International NGOs

Three NGOs run emergency actions to get letters, telexes, etc., sent to officials in authority when there is a fear of or actual torture. They also campaign for remedies for victims and punishment of officials, especially at the UN.

- Amnesty International,
  1 Easton Street, London, WC1X 8DJ, England.
  TEL: +4471 413 5500 FAX: +4471 956 1157
- SOS Torture: Have 190 affiliated associations worldwide. To find the nearest one, contact:
  Case Postale 119, Rue de Vermont 37-39,
  CH-1211 Geneva, Switzerland.
  TEL: +4122 733 3140 FAX: +4122 733 10 51.
- Lawyers Committee on Human Rights: ONLY for lawyers and judges; the address is:
  330, 7th Avenue, 10th Floor,
  New York, NY, 10001, USA.
  TEL: +1212 629 6170 FAX +1212 967 0916.

International Committee of the Red Cross (ICRC): Are active worldwide, to "protect and assist all victims of war, civil war and internal strife". In almost all cases, work without publicity. For details of your nearest delegation, contact:
17 Avenue de la Paix, 1202 Geneva, Switzerland.
TEL: +4122 734 6001 FAX: +4122 734 8280

International Service for Human Rights (ISHR): Are dedicated to helping NGOs from around the world to use the UN procedures. Do not campaign themselves. The address is:
1, rue Varembe, P.O.Box/Case 16,
CH-1211 Geneva 20 cic, Switzerland.
TEL: +4122 733 5123 FAX: +4122 733 0826.

Rehabilitation Services

For details of rehabilitation centres and services throughout the world the place to contact is:
International Rehabilitation Council for Torture Victims, IRCT, Juliane Maries Vej 34,
P.O.Box 2672, DK-2100 Copenhagen 0, Denmark.
TEL: +45 31 39 46 94 FAX: +45 31 39 50 20.

UN Mechanisms on Torture

For all UN procedures, the first place to contact is:
UN Centre for Human Rights,
Palais des Nations, CH-1211 Geneva 10.
TEL: +4122 917 1234 FAX: +4122 917 0123.

Direct your information to "Secretariat for the Special Rapporteur on Torture, UN Centre..."or "Secretariat for the Human Rights Committee, UN Centre..." and so on.

EMERGENCY SITUATIONS

Special Rapporteur on Torture: can send urgent appeals to prevent torture occurring.

Working Group on Disappearances: Chairman can send cables where someone has "disappeared" and there is a fear of torture. DOES NOT act in wartime (→ NGOs: ICRC below).

UN Secretary-General: can use his "good offices" to intervene in humanitarian cases, eg where the victim is in poor health or old or if there is a large number of cases.

GENERAL SITUATIONS

Special Rapporteur on Torture: Examines questions relevant to torture and enters into dialogue with governments to investigate claims of torture; issues annual report.

1235/1503 Procedures of the Commission on Human Rights: These two procedures are additional ways of helping victims of human rights violations. There are many complicated rules and problems of strategy. The best approach is to ask for advice from an experienced NGO (some are listed below).

Special Rapporteurs on Afghanistan/Iraq/Iran/Myanmar: if the torture is occurring in one of these countries, these people should be informed; report to Commission on Human Rights.

