELY	DISAGREE MODERATELY	COMPLETELY DISAGREE
1	2	3	4

3. A person who thinks primarily of his/her own happiness is beneath contempt.

COMPLETELY AGREE	AGREE MODERATELY	DISAGREE MODERATELY	COMPLETELY DISAGREE
1	2	3	4

4. In the history of mankind there have probably been just a handful of great thinkers.

COMPLETELY AGREE	AGREE MODERATELY	DISAGREE MODERATELY	COMPLETELY DISAGREE
1	2	3	4

5. Most people just do not know what is good for them.

COMPLETELY AGREE	AGREE MODERATELY	DISAGREE MODERATELY	COMPLETELY DISAGREE
1	2	3	4

6. Once I get wound up in a heated discussion I just cannot stop.

COMPLETELY AGREE	AGREE MODERATELY	DISAGREE MODERATELY	COMPLETELY DISAGREE
1	2	3	4

7. The worst crime a person can commit is to attack publicly the people who believe in the same thing he does.

COMPLETELY AGREE	AGREE MODERATELY	DISAGREE MODERATELY	COMPLETELY DISAGREE
1	2	3	4

8. In this complicated world of ours the only way we can know what is going on is to rely upon leaders or experts who can be trusted

COMPLETELY AGREE	AGREE MODERATELY	DISAGREE MODERATELY	COMPLETELY DISAGREE
1	2	3	4

9. In the long run the best way to live is to pick friends and associates whose tastes and beliefs are the same as one's own.

COMPLETELY AGREE	AGREE MODERATELY	DISAGREE MODERATELY	COMPLETELY DISAGREE
1	2	3	4

10. While I do not like to admit this, even to myself, I sometimes have the ambition to become a great person like Einstein, Marie Curie, Shakespeare or Gabriela Mistral.

COMPLETELY AGREE	AGREE MODERATELY	DISAGREE MODERATELY	COMPLETELY DISAGREE
1	2	3	4

PART E:

NOW, WE WOULD LIKE TO KNOW ABOUT SOME OF THE EVENTS THAT HAVE TAKEN PLACE IN YOUR LIFE OVER THE PAST YEAR. YOU WILL FIND A LIST OF EVENTS AND FOR EACH, PLEASE LET US KNOW IF IT OCCURRED AND FOR THOSE EVENTS YOU EXPERIENCED, LET US KNOW, ON A SCALE OF 1 TO 5, HOW STRESSFUL YOU FOUND IT. A SCORE OF 1 WOULD INDICATE THAT IT WAS NOT AT ALL STRESSFUL, 3 THAT IT WAS SOMEWHAT STRESSFUL, AND 5 THAT IT WAS VERY STRESSFUL.

Event		Occured yes	Occured no	Stress value 1-5
a.	Moved to a new residence	____	____	____
b.	Death of your spouse	____	____	____
c.	Death of close family member	____	____	____
d.	Problems with the police or courts	____	____	____
e.	Marital separation/divorce	____	____	____
f.	Serious personal illness	____	____	____
g.	Loss of a job	____	____	____
h.	Been the victim of a crime	____	____	____
i.	Discipline problems with any of the children	____	____	____
j.	Change of job	____	____	____
k.	Child left household	____	____	____
l.	Someone close had a serious illness	____	____	____
m.	New person added to household	____	____	____
n.	Debts	____	____	____
o.	Death of a friend or neighbour	____	____	____
p.	Spouse began to work	____	____	____
q.	Arguments with spouse	____	____	____
r.	Other, specify:	____	____	____

PART F:

IF YOU HAVE CHILDREN AGED 5 TO 16 ANSWER THIS SECTION. IF NOT, PROCEED TO PART G. THE QUESTIONS OF THIS SECTION (F) ARE REPEATED 3 TIMES. IF YOU HAVE ONLY ONE CHILD BETWEEN 5 AND 16 YEARS OF AGE, PLEASE COMPLETE ONLY THE FIRST QUESTIONNAIRE AND PROCEED TO PART G. COMPLETE THE OTHER QUESTIONNAIRE ONLY IF YOU HAVE OTHER CHILDREN IN THIS AGE GROUP (UP TO TWO OTHERS).

BELOW IS A LIST OF PROBLEMS WHICH MOST CHILDREN MAY HAVE AT SOME TIME. PLEASE TELL US HOW OFTEN EACH OF THESE HAPPENS WITH THIS CHILD BY CHECKING THE APPROPRIATE BOX.

	Never in the last year	Less often than once per month	At least once per month	At least once per week
1. Complains of headaches	( ) 1	( ) 2	( ) 3	( ) 4
2. Has stomach ache or vomiting	( ) 1	( ) 2	( ) 3	( ) 4
3. Complains of biliousness	( ) 1	( ) 2	( ) 3	( ) 4
4. Wets his/her bed or pants	( ) 1	( ) 2	( ) 3	( ) 4
5. Soils him/herself or loses control of bowels	( ) 1	( ) 2	( ) 3	( ) 4
6. Has temper tantrams, i.e., complete loss of temper with shouting, angry movements, etc.	( ) 1	( ) 2	( ) 3	( ) 4
7. Had tears on arrival at school or refusal to go into the building	( ) 1	( ) 2	( ) 3	( ) 4
8. Truant from school	( ) 1	( ) 2	( ) 3	( ) 4

	No	Yes, mildly	Yes, severely
9. Does she/he stammer or stutter?	( ) 1	( ) 2	( ) 3
10. Has she/he any difficulty with speech other than stammering or stuttering?	( ) 1	( ) 2	( ) 3
If 'yes' is the difficulty:			
a. Lisping	( ) 1	( ) 2	( ) 3
b. Cannot say words properly	( ) 1	( ) 2	( ) 3

Other problems, please specify: _____

	No	Yes, occasionally	Yes, frequently
11. Does she/he ever steal things?	( ) 1	( ) 2	( ) 3
If 'yes' (occasionally or frequently), when she/he steals, does it involve:			
1. Minor pilfering			( )
2. Sums of money, etc.			( )
3. Stealing of big things			( )
4. Both minor pilfering and stealing of big things			( )
When she/he steals, is it done:			
1. In the home			( )
2. Elsewhere			( )
3. Both in the home and elsewhere			( )
When she/he steals, does she/he do it:			
1. On her/his own			( )
2. With other children or adults			( )
3. Sometimes on her/his own, sometimes with others			( )

	No	Yes, mild	Yes, severe
12. Does she/he have any eating difficulty?	( ) 1	( ) 2	( ) 3
If 'yes', is it:			
1. Faddiness	( )		
2. Not eating enough	( )		
3. Eating too much	( )		
4. Other, specify:			
13. Does she/he have any sleeping difficulty?	( ) 1	( ) 2	( ) 3
If 'yes', is it difficulty in:			
1. Getting to sleep	( )		
2. Waking early in the morning	( )		
3. Other, specify_____			

	Doesn't apply	Applies somewhat	Certainly applies
14. Very restless. Often jumping up and down. Hardly ever still.	( ) 1	( ) 2	( ) 3
15. Squirmy, fidgety child	( ) 1	( ) 2	( ) 3
16. Often destroys own or others' belongings	( ) 1	( ) 2	( ) 3
17. Frequently fights with other children	( ) 1	( ) 2	( ) 3
18. Not much liked by other children	( ) 1	( ) 2	( ) 3
19. Often worried, worries about many things	( ) 1	( ) 2	( ) 3
20. Tends to do things on his own, rather solitary	( ) 1	( ) 2	( ) 3
21. Irritable. Is quick to "fly off the handle"	( ) 1	( ) 2	( ) 3
22. Often appears miserable, unhappy, tearful or distressed	( ) 1	( ) 2	( ) 3
23. Has twitches, mannerisms or tics of the face or body	( ) 1	( ) 2	( ) 3
24. Frequently sucks thumb or finger	( ) 1	( ) 2	( ) 3
25. Frequently bites nails or fingers	( ) 1	( ) 2	( ) 3
26. Is often disobedient	( ) 1	( ) 2	( ) 3
27. Cannot settle to anything for more than a few moments	( ) 1	( ) 2	( ) 3
28. Tends to be fearful or afraid of new things or situations	( ) 1	( ) 2	( ) 3
29. Over-particular child or fussy	( ) 1	( ) 2	( ) 3
30. Often tells lies	( ) 1	( ) 2	( ) 3
31. Bullies other children	( ) 1	( ) 2	( ) 3

PART G:

ONLY FOR PEOPLE WHO EXPERIENCED POLITICAL PERSECUTION, POLITICAL ARREST OR TORTURE IN THEIR COUNTRY OF ORIGIN. IF THIS IS NOT THE CASE WITH YOU, PLEASE GO ON TO PART I.

In this section we would like to find out details about the experience you had. Please check the answers that describe your experience. If necessary, check more than one answer. When necessary, please write your answer.

1. Before coming to Canada, did you experience:	YES	NO
Political persecution or harassment	( )	( )
Arrests or brief detention (less than 24 hours)	( )	( )
Political imprisonment, jail or concentration camp	( )	( )
Temporary disappearance (more than 1 month)	( )	( )

2. If you were persecuted, and not arrested, imprisoned or tortured, please indicate if you suffered:

Harassment at work because of your beliefs or political association	( )	( )
Discrimination and harassment of your family because of your ideas	( )	( )
Visits to your home or place of work by security forces	( )	( )
Loss of job because of your ideas	( )	( )
Asylum or refugee in an embassy; indicate duration:_____ months	( )	( )
Living in hiding, clandestinity; indicate duration:_____ months	( )	( )
Exile, forced or voluntary; indicate duration:_____ months	( )	( )

3. If you were arrested or imprisoned, please indicate the year and length:

First time: Year_____ Duration (in months)_____
Second time: Year_____ Duration (in months)_____
Third time: Year_____ Duration (in months)_____
Fourth time: Year_____ Duration (in months)_____

4. Description of arrest:

( ) Violent
( ) Arrest witnessed by adults in the family
( ) Arrest witnessed by my children
( ) Violence against the family
( ) Non-violent, polite
( ) Arrest not witnessed by adults in the family
( ) Arrest not witnessed by my children
( ) The family did not suffer violence

If the arrest was witnessed by your children, please indicate their current ages: lst:_____ years; 2nd:_____ years; 3rd:_____ years; 4th:_____ years.