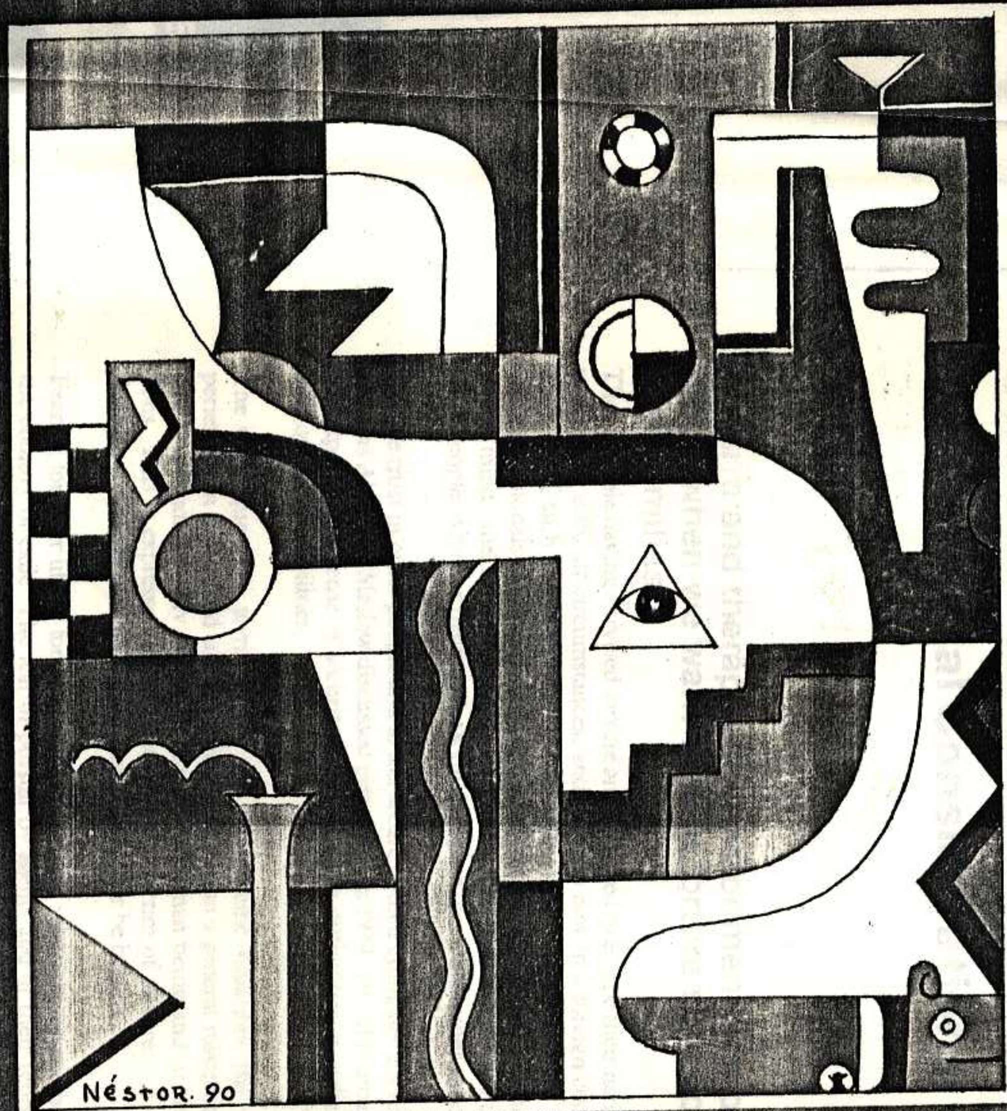
Human Rights Committee (ONLY for countries which are party to ICCPR): examines reports by governments on human rights in their countries; asks questions of the government based on information usually supplied by NGOs; issues own report.

Committee Against Torture (ONLY for countries which are party to CAT): examines reports by governments on protection from torture in their countries; inquires confidentially if hears of torture being commited; issues own report.

TORTURE SURVIVORS

– a new Group of Patients

Lone Jacobsen
Peter Vesti



Family at RCT. Photo: John R. Johnson

Chapter 4.

Nursing Care for Torture Survivors.

Fundamental Considerations.

A warm and therapeutic environment is a precondition when we want to help torture survivors and their families.

Those people having survived torture and managed to escape their native country under very difficult circumstances, and who are now in a foreign country, have lost a lot of faith and trust both in themselves and in other people. The health care professionals treating and caring for the survivors of torture will have to keep this in mind, and in their attitude and behaviour try to re-establish the trust of these people, whether treating the sequelae of torture or any other condition.

To have trust in other people and to feel secure in their company is a fundamental need, as Abraham Maslow discussed previously in 1954 (19). If human beings do not experience a sense of security, they will have difficulties in feeling love and developing their abilities.

The techniques, the torturers use and the extreme situations the victims experienced in prison and under torture have lead to a general mistrust of people, and to a fundamentally changed view of the human being and its living conditions. This is expressed in this quote from a victim of torture: "A crack went through the image of God, a crack that could never be healed."

Fearing for your life or for others does not cease, when the escape has ended in the country of exile. The fear of pursuit by agents and of their reprisals can be genuine,hence for long periods of time the refugees live hidden, changing addresses, even name. Still they receive letters from the authorities of their home country via the embassies; this creates a very difficult choice, as the letters are ap-

pealing to them to come home. If they do not do that, the authorities will arrest for instance a close relative. For security reasons the contact to family and friends have to be disconnected for a time. Often the mistrust is greatest of fellow countrymen in the country of exile, something we need to consider seriously when we use interpreters.

How do we create an environment that is therapeutical and which helps the patient to feel secure?

The therapeutic environment is defined as being based on the social and psychological wellbeing of the patient. When the patient feels better as a result of the contact with those who give treatment and care, then the right therapeutic environment exists. What the patient is feeling, is important- not what those caring for him are feeling. Naturally, the feelings of the nurse are important in that she has to try and understand her own attitudes and emotions when meeting the patient. This particularly applies when the partners in care are from different cultures, as we cannot divorce ourselves from our background. Situations can easily arise when the nurse will have to suppress her own reactions in order to avoid conflict in relationships with the patient. It will be therapeutic to let the patient talk about his background, to let him express opinions and feelings without the nurse making her own interpretations. Discussions that make the patient unhappy, angry or in some other way disturbed the nurse must avoid. It has to be the reactions of the patient, and the trained nurse's ability to control the situation that will decide how far they can get in a dialogue concerning opinions in sensitive areas like social or political matters.

The need for self-esteem and dignity, to belong, are components in the feeling of safety and security.

The communication must include respect for the patient: especially during the patient's first visits to the Centre. when he and the therapists do not know one another very well,it is important to promote these feelings. We have to show the patient, that he is welcome and expected, and that we have an open and friendly attitude. In the past the patient has experienced in prison a de-personalisation, when he was not called by name, but by number and has been commanded to perform unacceptable deeds. Therefore, you must use **the patient's name,** try to obtain eye-contact and sit down next to him during the presentation/interview to ensure that you are both on the same physical level and thus avoid talking down to the patient. If the culture allows body contact like a handshake, possibly a hand on the shoulder, it is a signal to say: I am aware of you as a **whole** person and you are important.

The physical frames of a treatment centre for torture survivors must have the characteristics of "a home" with a kind and warm atmosphere. It must not look like an institution, and the therapists only wear uniform in special circumstances (e.g. during the taking of blood or a somatic investigation). As described, RCT is therefore situated in two smaller houses furnished with pictures on the walls and green pot plants. The furnishing is comfortable, and in the reception hall the furniture is placed so that one can sit and talk in a relaxed way around a table, where tea and coffee are always available.

A centre like RCT always has many enquiries from health care professionals, journalists etc. Out of consideration for the environment we neither conduct study tours in the areas or in the rooms where the patients are, nor are the houses presented to large groups of people during the hours when treatment is taking place.

Likewise it is of vital importance that the Centre is independent of any government authority. Furthermore, we have obtained an agreement that uniformed police are not admitted to the premises.

The co-operation between the patient and the trained nurse must take place in a relationship of equality with the trained nurse informing openly, honestly and completely about the intentions of the Centre, and she will have to give equal value to the statements of the patient a weight equal to her own. The patient and the family have the right to say no and are shown full respect for this decision. It is an aim to have the patient as partner in care,involved in planning the treatment and other matters concerning him.

These conditions are ordinary democratic conditions for therapists in our part of the world. However, RCT treats people from **cultures with other values** than our own. Thus, it is not always possible for the trained nurse to follow her own traditions and include the patient in all parts of the decision process. Some patients expect the trained nurse to make all the decisions.

Culturally, RCT is a small pluralistic community, where knowledge of the individual patient/family's culture will help the trained nurse to work more effectively. One has to gain knowledge about and insight into the social structure, belief, values, perception relating to concepts of health care and the traditions of nursing in the patient's culture. It is important not only to focus on the differences, but also the similarities in the cultures. However, it is the differences that cause problems. This raises the question to what degree have we the right to change the culture of other people? Put differently : When we feel that a cultural characteristic is adverse to treatment /care, are we entitled to persuade the patient to accept our culture, just because it is better for him?

Aspects of these considerations are often discussed among the team of therapists, under the common heading: to what degree do we rehabilitate the patient and his family. Rehabilitation has to be seen in the widest sense, a process in which the patient is working towards regaining the ability to take care of himself and his health. This does not mean physical health only, but also emotional, intellectual, and social health. Behind this interpretation are hidden many values of a cultural nature.

In the Western cultures we put great importance on the individual and his ability to manage on his own. On the contrary in Islamic cultures importance is on the individual as part of a larger unit, the family. If the family is religious, then many things in everyday life have been determined in advance by the precepts of the religion. Therefore, it does not always make sense to discuss how the individual is to behave, or what he should think about this or that.

It has rightfully been claimed that we must accept the right of human beings to act according to the values of their own culture.

However, in certain circumstances one might find a good reason to try and bring about a cultural change. Especially where health is concerned, one may feel that this is not violating the rights of the individual, when a thorough explanation knowledge is given about why it is reasonable to change behaviour. Thus the patient is given the possibility of deciding for himself. That way, as a minimum we open the possibility for the patient to be able to live and function in our society.

As an example, I can mention that many of our patients suffer from gastritis and will start the day by smoking cigarettes and drinking coffee. In their culture the main meal of the day is taken during the afternoon, and they will not wish to eat in the morning. This is an inappropriate treatment of gastritis, as food has to neutralise the acid in the stomach, acid greatly prompted by cigarette smoking. Explaining this to the patient gives him the possibility to acknowledge, that it is a good idea to have a meal in the morning before smoking, or possibly even to stop smoking altogether.