If you suffered any ill treatment or torture, please indicate:

5. PHYSICAL ASSAULTS: (check as applicable)	YES	NO
Slapping or kicking or punching	( )	( )
Blows with rifle butts, sticks, whips, irons	( )	( )
Exposure to extreme cold or heat, hanging, prolonged standing up	( )	( )
Submarine, immersion, asphyxiation, strangling		
Burnings	( )	( )
Electrical shocks	( )	( )
Rape	( )	( )
Other forms of torture; specify:_____		

Total score (range 1-8) =

6. DEPRIVATION:	YES	NO
Was deprived of food, comfort or communication	( )	( )
Incommunication, minimal food and comfort, overcrowding for more than 2-3 days	( )	( )
Lack of water (more than 48 hours)	( )	( )
Immobilization, total darkness (more than 48 hours)	( )	( )
Lack of sleep (less than 4 hours per night) for 5 days or longer	( )	( )
Lack of needed medication or medical care for more than 48 hours	( )	( )
Other forms of deprivation; specify:_____		

Total score (range 1-6) =

7. SENSORY OVER-STIMULATION:	YES	NO
Constant noises	( )	( )
Screams and voices	( )	( )
Powerful lights	( )	( )
Special devices	( )	( )
Drugs	( )	( )
Other forms of sensory over-stimulation; specify:_____		

Total score (range 1-6) =

8. PSYCHOLOGICAL TORTURE AND ILL TREATMENT:	YES	NO
Verbal abuse	( )	( )
Threats against person	( )	( )

False accusations	( )	( )
Abuse with excrement	( )	( )
Sexual abuse (without violence)	( )	( )
Menaces against own life or family	( )	( )
Simulate execution	( )	( )

Other forms of psychological torture; specify: _____

Total score (range 1-8) =

9. OTHER TRAUMATIC ASPECTS OF YOUR EXPERIENCE:
All tortures total score (range 1-29):

PART H:

SOCIAL INTEGRATION AND RESPONSIBILITY

1. Were you a supporter, a member or an active member of any persecuted social, political, religious, cultural, sindical or professional organization or institution that became persecuted in your country of origin? ( ) YES (1) ( ) NO (2)

2. If your answer to the previous question was "yes", please indicate if you were: ( ) A supporter (1) ( ) A member (2) ( ) An active member (3)

3. Please indicate the kind of organization (s): ( ) Sportive (1) ( ) Cultural (2) ( ) Social (3) ( ) Professional (4) ( ) Religious (5) ( ) Trade union (6) ( ) Political (7)

4. If you were an active member, please indicate your highest level of responsibility in any one organization:

Active member without leadership position (1)	( )
Member of local leadership (2)	( )
Member of regional leadership (3)	( )
Member of national leadership (4)	( )

PART I:

PERSECUTED, DEAD OR MISSING RELATIVES FOR POLITICAL REASONS

1. Has any member of your family suffered direct political persecution? ( ) YES (1) ( ) NO (2)

2. If "yes", indicate relationship:
( ) Spouse (1) ( ) Father (2) ( ) Mother (3) ( ) Son (4)
( ) Daughter (5) ( ) Brother (6) ( ) Sister (7)
( ) Brother-in-law (8) ( ) Sister in Law (9)
( ) Other (10), specify: _____

3. Type of persecution:	YES	NO
Political persecution or harassment (1)	( )	( )
Arrest only or brief detention (less than 24 hours (2)	( )	( )
Political imprisonment (3)	( )	( )
Ill treatment and torture (4)	( )	( )
Disappearance (specify relative, length, outcome) (5)	( )	( )
Death (6)	( )	( )

4. If any of your relatives disappeared temporarily or has currently disappeared, please indicate your relationship, length of disappearance and outcome (Please mark first only your closest relative):
( ) Spouse (1) ( ) Father (2) ( ) Mother (3) ( ) Son (4)
( ) Daughter (5) ( ) Brother (6) ( ) Sister (7)
( ) Brother-in-law (8) ( ) Sister in Law (9)
( ) Other (10), specify: _____
Length of disappearance:_____ months
Outcome:
( ) Disappeared (1)
( ) Death confirmed (2)
( ) Alive and currently in jail (3)
( ) Appeared and currently free (4)

5. If more than one of your relatives has been or still is disappeared, please indicate the relationship, length and outcome (second relative):
( ) Spouse (1) ( ) Father (2) ( ) Mother (3) ( ) Son (4)
( ) Daughter (5) ( ) Brother (6) ( ) Sister (7)
( ) Brother-in-law (8) ( ) Sister-in-law (9) ( ) Other (10), specify: _____
Length of the disappearance: _____ months
Outcome:
( ) Disappeared (1)
( ) Death confirmed (2)
( ) Alive and currently in jail (3)
( ) Appeared and currently free (4)

6. Please indicate if more than two relatives have been or still are disappeared:
Relationship: _____ Length: _____ Outcome: _____

YOU HAVE FINISHED THE QUESTIONNAIRE. PLEASE MAKE SURE THAT ALL PERTINENT QUESTIONS HAVE BEEN ANSWERED. PLEASE PUT THE QUESTIONNAIRE IN THE ENVELOPE PROVIDED AND DROP IT IN THE MAIL. THANK YOU.

SELF REPORTING QUESTIONNAIRE USED BY AMNESTY INTERNATIONAL:

AMNESTY INTERNATIONAL QUESTIONNAIRE Completed on:

1. Personal Information

Surname: Date of birth:

First name(s):

Present address:

Address where you can be contacted: (if other than above)

Country of origin: (region of origin, if relevant)

Nationality: Religion:

Ethnic origin (if relevant):

Occupation/career:

Trade union affiliation:

Why did you leave your country?

Was your arrest or persecution related to your political sympathies or associations?

How would you describe your political sympathies or associations?

Social background (material circumstances, schooling or any other relevant information you wish to mention related to your background):

What was your journey? (give dates and persons/organizations who helped you throughout)

Who paid for the tickets?

Do you have a passport, travel document, other?

2. Arrest

Date: Time:

Place (home, work, other):

Carried out by (military, police, other):

Arrest warrant or other document shown?

Were you arrested with anybody else?

Were any reasons for arrest given?

Was violence used? (explain)

Was your detention acknowledged to outsiders? When? How?

3. Prison conditions in detention centre (s) you have been held at (NB): Please complete a separate form for each centre you have been held at.)

Name of detention centre:

Period spent there From: To:

Size of cells:

Number of prisoners per cell:

Total number of prisoners in prison:

Type of prisoners (i.e. political, criminal, describe):

Sanitation:

Light:

Temperature:

Food (quantity):

Food (quality):

Food (religious consideration if relevant):

Access to fresh air and exercise:

Visiting by family or friends:

Visiting by lawyer:

Mail:

Access to newspapers, books or radio:

First examination or visit by a doctor:

Subsequent visits?

Nature of relations with prison personnel (informers present?)

Were you questioned? (If so, by whom, how often and what was the nature or the subject of the questioning?):

Were you questioned by the same body which operated the prison you were in?

Did you know the charges against you?

Were any threats made to you?

Were you asked to sign any statement?

Comment on the nature of the interrogation (atmosphere):

If you have any other information you consider relevant for Amnesty International, please write it down.

4. Legal Facts

Charges:

Date and place of trial:

Were there other defendants at the trial?

Civil/military court:

Articles of legislation invoked:

Name of presiding judge:

Sentence (give dates):

Defence (private, public):

Name of lawyer:

Other details of trial:

How did you plead?

Appeal (give details):

Were trial and appeal fair? (explain):

Name and location of place where you served your sentence:

Prison conditions and treatment: (Describe and comment on those aspects you perceive as most significant in your imprisonment. You may wish to refer to points on pages 3 and 4, or others like punishments, which were not included there. If you need more space than is provided here, pleased add more paper.)

QUESTIONNAIRE ON TORTURE AND ILLTREATMENT

If you have been subjected to torture or ill treatment in more than one detention centre or prison, please complete on questionnaire for each of the places in which this took place.

Detention centre:

Any purpose for torture given?

Personnel who participated (security, military, other, give names if possible):

Were you questioned during torture?

Did the torturers try other means to achieve their purpose besides torture (e.g. promises) ? If so, describe:

Did you have to sign a statement that torture did not take place?

Were you forced to sign a confession?

Describe the nature, duration and frequency of torture. Try to give details as to the type of torture, e.g. beatings, restriction on movements, asphyxiation; if you were given electric shocks; if there was any sexual assault or other form of physical violence.

Include in your description any form of psychological torture you may have been subjected to, e.g. threats to you or your family; mock execution; isolation; excessive noise, light or smell or any particular kind of humiliation.

Was a medical officer present during torture?

Was he called to see you before torture?

Was he called to see you after torture?

Did he actively participate in the torture?

What was his role?

Did he make any recommendation?

Do you know his name?

Did you need medical treatment after torture?

Were you offered medical attention? What kind?

Are there any physical consequences of torture evident?

Are there any psychological consequences of torture evident?

Please add any other information you consider relevant to Amnesty International's campaign against torture.

QUESTIONNAIRE USED BY PETERSEN

(reproduced with the courtesy of Dr. Hans Draminsky Petersen, Copenhagen).

		dy mo yr
1. Date of Examination	1.	____ ____ _____
2. Examiner	2.	_____
3. Proband No.	3.	_____
4. Nationality (first three letters)	4.	_____
5. Age	5.	_____
6. Sex female = 1, male = 2	6.	_____
7. Arrest during which torture was inflicted most recently	7.	dy mo yr dy mo yr From___ ___ ___to___ ___ ___
8. Country in which torture was inflicted	8.	_____
9. Have you previously been exposed to torture. If yes, indicate when	9.	No___Yes___mo___ yr____

The following questions concern only the last occasion on which you were exposed to torture:

10. Did you receive medical treatment during your detention? 10. No___ Yes, no.___

If Yes state by number
Which treatment:
1. Medicine
2. Dressing/plaster of Paris
3. Operation

For which condition were you treated? (11-12)

11. Fracture: If yes, state by number 11. No___ Yes___ no.___
1. Rib
2. Back and/or pelvis
3. Skull incl. jaw and nose
4. Arms and/or legs (not hands or feet)
5. Hands/feet
6. Teeth

12. Other injuries: If yes state by number: 12. No___ Yes___ no.___
1. Injuries to or bleedings in abdominal or thoracic viscera
2. Injuries to the central nervous system including eyes and ears
3. Vascular injuries, including bleeding of limbs
4. Injuries to skin, muscles, joints or peripheral nerves
5. Other somatic injuries
6. Mental disorders

13. For how many days were you exposed to physical torture? 13._____

Were you exposed to beating or kicking of (14-19)?:

14: Head, incl. banging of head against	14. No___, 1-10 times_____ >10 times_____
15. Neck	15. No___ Yes___
16. Trunk	16. No___ Yes___
17. Arms and/or legs	17. No___ Yes___
18. Genitals	18. No___ Yes___
19. Feet	19. No___ Yes___
20. Burns, e.g. with cigarettes	20. No___ Yes___ >5times_____

21. Electrical torture — 21. No____,1-10 times >10 times _____

22. If yes to 21, state which region (s) by number
1. Head
2. Mammaries
3. Genitals, anus
4. Others
— 22. _____

23. Suffocation or drowning — 23. No____1-3 times_____ >3 times _____

24. "operating table" — 24. No____1-3 times_____ >3 times

25. Wet submarino (la banera) — 25. No____1-3 times_____ >3 times _____

26. "Parrot perch" or other suspension — 26. No____1-3 times_____ >3 times _____

27. Exhausting physical activity — 27. No____Yes____

28. Cooling, e.g. with water — 28. No____Yes____

29. Insertion of object into the rectum — 29. No____Yes____

30. Insertion of object into the vagina — 30. No____Yes____

31. Other form of physical torture — 31. No____Yes____

32. For how many days were you exposed to physical torture: — 32. _____

33. For how many days no possibility of more than 0-4 hours of sleep — 33. _____

34. Sexual assault — 34. No____1-3 times_____ >3 times _____

35. Threats to yourself, your family or friends — 35. No____Yes____

36. Sham executions — 36. No 1-3 times_____ >3 times _____

37. Blindfolding — 37. No____1-3 days _____ >3 days _____

38. Witnessed torture of others — 38. No____Yes____

39. Other psychological torture — 39. No____Yes____

40. Solitary confinement, number of days (possibly 0) — 40. _____

41. Did you lose consciousness as a result of torture — 41. No____1-3 times_____ >3 times _____

42. Was unconsciousness due to:
1st occasion: 1. Suffocation or drowning
2. Direct violence to head
3. Others
— 42. _____