Another example of cultural conflict arises during treatment when we wish to promote the ability of the patient to express anger against the torturers and anger in other relevant contexts. In some religious subcultures it is not legitimate to feel/show anger, and because of that the patients have demonstrated great self control, which can be a barrier in the therapy.

Any deliberate attempt to change the cultural behaviour of people will always have to happen in co-operation with the patient and only after thorough discussion and consideration by the full team of therapists. One person alone should never take such a decision.

Situations reminiscent of torture, create unrest and anxiety in the patient.

The experiences of torture the patients have been exposed to are deep seated in them. We have heard how they surface in dreams night after night, and we see how the patients are feeling tense and anxious, they might even relive the torture when associations are made. Some patients experience this as a sudden explosive type of headache, when they are confronted by certain situations.

It requires respect and prudence to examine and treat torture survivors, and the trained nurse must remember that the reactions of the patient in certain situations always have a reason and can be explained, however impossible they might seem.

To predict the situations that might occur of this nature, the trained nurse will, like the rest of the team, need to know the patient's history of torture and gain information about methods of torture from reports, from the patient's medical notes, or from colleagues who know the patient well.

This information is not always available to trained nurses or others having contact with torture survivors outside RCT (hospitals, G.P. surgeries, district nursing etc.). Naturally, those staff members cannot burden the patient by asking about the torture again and again. Instead they have to thoroughly inform the patient about what is going to happen, giving him the possibility to anticipate his reaction.

Torture survivors often present themselves with a complete and neat facade, making it difficult to imagine the sudden and violent reaction to a situation which, for others, would be quite neutral.

The following is such an example. A young woman being treated by us and who was progressing well, had been subjected to severe beatings on the head and suffered periodically terrible headaches. During the torture she had been isolated in a small room for several months. To exclude any pathological conditions, a CT-scanning was planned where she had to lie on a trolley in a room in the x-ray department. To keep the head completely still while the x-ray is done, the head is fastened to the trolley by a wide strap padded with foam rubber. The patient had previously been prepared for the investigation, had been to the x-ray department with the nurse and met the staff conducting the investigation.

She arrived at RCT as agreed and a trained nurse accompanied her to the hospital, where the examination had to take place. It was obvious that she was becoming increasingly restless and had a headache. It appeared that the night before the investigation she had convinced herself that it was an investigation and not torture she was going to. Still she was not able to go through with the investigation, and the rest of the day she had a terrible headache which proved difficult to relieve. Later the experience was worked through in psychotherapy. Only months later was she able to go through with the investigation.

It has to be emphasised, that there are individual differences in the reactions. Not everyone reacts as strongly.

Through the years, we have experienced many situations that require prudence. This has often been the case with investigations using instruments looking into the cavities of the body such as otoscopy, proctoscopy, gastroscopy, and gynaecological examinations. The proctoscopy and gastroscopy will in most cases be done under general anaesthetic, causing the least psychological burden to the patient. It goes without saying that a gynaecological examination for a woman, previously exposed to sexual torture, can strain her with memories of the humiliating violations, and to do the examination requires good preparation of the patient, showing respect and care.

To examine torture survivors requires great consideration. Here the patient is having an ECG traced by a trained nurse at the RCT. The room has hardly any clinical appearance.
Photo: John R Johnson.

With investigations like ECG, EEG and CT-scanning, even the sight of clinical equipment and apparatus (recovery rooms, operating theatres, laboratories, needles, sharp instruments etc), can create tension and anxiety rising to panic.

Some of our patients have not dared visit a dentist since the torture. Therefore the first dental examination will take place at the Centre, so that the contact can be made in known surroundings without clinical equipment, strong light etc.

Sedation and especially the recovery are in most cases critical periods for the patient, as he risks reliving the torture. This will be discussed further in the chapter, "When torture survivors are admitted to hospital."

Most investigations can be done at RCT, but in some cases it is necessary to refer the patient to other specialists. If considered necessary, an interpreter as well as a member of staff, frequently the trained nurse or the psychotherapist,who knows the patient well, will accompany the patient.

Nursing Care for Torture Survivors.

The theoretical model for the nursing care at RCT follows the Orem model of self-care (20). By self-care is meant the acts, the individual takes the initiative in order to sustain life, wellbeing and health. The model for self-care respects the integrity of the human being, and the aim of the nursing care is to strengthen the active efforts of the patient towards his own health.

Guidance and Teaching.

Based on the model of self-care the trained nurse and the patient will assess the problems, that will need guidance and teaching to promote health and prevent illness. During the initial interview with the patient the trained nurse will have to avoid asking stereotypical questions, and to use strongly lit lamps, as it has to be remembered that the patient have been exposed to long and exhausting interrogations in connection with the torture. The surroundings have to be pleasant as described above under physical frames, and plenty of time must be available to conduct the interview.
Tolerance promotes a good interview. It is of special importance to respect silence, as this may support the patient in accepting his feelings.

It may be necessary to discuss problems about sleeping, dietary problems or problems relating to other areas of the patient's life.

RCT have researched into the sleeping patterns of torture survivors and found that they do not go through the normal phases (21). This corresponds to the sur-

vivors' own account of **a very poor and inter-rupted sleep.** These irregularities increase the irritability and anxiety of the patient.

In the psychotherapy, effectively working through the experiences that occurred during torture will increase the quality of sleep. The trained nurse can help the patient to discover which activities previously in life tended to promote sleep and suggest that he takes them up again.

It is common knowledge that sleep is preceded by a phase of relaxation, and some patients will gain from learning the technique of relaxation. For example, a patient can be assisted to relax by having him take several deep breaths. On the last breath encourage him to try to feel as limp as possible. Then, while the patient is in a comfortable position instruct him to feel the muscles in one leg and then purposely allow the leg to go limp. Have him repeat this for the other leg, the gluteal muscles, each arm and shoulder, and the face, each time stressing that he must first purposely contract the muscles and then allow them to go limp. Gentle massage helps muscles to relax. Therefore, massage of the back is often helpful in precipitating sleep. A spouse or some other person can be instructed to give the patient massage.

The survivors often enjoy cooking, both food from the new country and from their homeland. Here a cookery lesson is supervised by a compatriot.
Photo: Heine Pedersen, Copenhagen, Denmark.

Many torture survivors have lost weight during and after prison and tell how they **have lost the appetite** and thus do not get their dietary requirements. The lack of appetite has to be seen as part of the poor mental state they are in at the time, but it is necessary to find out, if other factors like illness are involved. Some do not get the right nutrition/diet they need, as they were not responsible for shopping and cooking earlier. They might also lack the necessary knowledge about, what the right diet can mean for their health. The trained nurse will have to instruct about nutrition and give guidance about a healthy diet; perhaps making menu suggestions, and possibly teaching the patient to go shopping.

Some of these patients have with a favourable result participated in courses on cooking from both their own countries and Denmark. The RCT's interpreters from the relevant countries have been in charge of the teaching that has taken place at RCT, and the finished meals have been eaten under pleasant circumstances together with members of the staff.

Support.

The patient and his family will benefit from support during periods of anxiety and depression.
It is the job of the trained nurse to support the patient during difficult situations that will create unrest and anxiety. Furthermore, she can offer support if the patient needs to calm down, cry or vent aggressive feelings.

Torture survivors can have outbursts of violent emotions. They have their background in both the terror they have been through, but also some present frustrations ie the new culture they now have to live in, may be the cause. Bad news from home, such as the family being imprisoned or tortured, or that acquaintances have been executed, can also provoke outbursts of violent emotions. The types of aggression we see in the torture survivors range from threatening behaviour/implied threats to sheer aggression against dead things. Violent attacks on staff are **extremely** seldom. An example of passive aggression occurs when the patients refuse to leave the room unless we do certain things or promise something.

Torture survivors have experienced strong anxiety and aggressiveness,with the emotions being prevented from being expressed against the right person, and therefore the emotions can now be directed at other people, in this case the therapists.

It is obvious that a strong emotional reaction can provoke fear, anxiety or anger from the staff, which will influence negatively their ability to judge and tackle the situation. Therefore it is important to be prepared and to know what to do in those circumstances. The team of therapists as a group will have to agree guide-

lines and discuss their attitudes towards helping the patient and how to help one another afterwards. One is not always able to prevent a patient losing control, but one can attempt to lessen the stress and frustration and thus perhaps the aggressive attack.

The body language and the verbal expression will help to indicate the beginnings of aggression. The patient is angry or excited, he is easily startled by noise or disturbance, hurls threats but reacts to questions. It is important to try and have a good contact to the patient and convince him, that we will help him. The aggressive behaviour can be aggravated until the patient, more irate will not listen to what is being said. He protests and makes verbal provocations. His hands are often clenched and eyes are staring. At this stage,the therapist must set firm limits and avoid having to plead or negotiate on an unrealistic basis.

If the trained nurse is on her own in this situation, she must consider calling for help, before the behaviour reaches the last stage, ie where an actual physical attack takes place. Should this happen, she must immediately leave the room.

With her actions, the trained nurse must try and support the patient's feeling of security and responsibility for the situation, and she must avoid taking personally any verbal/physical aggression. From the patient's point of view such aggressive behaviour is only an attempt to gain control over a difficult, incomprehensible situation.