43. 2nd occasion: 1. Suffocation or drowning
2. Direct violence to head
3. Others
— 43. _____

44. 3rd occasion: 1. Suffocation or drowning
2. Direct violence to head
3. Others
— 44. _____

45. Fracture of bones: If yes, state location by number: — 45. _____
1. Rib, clavicle
2. Back and/or pelvis
3. Skull, including jaw and nose
4. Arms and/or legs (not hands or feet)
5. Hands/feet
6. Teeth

46. Reason for presenting for this examination
1. Wish for treatment — 46. _____
2. Wish for sick leave
3. Wish for attestation of torture for use in legal proceedings or the like
4. Others

PREVIOUS STATE OF HEALTH (before last episode of torture)

47. Fractures: — 47. No____ Yes____ no____
If yes, state location by number
1. Rib, clavicle
2. Back and/or pelvis
3. Skull, including jaw and nose
4. Arms and/or legs (not hands or feet)
5. Hands/feet
6. Teeth

48. Accidents or other traumas causing unconsciousness — 48. No____ 1-3 times_____ >3times _____

49. Have you preveiously undergone operations
If yes, state nature of operation (s) by number (possible more than one on the line:
1. craniotomy — 49. No_____ Yes, no_____
2. Thoracotomy
3. Laparotomy, incl. gynaecological operations.
4. Fractures
5. Others

50. Previous mental diseases — 50. No_____ Yes, no.____
1. Psychosis
2. Depression
3. Neurosis
4. Psychopathy
5. Alcohol or drug abuse

51. Previous or present cancer (exclusive of cancer in situ and not serious skin cancer) — 51. No_____ Yes_____

52. Chronic diseases
If yes, state by number (possibly several)
1. Heart — 52. No_____ Yes, no____
2. Lungs
3. Stomach or intestine
4. Kidney
5. Liver
6. Others

53. Chronic neurological diseases — 53. No_____ Yes, no____
If yes, state by number:
1. Epilepsy
2. Others

54. Daily use of tobacco
(nos. of cigarettes or g of tobacco): — 54._____

55. Daily consumption of beer, wine, and alcohol
(nos. of glasses= 10 g pure alcohol) — 55. 0-3_____, 3-6_____ >6_____

56. Daily use of medicine — 56. No____ Yes, no._____
if yes, state by number (possibly several)
1. Analgesics, antirheumatica
2. Hypnotics, sedatives
3. Major tranquillizers
4. Antidepressants
5. Others

57. Have you completed an education? — 57. No_____ Yes, no.____
If yes, of how long a duration after leaving school, stat by number:
1. 0-3 years
2. 3-6 years
3. >6 years

58. What is your present occupation: — 58. _____
1. No occupation
2. Occupation corresponding to education.
3. Others.

59. Present state of health. Questions 59-81 describe the *daily* state of health. If some questions are answered in the affirmative, state, in the extreme right-hand column, the aproximate duration of the symptoms concerned in number of month.

Suffers daily from:

59. Headache — 59. No_____ Yes____ _____
60. Dizziness — 60. No_____ Yes____ _____
61. Impaired concentration — 61. No_____ Yes____ _____
E.g. difficulty in following a conversation or a TV-programme.
62. Impairment of memory — 62. No_____ Yes____ _____
63. Impairment of hearing — 63. No_____ Yes____ _____
64. Attacks of violent malaise with a great need to lie down — 64. No_____ Yes____ _____
65. Numbness of pins and needles in the arms of legs — 65. No_____ Yes____ _____
66. Reduced strenght in the arms or legs — 66. No_____ Yes____ _____
67. Pains in the shoulders or arms — 67. No_____ Yes____ _____
68. Pains in the legs, including feet — 68. No_____ Yes____ _____
69. Backache — 69. No_____ Yes____ _____
70. Chest pain — 70. No_____ Yes____ _____
71. Dyspnoea — 71. No_____ Yes____ _____
72. Palpitations — 72. No_____ Yes____ _____
73. Abdominal pains — 73. No_____ Yes____ _____
74. Mausea — 74. No_____ Yes____ _____
75. Vomiting — 75. No_____ Yes____ _____
76. Pirosis or eructations — 76. No_____ Yes____ _____
77. Diarrhoea — 77. No_____ Yes____ _____
78. Constipation — 78. No_____ Yes____ _____
79. Pain on urination — 79. No_____ Yes____ _____
80. Male pain in the genitals, female pelvic pain — 80. No_____ Yes____ _____
81. Lacking control of urination or defecation. — 81. No_____ Yes____ _____
82. Have you had convulsions with loss of consciousness in the course of the past month. — 82. No_____ Yes____ _____

83. Do you suffer from menstrual disturbances.
If yes state by number: 83. No_____ Yes___ ___
1. Absence of menstrual periods
2. Too frequent periods
3. Bleeding between the periods
State duration of menstrual disturbances in number of month.

Are you at present (during the past week) suffering from: If yes, to questions 84-89, state in the extreme right-hand column the approximate duration of the complaints concerned in number of months.

84. Difficulty in falling asleep 84. No_____ Yes___ ___
85. Interrupted sleep 85. No_____ Yes___ ___
86. Nightmares 86. No_____ Yes___ ___
If yes to 86, fill in 87:
87. Are these nightmares always of the same content?: 87. No_____ Yes___ ___
88. Fatigue 88. No_____ Yes___ ___
89. Anxiety 89. No_____ Yes___ ___
90. Depressions 90. No_____ Yes___ ___
91. Sexual problems 91. No_____ Yes___ ___
92. Self-reproach 92. No_____ Yes___ ___
93. Attacks of panic 93. No_____ Yes___ ___
94. A feeling of guilt against other persons 94. No_____ Yes___ ___
95. Are you quick-tempered and easily irritated?. 95. No_____ Yes___ ___
96. Are you apt to isolate yourself from others? 97. No_____ Yes___ ___
97. Tendency to weep 97. No_____ Yes___ ___
98. Reduced working capacity 98. No_____ Yes___ ___
99. Reduced ability to get into contact with other people 99. No_____ Yes___ ___
100. Present daily consumption of tobacco (nos. of cigarettees or grams of tobacco) 100._____
101. Present daily consumption of beer, wine and alcohol (nos. of glasses = 10 g pure alcohol) 101. 0-3___, 3-6___ >6___
102. Present daily use of medicine 102. No___ Yes, no._____
If yes, state by number (possibly several)
1. Analgetics, antirheumatics
2. Hypnotics, sedatives
3. Major tranquillizers
4. Antidepressants
5. Others

		dy	mo	yr
1. Date of examination	1.			
2. Examiner	2.			
3. Control person No.	3.			
4. Nationality (first three letters)	4.			
5. Age	5.			
6. Sex (female = 1, male = 2)	6.			

PHYSICAL EXAMINATION

Fill in all spaces.
0. indicates normal findings.
1. indicates abnormal findings, most likely not due to torture.
2. indicates abnormal findings, most likely due to torture. Give brief description of all abnormal findings.

103. BP, systolic/diastolic	103.	_____/_____
104. Pulse rate	104.	_____/_____
105. Weight in kg.	105.	_____/_____
106. Eyes	106.	_____ _____
107. Ears	107.	_____ _____
108. Hearing	108.	_____ _____
109. Mouth	109.	_____ _____
110. Teeth	110.	_____ _____
111. Face	111.	_____ _____
112. Neck, shoulders	112.	_____ _____
113. Heart, ausculation	113.	_____ _____
114. Lungs, ausculation	114.	_____ _____
115. Chest	115.	_____ _____
116. Breasts, axillae	116.	_____ _____
117. Abdomen	117.	_____ _____
118. Arms, hands	118.	_____ _____
119. Legs, feet	119.	_____ _____
120. Spine	120.	_____ _____
121. Genitals	121.	_____ _____
122. Skin on head and neck	122.	_____ _____
123. Skin on trunk	123.	_____ _____
124. Skin on arms and legs	124.	_____ _____

OBJECTIVE PSYCHOLOGICAL EVALUATION
behavior during the examination

125. Tense 125. No_____ Yes_____
126. Inhibited, passive 126. No_____ Yes_____
127. Aggressive 127. No_____ Yes_____
128. Restless 128. No_____ Yes_____
129. Irritable 129. No_____ Yes_____
130. Apt to cry 130. No_____ Yes_____
131. Anxious 131. No_____ Yes_____
132. Appealing 132. No_____ Yes_____
133. Impaired memory 133. No_____ Yes_____
134. Impaired concentration 134. No_____ Yes_____
135. Discontinous, incoherent train of thoughts 135. No_____ Yes_____
136. Hallucinations 136. No_____ Yes_____
137. Paranoia 137. No_____ Yes_____
138. Depressions 138. No_____ Yes_____
139. Dissimulating 139. No_____ Yes_____
140. Aggravating, dramatizing 140. No_____ Yes_____
141. Phobis or compulsive acts 141. No_____ Yes_____
142. If another person is present during the examination, is it he/she who takes the initiative or who answers the questions? 142. No_____ Yes_____

APPENDIX V. SYMPTOMS AND SIGN

A: DERMATOLOGICAL

CASE HISTORY NO. V:A,1.

A 24-year-old unmarried Spanish woman, arrested at her job by the Spanish police in 1976, in the Basque country.

She was accused of belonging to the revolutionary workers' party (ORT). She was taken to the police station in Tolusa, where the police removed her glasses and untied her braids, then slapped her in the face. She fell down, but they picked her up by the hair. Six policemen stood in a circle around her, raining blows down on her while asking her for the names of other ORT members. About an hour later, she was taken into a smaller room. Here she was made to change from her own clothes into a pair of overalls. Her hands were tied behind her back with a piece of cloth. She was taken into another room, where there was a bathtub filled with dirty, contaminated water. The police forced her head into the water. She does not know for how long she was submerged. She became dizzy but did not lose consciousness. After being punched very hard in the stomach, she was taken into another room. The police punched her in the head, then told her to lie down on a bed. She was then hit hard with a stick, first on the soles of her feet, then on the fronts of her thighs and up to her stomach. She was turned over and they continued beating her on the backs of her thighs, as well as on her buttocks and back. She reports that three men were beating her. They helped her on with her clothes, as she was too weak to dress herself.

As her general condition was very poor, they called a doctor for her. He arranged for her to be admitted to hospital, where she remained for 10 days. There she was fed intravenously, and she says the personnel considered doing a dialysis, as her renal function was impaired.

Fig. App V:A,1 page 84 depicts this woman on her fifth day in hospital, demonstrating massive haematomas. She was never formally charged or tried, and after being discharged from hospital she was allowed to return to her family.

CASE HISTORY NO. V:A,2.

24-year-old journalist and writer, Burhan Al Shawi, reported to Amnesty International that he was arrested on 3 November 1978 in a Baghdad street by security officers (*Danielsen* in *Amnesty International* 1981 (Iraq), page 37-8, Danielsen & Berger 1981). He was blindfolded and brought to the district security headquarters. He was kept blindfolded throughout his detention, which lasted nine days.

Previous diseases

Some years before the dorsum of his left hand was accidentally burned by a hot plate.

Present diseases

During the first days of his detention he was given hard blows and beaten with sticks and rubber tubes on various parts of his body. He was also severely kicked. As a result of this punishment several areas of his skin became erythematous, and others became blue and tender. The lesions disappeared after two weeks.

During the last days of his detention he was burned on several areas of the skin – on the dorsum of the left hand, on the lower extremities and on the abdominal skin. As the patient was blindfolded, he did not see the instrument used, but suggests that it may have been solid and of the size of a cigarette. He also suggests that the same instrument was used in all the areas mentioned.

The instrument was pressed on one area of the skin at a time, for periods ranging from about 30 to 60 seconds; each area was burned only once. The pain was most intense for the first few seconds; it then decreased and towards the end of the burning the damaged area, as well as the surrounding skin, became numb for a few minutes. The pain was often so intense that the patient lost consciousness while he was being burned.

The damaged areas of the skin appeared as black holes, some of which became greenish after a few days. A whitish or yellow liquid was secreted from some of the ulcers and others resulted in inflammation of the surrounding skin. The deepest ulcers were those on the lower extremities.

After his release the patient consulted a doctor, and he was given capsules to take orally (probably tetracycline R), one every six hours for seven days; he was also given local treatment with ointments. The ulcers healed over periods ranging from two to four months; all of them left scars.

At present the patient experiences pains related to the scars on the lower extremities, following any slight physical effort, such as working for three quarters of an hour.

Physical examination

Five circular, sharply demarcated lesions with a diameter ranging from 8 mm to 12 mm were present on the dorsum of the left hand, four of them just above the knuckles (Fig. App V:A,2 page 84). Two oval, less sharply demarcated lesions, with a diameter of 5 mm were seen on the dorsum of the left hand. The sharply demarcated lesions were slightly erythematous with a narrow hyperpigmented zone in the periphery. The skin of the lesions was thin, atrophic and wrinkled, and there was moderate atrophy of the subcutaneous tissue. The two remaining lesions had a slightly lighter colour than the surrounding skin but no atrophy.

29 sharply demarcated lesions were present on the lower extremities; on the extensor and lateral aspects of the thighs, the flexor and lateral aspects of the legs, and the medial and lateral aspects of the feet. Some of the lesions were arranged in groups but most were placed at random, with no pattern or symmetry. Their size ranged from 5 mm by 5 mm to 27 mm by 18 mm. They were circular, oval, or had a more or less serpiginous periphery. Many had a regular round or oval centre, which was bluish-red and atrophic, and two zones in the periphery, an inner slightly infiltrated zone of normal or whitish colour, and an outer pigmented zone (Fig. App V:A,3 page 84). Other lesions were subdivided into such confluent circular areas with a diameter ranging from 5 mm to 10 mm. One lesion lacked the atrophic central area. Still others had an atrophic centre of thin, wrinkled and scaly skin, slightly lighter than the surrounding skin or slightly erythematous, and often a narrow hyperpigmented zone in the periphery. Many of the lesions on the thighs and legs showed considerable atrophy of the subcutaneous tissue.

One circular, sharply demarcated lesion with a diameter of 13 mm was present on the abdominal skin. The lesion had a white, hypertrophic centre and a hyperpigmented peripheral zone.

Discussion

The sharply demarcated lesions are almost certainly scars caused by deep necrotizing processes in the skin and subcutaneous tissue. Such scars may be the result of the destruction of connective tissue by trauma or by inflammatory processes, such as abscesses, granulomata, and necrotizing vasculitis. However, the sharp demarcation of the scars, as well as their distribution, is unlikely to be the result of spontaneously occurring inflammatory processes. Thus it is most likely that the scars were caused by trauma.

Taking into account an inflamed zone around the damaged areas, the size and shape of some of the scars are compatible with trauma caused by a burning instrument of the size described by the patient. A central necrotic area and a narrow distinctly demarcated inflamed zone in the periphery were characteristic findings in third-degree burns produced by an electrically heated metal instrument on the skin of pigs under systemic anaesthesia (*Danielsen et al* 1978b), and some of the scars were clearly associated with sequelae to such an inflamed zone. Reflex actions of the patient might have caused small movements of the instrument during burning, explaining the size and shape of the large scars. The patient might not have been aware of such movements because of the severe pain, the development of numbness, or because of loss of consciousness. The small scars with a diameter of 5 mm might be the result of a poor contact between the skin and the instrument, which might have been slightly convex. Furthermore, in pigs under systemic anaesthesia the application of varying amounts of heat energy has been shown to produce lesions with diameters of varying size (*Danielsen L.* Unpublished data.)

The scars could, therefore, be the sequelae of third-degree burns. Both alternating current of high frequency and direct current (cathode area) cause macroscopical alterations similar to third-degree burns, but often with a subdivision into small, circular, confluent areas. However, the patient was not aware of contact with another electrode, which does not exclude such a contact, but makes it less likely. Two electrodes placed within an area of the diamter of a cigarette would probably not produce a regular circular scar with a diameter of 12 mm.

The less demarcated lesions on the dorsum of the left hand might be scars resulting from accidental burning, as mentioned by the patient.

Conclusion

The sharply demarcated lesions on the skin have an appearance and localization which are compatible with the history of trauma to the areas described. They probably represent scars resulting from a third-degree burn involving all layers of the skin and the subcutaneous tissue. The possibility that the scars are sequelae of electrical current passing through the tissue is not likely, but cannot be ruled out entirely.

B: CARDIOPULMONARY

CASE HISTORY NO. V:B,1.

(*Amnesty International* 1980 (Spain)).

Emilio Mariano Gines Santidrian, a 32-year-old architect living in Madrid, gave the Amnesty International delegates the following account. He was arrested at approximately 2.30 a.m. on 11 February 1979 in the street after leaving a dinner party attended by some of his friends and was in perfect health. He was taken by 10 to 12 policemen in four cars to the Security Headquarters in the Puerta del Sol in Madrid. He was taken to a room where officers of the Cuerpo General de Policie (Police) began to punch him in the stomach and face and pulled his hair, at the same time urging him to confess that he was a member of Euskadi Ta Askatasuna (ETA), Basque Homeland and Liberty, or at least had some connection with the organization and its activities. Emilio Gines says he denied these accusations and was transferred to another room where he was treated in the manner described below.

Later that day, between further interrogation sessions, he was

forced to sign a document about a search of his house, where nothing incriminating had been found.

Further interrogations followed and during the night of 13/14 February he was examined in the jail by a doctor who diagnosed a strained groin. On 15 February Emilio Gines, who had become incontinent, noticed that he was passing blood in his urine. That night he was examined by a woman doctor who took samples of his urine and told him that he had two broken ribs as well. While in detention in the Puerta del Sol, Emilio Gines was seen by four or five doctors and was X-rayed. Finally, on 18 February after seven days of interrogation, interrupted by brief periods in a cell, the police decided to suspend any further questioning.

On the morning of 19 February 1979, Emilio Gines was brought before the Judge of Instruction Central Number 2 of Madrid who, as soon as he heard his and the police statement, ordered his immediate unconditional release.

Once he was released, Emilio Gines visited various doctors and obtained medical evidence to corrobrate his allegation (see below). He also prepared a brief description of 10 individual police officers who were involved. On 14 March 1979 a criminal charge against the police for coercion and injuries was presented to the Judge of Instruction, but to date no action has been taken.

During his eight-day detention, Emilio Gines was held totally incommunicado without any form of legal assistance.

State of health before arrest

Operation for inguinal hernia on the left side. Otherwise in good health.

Medical aid during detention

Three medical examinations, including X-rays, during police detention. No reports are available to Amnesty International on these examinations.

Period during which alleged maltreatment took place: Eight days, first quarter of 1979.

Imprisonment

Arrested 11 February 1979. Detained incommunicado and in solitary confinement in a police station for eight days, after which he was released.

Alleges having been subjected to the following

Threats

Threats of execution and suffocation. Threats to arrest his wife and treat her in a similar fashion and to summon his relatives to be present during his maltreatment.

Physical exhaustion

The food was bad and insufficient.

Physical maltreatment

Hit all over his body, including on the head and in the genital region, with fists and rubber truncheons. Suspended for long sessions from la barra (once all night), sometimes while being held over a heater with a plastic bag over his head. Sometimes in this position he was jabbed in the neck with a truncheon which was also forced into his mouth. Falanga while suspended from la barra. Finger torture. Stretched between two tables with his hands handcuffed to the table legs. On at least one occasion a crash helmet was placed on his head and it was beaten very hard with truncheons, producing a deafening noise inside.

Humiliations

Verbal. His cell was very dirty. There was no means of keeping clean. Insufficient access to the toilet.

Describes the following transient symptoms

Pain after the direct blows. A severe sensation of suffocation while suspended over the heater and while his head was covered with the plastic bag. Haematomas all over his body. Considerable swelling of his hands, genital region and feet up to the medial malleolus, lasting for a week or two. Severe pain in the left side of the chest. Pain in the left side of the abdomen and blood in his urine for about a week. Nightmares and disturbed sleep.

Describes the following persistent symptoms

Periodic occipital headaches. Constant mild pain in the left side of the chest. Periodic swelling, tremor, paraesthesias and impaired coordination of the right hand. Irritability, inhibitions over contact with others and anxiety.

Medical documentation

Medical report dated one day after release (issued by doctor number 1):

Injuries to the chest and abdomen.
Fracture of the ninth rib on the left side.
Haematuria, apparently due to injuries.

Medical report dated two days after release (issued by doctor number 2):

Fracture of the ninth rib on the left side.
Fissure in the 10th rib on the left side.
Left-sided haemothorax (i.e. blood in the pleural cavity).
Bruises and haematomas on the anterior and posterior aspects of the chest, both forearms, left shoulder, both knees, both thighs, both feet, and in the left mastoid region.

C: GASTROINTESTINAL

CASE HISTORY V:C,1.

35-year-old man arrested in 1976 while temporarily in Tanzania gave the following account of events:

Before arrest, he had suffered from upper gastric dyspepsia relieved by antacids. A few days after his arrest he was subjected to systematic torture performed by the security police. The torture lasted for a couple of hours and consisted interalia in beating with the stiffened side of the hand (karate chops) and forcing beer bottles into his rectum while he was standing naked and barefoot on a floor strewn with sharp small stones.

The torture was not stopped until he started vomiting blood. He was then taken to a hospital in Dar-es-Salaam, where the doctors recommended hospitalization but this was refused by the security police. He was brought back to prison and stayed in solitary confinement for 7 months, vomiting blood more or less every day, with frequent pain in the epigastrium. He received no medical attention and the diet was very poor.

D: MUSCULOSKELETAL

CASE HISTORY NO. V:D,1.