Different techniques can be used to counteract the effects of possible violent emotions. At the start of the attack one must show a calm and confident behaviour and try to show verbally that one understands why the patient is angry. One can ask him if he is afraid of losing control . It is important to keep the concentration of the patient, and when one talks to him to keep his attention by using simple sentences and his name. Attempts to try and persuade the patient to this or the other, which he does not want, will only increase the emotional intensity.

Earlier in this chapter was mentioned that body contact can bring about the acceptance of a human being. When it comes to aggressive behaviour, it is imperative to respect the "space" of the patient; this is understood as the patient experiencing a certain physical space around his body as a personal territory. To invade that without permission can provoke physical aggression.

It is obvious, that the best way to cope with the problem is prevention, and to be alert so as to intervene quickly, as it is easier to handle the situation before it becomes critical. The therapeutic environment is important in the prevention of the development of such attacks. If it is successful, mayor tranquilizers will hardly ever be used.

Management of the treatment.

The trained nurse has a shared responsibility for the planning and implementation of the somatic investigations and treatment programme. The standard programme of investigations has been mentioned in chapter 3 . Also among the investigations done routinely are ECG, analysis of blood samples to assess the haemoglobin, liver and kidney functions, screening of urine for albumen, blood and sugar, and the measuring the height and weight of the patient.

The above mentioned investigations are done by the trained nurse at RCT in surroundings that do not look like a laboratory, but are decorated in warm and soft colours. As mentioned before we seldom find results outside the norm, which is a great relief for the patients.

Planning the visits to consultants outside RCT is done by the medical secretary and the trained nurse. The nurse is also responsible for monitoring that all replies have been received. Suggested additional investigations and possible treatment are implemented by RCT, such as the administration of medicine to the patient.

Torture survivors have a tendency to somatise irrespective of where in the world they are from. By somatising is meant the bodily expressions of psychological conflicts. The patient often has recurring multiple complaints of a somatic nature over a period of years. Doctors have been consulted, but it has not been possible to find any obvious physical abnormalities. This reaction can be explained as the body's reaction against the massive attack by the torturers. We never neglect somatic complaints, but on the other hand we cannot allow the patient to stay in a chronic state of somatising. The trained nurse will have to be aware of this, as the patient often goes to her first with his somatic complaints.

Drug treatment is primarily relevant for somatic illnesses. Infections of the bronchia are frequent during the Autumn- and Winter months and are treated in the usual manner with antibiotics The trained nurse will hand out the prescribed drug and must ensure that the patient has understood why and how the drug should be taken. She makes sure, the patient comes back for assessment of the effect of the treatment.

In some countries there is a great belief especially in the healing effects of antibiotics and that at the onset of the slightest temperature a strong request for antibiotics is expressed even when we do not find any justification for it. In those circumstances the trained nurse will have to teach the patient about the body's ability to cope with infections, the limitations of antibiotics in this context and the harmful effects of indiscriminate use of antibiotics.

~~손문회생자들의 심리~~
손을 떼내자들의 정신병리학

~~빠른~~ 미국 메릴랜드의 B. 포렌스 하트만

철거 요부림치 때의 손문회생자들은 다른 논문을 쓰게 되다.

피상 당한 사례.

슬픔, 분노, 악몽 들이 주로 나타나던

행위에 있어서 무반응 (기쁨 ...) 이는

상아방도에 대한 죄책감과 수면 방해가 나타나며

철거의 한 여러가지 이하여

일상생활은 할 수 없는 정도가 좁아지고.

일의 능력도 저하되고

인간관계에 있어서 파괴이 된다

대부분의 경우 내면 갈등이 자기 없는 인간성이 변한다

나치 下에서도 철거 요부 下에서도 同一한 현상을 공통적으로 볼 수 있다.

손에 대한 반응이

꿈, 분노, 악, 등 등에 나타난 것 같으며

: 자신이 스스로 피해를 낸 때 (대부분 윤리적 자책이나 벌레가 없어도)

이러한 증상들은 대부분 심리 상태가 어둡게 깊다는 것을 나타낸다.

인간의 감성이 파괴 (破壞) 해진다,

손에 대한 사회여론

결백, 허위 (Falsehood) spaciality (공간)

Temporality (방안 도둑을 몰게했다, 차가웁게 했다)
(심리불안) 그러니 이들은 지속시키게 되지게 속사로 변하는 쪽에 가족을 통해 심리를 불안케 만듬)

여기에 자존심 같은 경우
중요 부분을 노출시킴으로써 스스로 수치감을 느끼게 함.
그 수치감 심리를 극도화시키게 한다.