Adriana Vargas Vasques, Chilean woman 29 years of age, was arrested March 1980 in Santiago because she was an active member in the non-political organization "Relations of Political Prisoners" (*Amnesty International* 1983 (Chile)).

She was tortured for four days at the interrogation centre in Santiago, and then released without any charges.

She was tortured with beating of the body and head, telefono, electrical torture, physical exhaustion, threats, mock execution, sexual humiliation, blindfolding, isolation, and suspension: she had to strip and was then suspended on the pau de arara (parrot perch), her wrists were tied together, she was made to crouch and her arms were forced over her bent legs. A rod was then pushed over her elbows and under her knees. In the course of this, her left elbow was injured. She was then suspended for about 15 minutes and again electrically tortured on the same parts of the body as before (head, breasts and body). She was unconscious for a short

while after being suspended on the pau de arara. Afterwards her wrists were very painful and there was a sore on the left elbow, and swelling and discolouration of the wrists and ankles.

CASE HISTORY NO. V:D,2.

25-year-old man arrested 1979 in Eritrea because of being an active member of the resistance movement, EPLF. No previous hospitalization and the state of health was good before arrest.

During the first 8 days of his detention, he was tortured by beating, stripped and placed in a bathtub filled with ice-cold water. Forced to sit in the water all day during these 8 days, only interrupted by toilet visits and electric torture. During electric torture he was fastened to a bench by wrists and ankles. It felt as if his right leg and arm were being torn off when the electricity was switched on, and he fainted. During the next four days he was semi-conscious, unable to move because of pain, especially in his right side. The pain in his right leg persisted for months and he was unable to walk.

He was released in 1980 and examined in Denmark in October 1981, 2-½ years after the torture had taken place. At the medical examination, a total rupture of the right quadriceps muscle was found, localised to the middle of the thigh. He walked with a limp.

The muscle rupture had probably been produced during the electric torture due to muscle spasm, the rupture being facilitated because the muscle was cold as a result of the extensive immersion in cold water.

SPECIAL RESEARCH ON FALANGA BY BRO-RASMUSSEN & RASMUSSEN 1978

The study took place in Greece in the summer of 1977, when *Frede Bro-Rasmussen* and the author concentrated on examining those victims who had complained at previous examinations of chronic difficulties in walking. At the same time information was gathered from Greek colleagues about other victims with similar symptoms.

The findings have been published in Danish Medical Journals (*Bro-Rasmussen & Rasmussen* 1978, *Bro-Rasmussen et al* 1982). Because the articles are in Danish, a detailed account will be presented:

Apart from the intense pain during and following falanga, the most obvious acute change was swelling of the feet, after which they became red and hot. Severe swelling would be accompanied by transient reduction of sensation, passing into numbness, weakness, and loss of function in the ankles, feet, and toes.

At the time of examination, fatigue and varying severity of pain in the feet, legs, and joints when walking was frequently reported (14 of 29 examined victims).

At the medical examination, 7 victims reported paraesthesiae or hypaesthesia of the toes (especially the big toe) or medially in the sole, especially when exposed to cold. 2 reported a tendency to oedema of the feet and ankles. No reduced or altered sensation to touch was found. In 4 victims, the plantar reflex was absent. 6 persons reported pressure tenderness in places in the sole, in good conformity with their difficulty in walking. 2 of the victims walked on their heels, and 4 had diffuse swelling and impaired function of one or both ankle regions. Skin temperature and pulsation in the pedal arteries were normal. X-rays of 4 victims with symptoms suggesting osteoarthritis in the ankle, knee, and/or hip joints were obtained. No abnormalities were seen. Radiological signs were found in the feet of only 2 victims. In one person there was an indolent, partially mobile tumour, about 1.5 cm in size, lateral to the fourth metatarsophalangeal joint on the left. The tumour was noticed by the victim after the swelling caused by the falanga had subsided. At that time, it had been extremely painful. The radiograph showed a round, sharply demarcated, non-homogeneous calcified tumour measuring 15×18 mm lateral and plantar to the fourth metatarsophalangeal joint on the left foot (Fig. App. V:D,1 page 85). The appearance and site were characteristic of an enchondroma.

No signs of Dupuytren's contracture or Morton's metatarsalgia were found.

In another person the radiography showed a small, periosteal calcification medially and proximally on the plantar aspect of the left metatarsophalangeal joint (Fig. App. V:D,2 page 85).

This man was subjected to falanga torture several times daily during one week in 1968, aged 22. It resulted in pronounced swelling of the feet and distal parts of the legs, as well as in severe pain when walking. After the torture was stopped, the swelling and pain on walking soon disappeared, but shortly after the pain on walking returned, mainly restricted to the toes and anterior parts of the feet, and gradually he developed pain also at rest.

Since then, he has developed stiff and painful toes; he walks on his heels and complains of pain in the back and knees. His condition has more and more affected him mentally.

He has been examined by several medical groups and has proved "resistant" to any form of physiotherapy.

Thorough neurological investigations at the Royal Free Hospital, London (Professor P. K. Thomas) have not shown signs of nerve injuries.

Repeated X-ray examinations have failed to reveal any abnormalities of the knees or back. On the other hand, ischaemic necrosis of bone has been detected in the proximal part of the phalanges of the third toe on the right and the second toe on the left, the latter also showing slight periosteal calcification.

It was therefore decided in July 1978 to resect the proximal half of the first phalanx of the second toe on the left.

Microscopic examination of the removed tissue revealed aseptic necrosis of bone with hyperplasia and inflammation of the surrounding soft tissues (periosteum, fibrous and synovial joint capsule, tendons, and tendon sheaths) (Fig. App. V:D,3 page 85).

The immediate result of the operation was excellent. The pain in the second toe on the left disappeared, the patient started bearing weight freely on his left foot, and he was using his right foot better. But when seen again in August 1979, he complained of returning pain in the left foot when walking. It was no longer localized to the second toe, but in the other – less injured – toes.

He refused further treatment.

The anatomy of the foot

The numerous victims having subjective late sequelae to falanga occasioned a study of the normal anatomy of the foot. 6 feet were dissected, anatomical preparations were reviewed, and injection experiments were done into the soles of the feet of fresh, unfixed cadavers of persons who had bequeathed their dead bodies to anatomical research and teaching. The results were compared with the studies of others on the anatomy of the foot.

The skin of the sole in the region of the heel, along the lateral margin, and on the forefoot is very tightly attached to the underlying plantar aponeurosis. In the region of the heel, and less so at the lateral margin of the foot, the cutaneous retinacula form small honeycomb chambers for the pads of the feet. In the forefoot the cutaneous retinacula form distinct, transverse strands which extend plantarly, almost like combs, from the plantar aponeurosis after removal of the skin.

The plantar aponeurosis consists of 3 distinct parts, medial, central, and lateral.

The central part consists of thick shiny fibres, predominantly longitudinal, which posteriorly serve as the origin of the short muscles of the foot. Posteriorly the aponeurosis is attached to the tuber calcanei, while anteriorly it spreads out fanwise into five longitudinal processes. These are inserted by superficial fibres into the skin over the metatarsophalangeal joints, and the deeper fibres go into the formation of the fibrous tendon sheaths of the toes. In addition, the aponeurosis contains transverse and arcuate fibres which knit the aponeurosis together, and in the forefoot pad the above-mentioned cutaneous retinacula are formed.

Distally, transverse fibres are lacking, so that between the 5

longitudinal processes of the aponeurosis, the superficial transverse metatarsal ligament and the distal margin of the aponeurosis, fat-filled squares are formed that contain the vessels and nerves of the toes.

From the medial and lateral margins of the central part of the aponeurosis there arise relatively thin fascial leaves which course around the medial and lateral muscles of the sole, inserting medially on the first and laterally on the fifth metatarsal bone. From the deep surface of the margins of the central part of the aponeurosis two strong septa, also serving for muscular attachment, course towards deeply and attach themselves plantarly on the first and fifth metatarsal bones (cf. Fig. V:D,1 page 20). This gives rise to three muscle compartments, one medial, one lateral, and one central.

The medial compartment contains the abductor hallucis muscle and the medial part of the flexor hallucis brevis muscle. The lateral compartment contains the muscles for the fifth toe. Deeply, the central compartment is limited by plantar ligaments and the plantar, interosseous fascia. From the medial edge of the central part of the aponeurosis a septum extends deeply towards the plantar interosseous fascia around the third metatarsal bone, dividing the central compartment into two. One contains the lateral part of the flexor hallucis brevis, the adductor hallucis, and the tendon of the flexor hallucis longus, while the other contains the flexor digitorum brevis, the quadratus plantae, the lumbrical muscles, and the tendons of the flexor digitorum longus. Anteriorly in the compartment, the tendons from the flexor digitorum longus and lumbrical muscles are separated from each other by sagittal septa which extend deeply from the plantar aponeurosis to the plantar interosseous fascia. The latter is attached, directly or by small fibrous septa, between the interosseous muscles, plantarly to the metatarsal bones, forming closed compartments for the interosseous muscles.

Injection experiments on the sole of the foot have shown that only a few drops of injection fluid can be injected superficially to the plantar aponeurosis in the region of the heel, in the lateral margin of the foot, and into the forefoot pad. Injection distally to the transverse cutaneous retinacula in the forefoot pad spreads the injection fluid to the distal, dorsal part of the foot.

Injection superficially in the soft part of the arch (5, 6, 12 millilitres) causes swelling of the arch, so that it becomes as hard as a board, spreading on the medial side of the foot, and "vermicular" swellings up behind the medial malleolus, presumably along blood vessels and lymphatics, gradually spreading around the ankle and distal part of the lower leg (cf. Fig. V:D,4 page 85). Injection deep to the plantar aponeurosis demonstrated that the medial, lateral, and interosseous compartments are more or less closed. The two compartments centrally are distinctly separated from each other. Both communicate along the flexor hallucis longus and flexor digitorum longus, posterior tibialis muscles, and vessels and nerves behind the medial malleolus with the flexor compartment on the lower leg. Injection into the compartments induces swelling proximally in the ankle region. Regardless of which compartment is injected, the injections result in the compartments becoming extremely hard, and subsequent retrograde injection of fixative under pressure through the femoral arteries prevents the spread of the fixative in the compartments.

We considered several hypotheses to explain the acute and chronic symptoms after falanga, e.g. the local symptoms from the foot and ankle regions, those from the ankle, knee, and hip joints, and in addition the more generalized, acute pain with weakness, dizziness, general malaise, and headache, in some cases leading to fainting.

There were no facilities in Greece for examining joints and bones for possible microfractures, posttraumatic osteo-arthritis, or necroses not demonstrable by X-rays. Nerve injuries with formation of neuroma could not be demonstrated.

When comparing the special anatomical features of the foot with the most outstanding symptoms of falanga from the feet and ankles, we feel that the symptoms are explicable as a closed compartment syndrome.

This syndrome is clear and well-defined in the lower leg, in both acute and chronic forms, affecting especially the extensor compartment. The chronic form is difficult to diagnose. In the upper limb the syndrome is known as Volkman's contracture. A special syndrome for the feet had not been described before, but later by others, e.g. *Bonutti & Bell* (1986).

The closed compartment syndrome is defined as painful ischaemic circulatory disturbances in connection with an increase in pressure and volume in a well-defined muscle compartment with fairly unyielding walls.

In the acute form the symptoms develop rapidly. The increase in pressure disturbs venous return, which causes increased resistance and reduced blood flow through the capillaries and arterioles. This entails a decreased supply of oxygen to the muscles, with accumulation of lactic acid and a tendency to oedema with swelling of the individual muscle fibres. This results in a further increase of volume, further arresting circulation in the small vessels and causing ischaemia of the muscles. It is accompanied by severe pain, erythema, heat, and tenderness; active and passive movements are painful, and there is gradual loss of function in the affected muscles with disturbances of sensation. Pulsation peripherally is usually normal in the large arteries. If the ischaemia persists, the tendency to edema increases and the volume increases further. A vicious circle of events can lead, if untreated, to necrosis and subsequent fibrosis of the muscles, giving a "silent" electromyogram. With less increase in volume, there will be a less violent course leading only to severe ischaemic pain in the muscles.

In the chronic form, the patient complains of pain in the affected muscles on exertion. If the exercise is interrupted, the symptoms generally subside after a varying period of time, but they may persist for hours. When exercise is resumed, the pain returns. Physical examination usually reveals only slight tenderness of the affected muscles and occasionally some pain on maximum movements in the joints. There are no neurological signs, and pulsation is normal.

Comparing the above with anamnestic data and the examination of the falanga victims, we must conclude that the similarity to the closed compartment syndrome on the lower leg is striking despite the macabre pathogenesis in the falanga victims. The anatomical conditions are present, the increase in volume in the muscle compartments is caused by oedema and bleeding due to the blows.

The signs found in the falanga victims have made us look for similar signs of the closed compartment syndrome in the feet of other patients. In our opinion, it does occur, even quite commonly. We have seen an acute, though mild, case in an out-of-training, but previously well-trained, skier after a downhill race on an icy and rough course. We have seen the more persistent, chronic form, in people who have resumed running exercises after a pause for varying lengths of time, causing in some cases such intense pain that they had to stop exercising. The symptoms occur also in athletes in severe competitive sport, and in recruits marching for long distances. In the great majority of patients, the symptoms are bilateral. They show a striking similarity, subjective as well as objective, to the symptoms seen in the closed compartment syndrome in the lower legs.

Conclusions

The symptoms following falanga torture are due to:

(1) The severe acute pain of oedema and bleeding superficial to the plantar aponeurosis, with tightening and tension of the cutaneous retinacula.
(2) Acute and chronic closed compartment syndrome in the muscle compartments of the feet.

On the basis of our examinations of falanga victims and the above conclusions of our results, we postulate that the closed compartment syndrome of the feet occurs, at least in a milder acute and more

chronic form, in athletes, and in people who exercise energetically, and others.

For good reasons, controlled therapeutic results are not available. There might be an indication for surgical treatment (fasciotomy) of the acute compartment syndrome in the falanga victims, as in patients with the closed compartment syndrome of the lower legs, but there is no definite indication for surgical treatment of the chronic closed compartment syndrome.

E: NEUROLOGICAL

CASE HISTORY NO. V:E,1.

37-year-old Chilean man, arrested in 1973, one month after the military coup in Chile. Before his arrest he was in sound health. He was arrested in his home at one o'clock during the night. He reports that he was kicked and whipped by the police when arrested, before being taken to the local police station. He had to undress and was tortured by beating with rifle butts on the head, and he experienced sham execution. After 8 hours, he was brought to a prison where he stayed for another six weeks. The conditions were poor with very bad and insufficient amounts of food, and he lost about 20 kg. there. He was then taken for further interrogation, during which he alleged beatings with fists and rods on the back of his head and against the stomach, electrical torture of the ears, hands, body and genitals, and burning with cigarettes. A pistol was forced into his mouth and he reports that two teeth were damaged.

Finally, he was thrown against a wall and lost consciousness. He was brought to the prison's sick quarters and remained unconscious for about six weeks.

He reported amnesia for those events, lasting some nine months. His worst complaint after the event was permanent vertigo leading to difficulty in walking.

At the medical examination in Denmark two years after the alleged torture, he still reported attacks of vertigo with difficulty in walking, but the attacks were less frequent. He had headaches more than once a week, and complained of easily becoming irritable. On examination, no neurological abnormalities could be found. X-ray of the skull showed changes consistent with previous fracture.

H: GYNAECOLOGICAL

CASE HISTORY NO. V:H,1.

A 25-year-old woman was arrested in her second month of pregnancy in Buenos Aires 1976. Her torture included being kicked and beaten with fists and an iron rod all over the body, but particularly on the head, chest, and abdomen. She was tied naked to a metal chair with electrical wires on her fingers and toes, and was also subjected to electrical torture all over her body, especially on the genitals, including vagina and clitoris. When a door was slammed on her head, she became unconscious. She was raped by the male warders.

She was threatened and experienced sham executions. She was deprived of sleep and kept in total isolation with adhesive plaster over her eyes for 2 months in a very small and cold cell without a toilet, so that she had to relieve herself in the cell.

The torture resulted in vaginal bleeding which persisted throughout her pregnancy. She gave birth to her child during the imprisonment. While in labour, which lasted for about 5 hours, she was placed on a bed, her arms and legs tied by a female warder. A doctor was present a few minutes before and during the delivery. The child was about 3 weeks premature, and weighed about 2,500 grams.

There was a small haematoma on one of its knees, and a haematoma was also found in the placenta. She was released 6 months after the delivery and expelled to Europe.

I: OTORHINOLARYNGOLOGICAL

CASE HISTORY NO. V:I,1.

A 30-year-old man who was arrested in Argentina in 1976. He was taken to the police station where he was interrogated and tortured. He was subjected to blows with a fist on his face, back and hips. He was also beaten on the feet, but not on the soles, subjected to telefono, and punched with brass knuckles. He was subjected to wet submarino, during which his head was held in a pail of clean water, and dry submarino, when a plastic was bag pulled over his head. During the latter, he felt as though he was suffocated and nearly lost consciousness. His torturers could not get the bag off his head, so they burnt an air hole in it with a cigarette.

He was then transferred to prison, and after about 2 weeks was again brought to the police station for interrogation. He was beaten for some two hours, and electric current was applied to his handcuffs. He was subjected to electrical torture with electrodes placed on his temples, throat, back of the neck, fingers and a number of other places on his body. He lost consciousness several times. At one point, he fell forward in a spasm and hit his forehead on the floor. He was also subjected to electrical torture to the auditory canals, which produced a screeching sound, like a dental drill, in his ears. Immediately after the telefono torture, there was some secretion from the left ear. He did not immediately notice any hearing loss, but a low frequency, pulsating tinnitus developed. He experienced no balance disturbances, and no dizziness.

The hearing, especially in the left ear, became increasingly worse. He was examined in prison, and found to have an inflamed eardrum, but was not treated for it.

Since then, his hearing has continued to deteriorate. He also suffers from increased sensitivity to noise. At the medical examination, both outer ears and external meatuses were normal. There was a healed atrophic scar in the pars flaccida of the left eardrum together with dilated temporoparietal capillaries. Neither drum was retracted, and no performations were seen. Reflexes were normal. Audiometry demonstrated a marked bilateral hearing loss in the high-frequency field over 1,000 Hz.

This was most pronounced on the left side, where sensitivity decreased rapidly above 500 Hz. Hearing was better in the low-frequency field, with 35 dB masking.

K: DENTAL

CASE HISTORY NO. V:K,1.

A 21-year-old Chilean man was arrested in the first quarter of 1982. He was held at the interrogation centre in Santiago for 19 days during which he was held incommunicado in a 2m by 2m concrete cell that contained a concrete bunk and a thin mattress. He wore overalls and sandals and was forced to wear a mask except when alone in his cell. His cell light was always on.

For the first five days he was interrogated several times daily, and was simultaneously tortured, mainly physically. He was slapped and struck on the head, mouth, body and genitals, and his buttocks and extremities were kicked. He was also electrically tortured on two occasions, each lasting five minutes. He was made to sit on a chair and electric current was applied to his back via a cable conducting current from a machine he thought was hand-driven.

During the last 14 days, the torture was exclusively psychological. It included threats of execution (a pistol was aimed at his temple) and threats to arrest his family.

Following this torture period, he was transferred to the Public Prison, whence he was released on bail after a further 26 days of detention.

Early symptoms described

He had aches and pains and felt weak all over, especially in the arms and legs.

After being hit on the mouth he lost an upper tooth, +4, and the frenulum of his lower lip bled.

He had diarrhoea for three or four days while at the interrogation centre. He attributed pain in the buttocks and near the anus to being kicked, and in the left testis to being beaten.

Throughout his detention he had headaches everyday. After being allowed to remove the mask he found his vision was impaired.

Periodically he had double vision and his eyes tired quickly when he read (the letters began to blur after about 10 minutes).

He had retrosternal pain several times a week, and palpitations of the heart lasting for about 15 minutes, when resting. (This was related to anxiety, he thought.) He had never had such symptoms before. While he was at the interrogation centre he lost his sense of time and could not tell night from day. He felt suicidal because of anxiety lest he reveal information. He suffered from insomnia and nightmares and was gloomy, emotionally labile, and indifferent.

Symptoms described at the time of examination

He felt unusually tired and weak and still had pain in his left testicle, although this was diminishing. Headaches started at about noon everyday. They were exacerbated by reading, and his visual problems persisted unchanged.

He still felt gloomy, emotionally labile and indifferent. He stayed at home most of the time and was not involved in anything (partly because he was under surveillance and could not meet his former friends outside his home).

He still suffered, though less frequently, episodes of precordial pain and palpitations of the heart while resting (probably due to anxiety) , and from insomnia and nightmares.

Clinical examination

He seemed depressed. Although prepared to cooperate, he was passive, slow, and hard to make contact with. He had difficulty expressing himself.

The clinical examination revealed bad teeth, many of them decayed. There was a large cavity in +4 and the crown was almost completely gone (see Fig. App. V:K,1 page 85). The lower frenulum of the lip was irregular and had small sores on it. He had muscular pains in the left flank and tenderness in the epididymis.

APPENDIX VIII. MEDICAL INVOLVEMENT

EXAMPLES OF MEDICAL PARTICIPATION IN TORTURE

Gustavo Oviedo, a 24-year-old man arrested in *Colombia* on 18 October 1978, was tortured for four days. Among other forms of torture, he was burnt with cigarettes and forced to squat on his ankles all night. After the four days, he was hooded and examined by a doctor at military headquarters. In spite of the fact that he had obvious bruises on his chest, the doctor said: "All you need is some food". On examination, the AI medical delegate found scars which were undoubtedly a result of burning with cigarettes (*AI* 1980 (Colombia)).

From *Spain* the author Eva Forest writes of her encounter with the police doctor (*Forest* 1977): "The doctor-accomplice comes and asks: "What's happened? How awful! Did you fall down? Did you jump from a high place? Were you playing, or dancing, perhaps?" With a sweeping gesture, he takes your hand and puts his stethoscope on you, precisely where it is of no importance. "It's nothing", he says, "a slight rattle, a nightmare, nerves, tension, hysteria, anxiety. Go on, continue, buckle down, finish it off, I'll come again later".