Nursing 고문으로 생존자들의 치료(간호방법) p47

Care for Torture Survivors

훈련된 간호원들이 아기도 마찬가지
특히 밝힌 것들을 피해야 하는
강렬한 불빛(램프 등)은 사용하지 않아야 한다
그 이유는 그 사람이 과거에 대해서 오랜 동안
노출되어 왔었기 때문이다.

가능하면 환경을 밝게 해주고.
생활방식을 조절할 수 있도록 만들어주고
가능하면 많은 이야기를 하라. - 토론하라
ㄴ) 환자의 인내심을
키워주기 위해서이다.
이때는 가능한 환자의 이야기를 다 받아주면서
환자로 하여금 안도감을 갖게 한다.
(환자의 생활 전반에 걸쳐서)

불안감[illegible] 것의 가장 기본은 수면 부족이다 그러므로
수면을 취할 수
있도록 한다.
- 숙련된 간호원들은 5일은 [illegible] 한다.

진료시에는 불도(공포심), 옷을 등을 신중히 시켜줘야 한다.
(강력히 거절하는)
고문희생자들은 신체에 폭행하는 폭력적인 사람을 보고 있으므로
그것을 신중시켜줘야 한다.

Evidence of torture

Polical repression and human rights abuses in South Africa

By
*Leslie London, MB BSc (hons)**
Terence L. Dowdall, MA (Clin Psych)#

"Everyone has the right to life, liberty and the security of person."

"No one shall be subject to arbitrary arrest, detention or exile."

"Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations, and of any criminal charges against him."

Millions of South Africans still await the day when these 3 articles of the *Universal Declaration of Human Rights* become a reality in our country.

The death in detention of Mr *Steve Biko* – after being injured during interrogation by South African security police in 1977 – catapulted South Africa and the South African medical profession into the international Human Rights' limelight.

Deaths in police custody represent only the extreme manifestation of a systematised strategy developed by the *Apartheid government* to curb widespread political opposition to its iniquitous political ideology. Detention without trial has been the mainstay of political repression in South Africa for many years[1,2].

However, during the period 1985 to 1990, with the imposition of successive states of emergency by the South African government, unprecedented numbers of South Africans were subjected to arbitrary detention and arrest on a scale never encountered previously[2]; particularly children, who constituted anything between 10 and 25% of persons detained under emergency regulations[1,3].

The *Human Rights Commission* estimates that at least 73,000 detentions have taken place since 1960, of which 70% occurred since 1984[2]. These detentions were not simply of political leadership but of community members at all levels, and they had a profound impact on the social fabric of South Africa's oppressed communities[1,3-5]. It was virtually impossible to encounter ordinary people in the communities who did not have some experience of the effects of detention, either of themselves, family members or friends.

At the same time, allegations of assaults, beatings and torture during this period of unlimited police powers were abundant[3,6]. These abuses were not restricted only to detainees, but affected entire communities[6,7].

83% of detainees report on physical torture

The evidence of torture of South Africa's political prisoners was particularly embarrassing to the South African government, which sought at all costs to prevent such information being publicised through repressive laws and banning of human rights organisations[1,3]. However, a number of studies conducted with ex-detainees and political prisoners have confirmed that torture has been systematically practised in South Africa[8-10]. Foster and Sandler found that 83% of a sample of people detained between 1974 and 1984 reported that they had been physically tortured during their detention (Table I)[8].

A study with 131 ex-detainees, described at the 1987 NAMDA conference, found that 72% alleged that they had been physically tortured during their detention, and, of this group, 75% at the time of their release still had physical evidence on examination that was consistent with the history of torture. Psychological abuse was reported by 79% of ex-detainees, and 63% had

Table I. *Torture of ex-detainees and political prisoners in South Africa.*[8,9,10]

	Foster/Sandler	NAMDA/Braude	Winslow
Number of detainees or prisoners	176	131	23
Period af study	Released 1974-1984	Released 1984-1986	Released 1990-1991
History of physical torture	83%	72%	89%
Forms of physical torture reported	Beatings Abnormal posture Forced exercise Electric shock Strangulation Hand cuffing Genital abuse Falanga	Beatings Suffocation Abnormal posture Electric shock	Beatings Suffocation Nakedness Sexual assault Food deprivation
History of mental torture	83%	79%	78%
Forms of psychological torture	Threats Verbal abuse False accusations Witnessing torture of other people Forced undressing Sleep deprivation	Threats Interrogation Humiliation Physical deprivation	Threats Verbal abuse Mock killings Sensory deprivation Sleep deprivation
Solitary confinement	79%	34%	No info
Psychological after-effects	Depression 24% Relationship difficulties 35% Irritability 31%	PTSD 21% Anxiety 7% Depression 12% Other 23%	No info

psychological disorders related to their detention (Table I)[9].