On 5 March 1979, the 39-year-old Maria Teresa Sol Cifuentes (one of the torture victims included in the present study) was arrested in Barcelona, *Spain,* and taken to a police station. For the next five days, she was subjected to torture, including threats, mock executions and the "motorcycle". In this, the victim is made to sit on a chair with the hands cuffed behind the chair back. The legs are spread and the knees bent, so the victim is sitting astride the chair with the hips flexed and the knees maximally flexed, which after a time causes intense pain in the knees. This can be intensified by the torturers' forcing the victim's calves up to the thighs. A helmet is placed on the victim's head and then banged with truncheons, causing a deafening sound inside.

Maria Cifuentes was prevented from sleeping for five days. At one point, she fainted during torture and a doctor was called in. He examined her and gave the go-ahead to continue the torture.

In *Brazil,* Fayal de Lira was "treated" by "the mad dentist". He was strapped into a chair, and his mouth was forced open and fixed with a dental instrument. His teeth were then drilled so forcibly that three of them were broken. He was then taken to a doctor who gave him an injection and said the torture could continue (*AI* 1972 (Brazil)).

The *Greek* doctor Dimitrios Kofas was known as the "orange juice doctor" because he prescribed orange juice as a universal remedy for many of the serious sequelae of torture, e.g. a prisoner named Stapas was prescribed orange juice as a remedy for haematuria after being tortured severely. After the fall of the junta, Dr. Kofas was sentenced to seven years in prison for 11 documented cases of dereliction of medical responsibility (*AI* 1977 (Greece)).

Dr. Harry Shibata, former head of the forensic medical institute in Sao Paolo in *Brazil,* was expelled from the Brazilian Medical Association in 1980. In 1975, Dr. Shibata was accused by a member of parliament, Marco Coelho, of having completed a medical certificate to the effect that there were no marks on his body after torture. In court, Mr. Coelho revealed bruises and burns on his body. Dr. Shibata was also charged with filling out and signing false death certificates on 25-year-old Vladimir Herzog, who died in detention in October 1975, ostensibly by hanging himself. His fellow prisoners testified that he had been severely tortured before he died.

Photographs of Vladimir Herzog's corpse led medical experts to challenge the finding. Later, Dr. Shibata admitted he had actually not seen the corpse (*AI* 1980 (Shibata)).

Dr. Samuel Nkulila, former head psychiatrist at Bugunda Hill Hospital in Mwanza, *Tanzania,* testified that in 1976, officers interrogating two men and one woman had requested him to inject them with 1.5 cc Methedrine (amphetamine), and that he had obeyed. On being asked whether his actions had been ethically defensible, he replied: "I believed it was in order because it would minimize the effect of the torture on these people ... I thought it was all right for me to use this method; it was scientifically reliable and had been proved by experts to be safe. I did all this to facilitate easy communication between the interrogators and those people". Dr. Nkulila also testified that he had examined the prisoners before giving the injections to make sure they could tolerate them. He was also present when the interrogations began. One of the prisoners died a few hours later. Dr. Nkulila testified that the autopsy showed the prisoner who died to have suffered from severe malnutrition, but unfortunately the autopsy report had disappeared. Amnesty International's Medical Adviser in London wrote to Tanzania's Minister of Health, Dr. L. Stirling, who replied that these were isolated incidents and that Dr. Nkulila was no longer allowed to practice his profession.

On 12 September 1977, Steve Biko died in detention in *South Africa.* He had been interrogated by the security police five days before his death, and witnesses testified that, as far as they could tell, he had been severely beaten. Over the next 2-3 days, Steve Biko became increasingly delirious, and even though medical examinations showed that he was suffering from brain damage, the doctors who examined him decided that he could be driven to a hospital more than 700 miles away, without medical attendance. He died shortly after arrival at the hospital (*Mertz* 1980).

A 24-year-old *Chilean,* Rifo Navarrel (one of the torture victims included in the present study) , was arrested by the CNI (Chilean secret police) on 8 March 1982 at his place of work and then brought to the interrogation centre in Santiago, where he was held for nineteen days. On arrival, he was stripped naked, dressed in

a boiler suit and sandals, and blindfolded. He was then taken for a medical examination and was asked about earlier illnesses. His blood pressure and pulse were recorded, and his heart and lungs examined with a stethoscope. The doctor told him he should cooperate with "the boys", otherwise things would go badly for him. Navarrel was interrogated and tortured for the next sixteen days. The torture consisted of fist-blows on his face, chest, and other parts of the body, and electrical shocks on his temples, mouth, fingers, penis, testicles, back, and in the rectum. He was completely naked and placed on a chair most of the time. He was also subjected to threats and a mock-execution. Before he was transferred from the torture centre to prison, he was once again examined medically.

In *Sweden,* a nurse forcibly administered medicine to some of 24 Chileans who were being deported after being denied political asylum. The authorities had chartered a plane to transport all 24 of them back to Chile on 19 March 1982. Even before the plane took off, the Chileans began to protest, and several of them were handcuffed by police on board the aircraft. A nurse who was also on board forcibly injected 5 of them with 2.5 mg Haloperidol each before the plane took off. During the journey, two of the passengers who were "causing trouble" were unknowingly given tea containing 0.5 mg Haloperidol drops. The nurse had been given the medicine by a police doctor (*Rasmussen* 1982) , and it is an example of how the authorities, in this case the Swedish police, use medical personnel for forced medication in order to make their jobs easier. Protests arose in this case and the Chancellor of Justice promised to conduct a thorough investigation. The long report resulting from the investigation concluded: "The use of tranquillizers in such cases seems to me to be totally justified. In the future, consideration should be given beforehand as to whether the use of tranquillizers will be necessary, and, if so, a medical evaluation of the case should always be obtained. If possible, a doctor should be present on the journey". The Central Committee of the Swedish Medical Association to whom the case was brought approved that:

1. Doctors should never, themselves or through instructions from others, collaborate in forced medication of persons who are not mentally ill or of patients who are unable, for other reasons, to give their consent. Medication should always be in the patient's own interest and not for the attainment of political objectives or those of the police.
2. Persons who are not mentally ill must not be "medicated surreptitiously", i.e. be given medicine orally or in other ways without having been informed thereof and without having given their consent.

Both these rules apply universally, but quite particularly in the cases of persons who are forcibly detained by the authorities, e.g. arrested persons and prisoners or persons who have been taken into custody to be expelled from a country.

A doctor working in situations where he or she has to decide on the treatment of persons who are forcibly detained by the authorities must bear in mind that in deciding upon medical procedures he or she should be guided exclusively by the regard to the patient's best interest. Thus, he or she should not take orders, e.g. from the police authorities, but should make his or her independent decision (*Svenske Laegeforening* 1983).

On 19 September 1980, the right hands of three thieves were amputated in *Mauritania* (*AI* 1980 (Medical Struggle)). The amputations took place in the desert outside the capital of Nouakchott and were the punishment prescribed by the country's Islamic code of law. The amputations were performed by a doctor.

THE DECLARATION OF TOKYO

BY THE WORLD MEDICAL ASSOCIATION

Guidelines for Medical Doctors Concerning Torture and other Cruel, Inhuman or Degrading Treatment of Punishment in relation to Detention and Imprisonment.

Adopted unanimously by the 29th World Medical Assembly, Tokyo, Japan, 10 October 1975.

Preamble

It is the privilege of the medical doctor to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity.

For the purpose of this declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

Declaration

1. The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.
2. The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.
3. The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment is used or threatened.
4. A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive-whether personal, collective or political-shall prevail against this higher purpose.
5. Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgement concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgement should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner.
6. The World Medical Association will support and should encourage the international community, the national medical associations and fellow doctors to support the doctor and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

PRINCIPLES OF MEDICAL ETHICS

Principles of medical ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment, adopted by the United Nations General Assembly, 18 December 1982.

Principle 1

Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

Fig. App. V:A,1. *A 24-year-old Spanish woman admitted to hospital after being beaten in prison. The photograph was taken on her fifth day in hospital.*

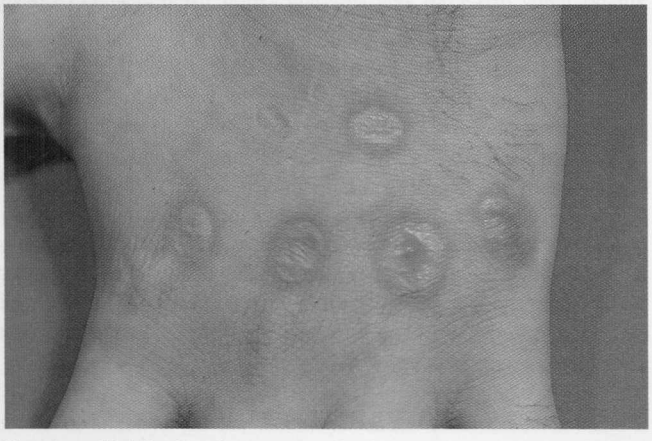

Fig. App. V:A,2. *Circular scars on the dorsum of Burhan Al Shawi's left hand one year after burning with an electrically heated instrument of the size and shape of a cigarette (Amnesty International 1981 (Iraq). They show an atrophic centre and a demarcated hyperpigmented peripheral zone.*
Such scars are characteristic findings following burns produced by an electrically heated circular instrument.

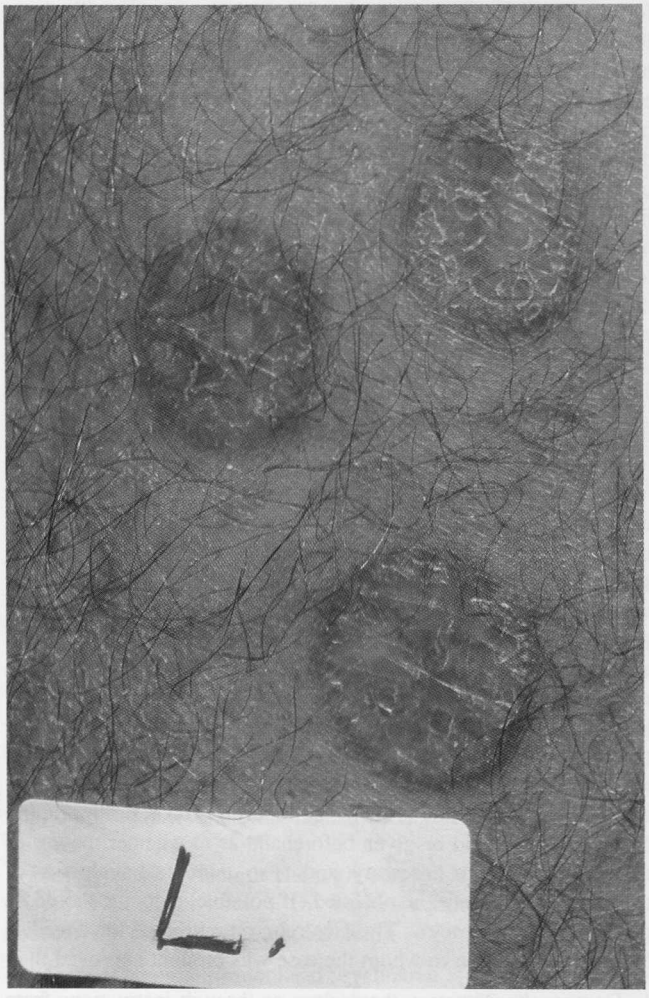

Fig. App V:A,3. *Circular scars on Burhan Al Shawi's left leg following burning with an electrically heated instrument of the size and shape of a cigarette (Amnesty International 1981 (Iraq)). They show an atrophic centre and a demarcated hyperpigmentated peripheral zone.*
Such scars are characteristic findings following burns produced by an electrically heated circular instrument.

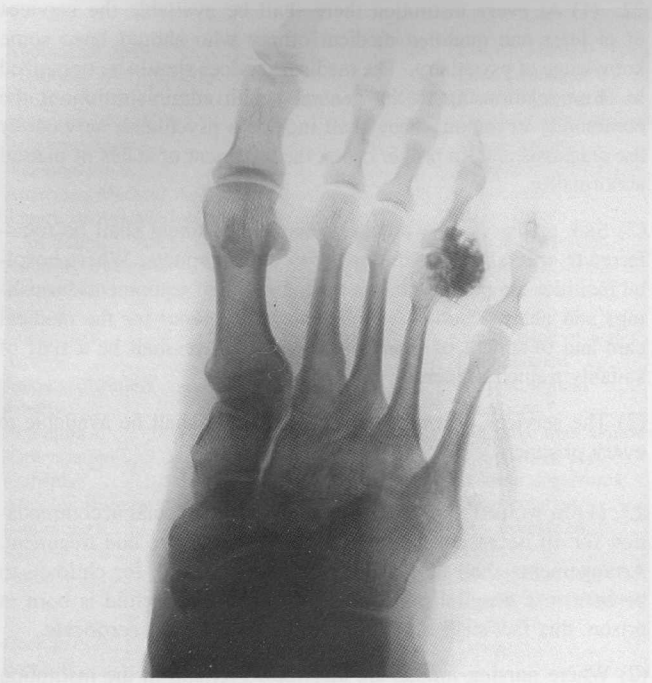

Figure App. V:D,1. *Falanga torture victim with asymptomatic enchondroma on the lateral and plantar side of the fourth metatarsophalangeal joint on the left* (Bro-Rasmussen & Rasmussen *1978).*
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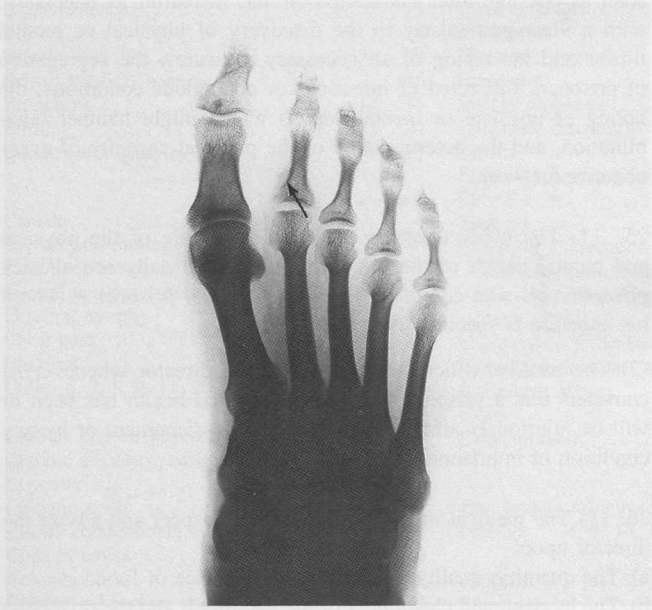

Figure App. V:D,2. *Falanga torture victim with mild periosteal calcification on the medial, plantar, and proximal side of the second metatarsophalangeal joint on the left* (Bro-Rasmussen & Rasmussen *1978).*
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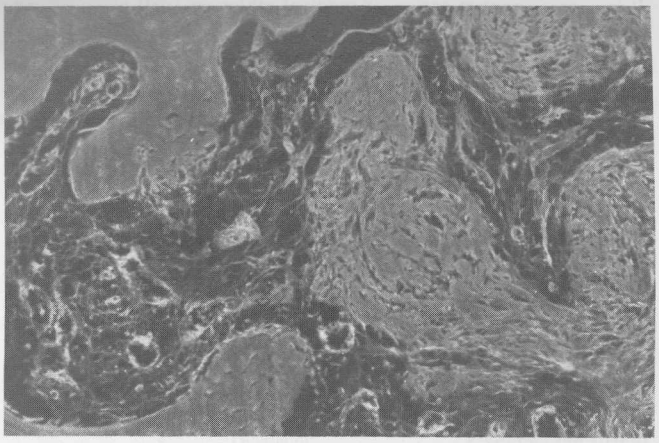

Figure App. V:D,3. *Microphotograph of resected specimen shows spongiose bone with aseptic necrosis, centre and right, with slight lymphocytic infiltration in surrounding connective tissue. Orig. mag. ca.×300* (Bro-Rasmussen et al *1982).*
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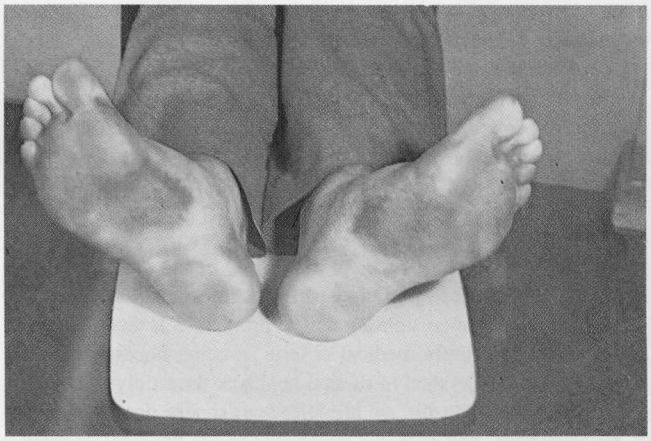

Figure App. V:D,4. *The feet of a young man (Spaniard) after falanga torture. Note that the swelling of the feet extends from the arch up to the medial aspects of the feet and ankles. Severe erythema of the skin in the arch is seen* (Bro-Rasmussen & Rasmussen *1978).*
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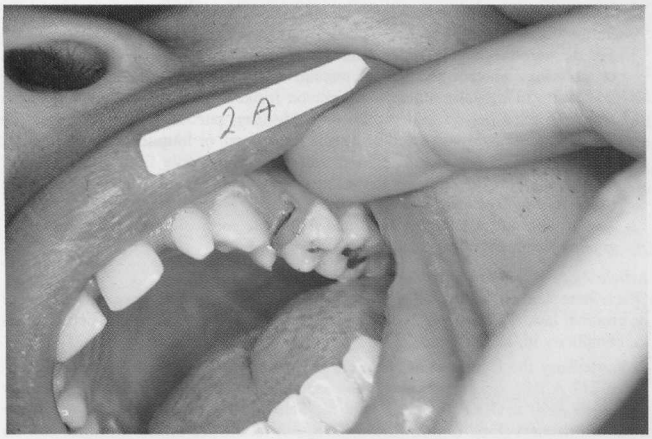

Fig. App. V:K,1. *The picture shows a large cavity in +4 from which the crown was almost completely missing. Allegedly a result of beating.* (AI *1983 (Chile).*

Principle 2

It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment. 1)

Principle 3

It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health.

Principle 4

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

a) to apply their knowledge and skills in order to assist in the interrogation of prisoners and detainees in a manner that may adversely affect the physical or mental health or condition of such prisoners or detainees and which is not in accordance with the relevant international instruments; 2)

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

Principle 5

It is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, or his fellow prisoners or detainees, or of his guardians, and presents no hazard to his physical or mental health.

Principle 6

There may be no derogation from the foregoing principles on any grounds whatsoever, including public emergency.

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1) See the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (General Assembly Resolution 3452 (XXX) , annex) , article 1 of which states:

"1. For the purpose of this Declaration, torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted by or at the instigation of a public official on a person for such purposes as obtaining from him or a third person information or confession, punishing him for an act he has committed or is suspected of having committed, or intimidating him or other persons. It does not include pain or suffering arising only from, inherent in or incidental to, lawful sanctions to the extent consistent with the Standard Minimum Rules for the Treatment of Prisoners.

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

Article 7 of the Declaration states:

"Each State shall ensure that all acts of torture as defined in article 1 are offences under its criminal law. The same shall apply in regard to acts which constitute participation in, complicity in, incitement to or an attempt to commit torture."

2) Particularly the Universal Declaration of Human Rights (General Assembly resolution 217 A (III), the International Covenants on Human Rights (General Assembly resolution 2200 A (XXI) , annex) , and the Standard Minimum Rules for the Treatment of Prisoners (First United Nations Congress on the Prevention of Crime and the Treatment of Offenders: report by the Secretariat (United Nations publication, Sales No. 1956.IV.4), annex I.A).

STANDARD MINIMUM RULES FOR THE TREATMENT OF PRISONERS AND RELATED RECOMMENDATIONS

Adopted by the first United Nations Congress on the prevention of Crime and the Treatment of Offenders, held at Geneva in 1955.

Medical Services

22. (1) At every institution there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry. The medical services should be organized in close relationship to the general health administration of the community or nation. They shall include a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality.

(2) Sick prisoners who require specialist treatment shall be transferred to specialized institutions or to civil hospitals. Where hospital facilities are provided in an institution, their equipment, furnishings and pharmaceutical supplies shall be proper for the medical care and treatment of sick prisoners, and there shall be a staff of suitably trained officers.

(3) The services of a qualified dental officer shall be available to every prisoner.

23. (1) In women's institutions there shall be special accommodation for all necessary pre-natal and post-natal care and treatment. Arrangements shall be made wherever practicable for children to be born in a hospital outside the institution. If a child is born in prison, this fact shall not be mentioned in the birth certificate.

(2) Where nursing infants are allowed to remain in the institution with their mothers, provision shall be made for a nursery staffed by qualified persons, where the infants shall be placed when they are not in the care of their mothers.

24. The medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary, with a view particularly to the discovery of physical or mental illness and the taking of all necessary measures; the segregation of prisoners suspected of infectious or contagious conditions; the noting of physical or mental defects which might hamper rehabilitation, and the determination of the physical capacity of every prisoner for work.

25. (1) The medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed.

(2) The medical officer shall report to the director whenever he considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.

26. (1) The medical officer shall regularly inspect and advise the director upon:

a) The quantity, quality, preparation and service of food;
b) The hygiene and cleanliness of the institution and the prisoners;
c) The sanitation, heating, lighting and ventilation of the institution;
d) The suitability and cleanliness of the prisoners' clothing and bedding;
e) The observance of the rules concerning physical education and sports, in cases where there is no technical personnel in charge of these activities.

(2) The director shall take into consideration the reports and advice that the medical officer submits according to rules 25 (2) and 26 and, in case he concurs with the recommendations made, shall take immediate steps to give effect to those recommendations; if they are not within his competence or if he does not concur with them, he shall immediately submit his own report and the advice of the medical officer to higher authority.

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