These findings are similar to those in a recent study of the detention experiences reported by prisoners released from Robben Island in 1990-91[10]. These allegations of torture are corroborated by the contents of an affidavit submitted by Dr *Wendy Orr*, who, while working as a district surgeon in *Port Elizabeth* in 1985, saw accumulating evidence in her work of assaults and torture of political prisoners.

She found that, out of 286 detainees who complained of assault, 153 had evidence on examination of unlawful injury.

This included 60 with facial injuries, 8 with perforated eardrums, and 26 with wheals and blisters consistent with being struck with a quirt[11].

A crucial feature of South Africa's security laws has been the use of indefinite solitary confinement[1,12], recognised worldwide as a form of torture[13]. Section 29 of the Internal Security Act allows for indefinite detention in conditions of solitary confinement for purposes of interrogation until the detainee has satisfactorily answered all the questions put to him or her[2]. Children held in detention have also frequently been subjected to solitary confinement[1,3,14], and it is disturbing to note that section 29 is still in regular use in South Africa today[15].

Confessions extracted under conditions of solitary confinement have been unquestioningly accepted by South Africa's courts, thereby facilitating the ongoing use of this practice. It has usually been under conditions of solitary, where the prisoner or detainee is totally isolated, that the worst physical and psychological abuses have taken place.

Towards the end of the 1980s repression of political activists began to take on different forms, with the emergence of vigilante groups, assassinations and harassment, that have come to be termed informal repression[1,12,16]. This coincided with the implementation of a new state strategy of serving restriction orders on released detainees[17].

Many of these restrictees were then *sitting targets* for assassination by mysterious hit squads[1,17,18]. In many ways, the changing nature of repression in South Africa appeared to reflect an adaptation and refining of repression techniques used in other regimes, as well as a *pioneering* of new techniques which serve as a model for others to follow[12].

With the unbanning of political organisations announced by the Nationalist government in February 1990 and the general easing of space for political activity, vigilante and informal violence has escalated hideously out of all proportion to previous experiences. Assassinations, abductions, and mass killings have become almost everyday occurrences in South Africa's already poverty-stricken urban and rural townships.

Allegations of police complicity and cooperation in these events lend credence to an argument that elements within the security forces are fermenting this violence to prevent the political organisations from mobilising and building themselves effectively in the process leading up to negotiations[7]. At the same time, while police detentions have declined in the past year, there is still ample evidence of ongoing use of detentions and, in particular, of solitary confinement, especially in the *bantustans* where assault and torture of detainees is a routine event[1,16].

What is even more worrying is the fact that persons taken into police custody continue to be tortured and continue to die whilst in detention[16,19], despite an apparent liberalisation in the security forces' attitude to political organisation.

Second highest rate of judicial executions

Another area where South Africa holds notoriety is in its commitment to capital punishment. South Africa has the dubious honour of being the hanging capital of the world, with the second highest rate of judicial executions in the world (second only to Iran)[20]. Conditions of prisoners awaiting execution on *Death Row* are in many ways far more devastating than for ordinary prisoners[21].

Since 1984, a growing number of executions have been for "political" crimes unrecognized by the South African regime as legitimate actions of freedom fighters, but rather treated as criminal actions. In the past 5 years, intense public campaigns have focused on the plight of political prisoners on death row. This pressure has, in some measure, forced the State to suspend its executions.

The result is that some cadres have now been released after spending years on *Death Row*, watching while others less fortunate than themselves were executed. To return from a situation where one was waiting for one's own execution is a torture that few can really appreciate adequately, and is one of the many sorts of stressrelated problems that counselling services for expolitical prisoners and detainees are having to deal with.

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Trafficking in human organs

We are a group of two doctors and four medical students who are trying to document the extent to which human organs for transplant are bought and sold worldwide, how much the poor and children are used as organ donors, and how important international legislation would be in this respect.

If any reader of this journal has knowledge and/or documentation of this problem, we would be very pleased if you would contact us.

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The *Argot* of the victim

Explanation of expressions peculiar to the use of torture in Iran

By
*Mohammad Beh.**

Testimonial

Torture was practiced in more than 70 countries – in 1992. Throughout the whole world, torturers learn from each other, and train each other – in ever more sophisticated methods, with respect both to physical and to psychological torture.

The torturers have their own freemasonry, their own language. It is almost baroque that they mock their victims by giving their torture methods strange names - but for the victims it is certainly not baroque, but an additional humiliation.

Language is important. For the therapists it is of great importance to understand the torturers' dialect, their jargon – how can they treat otherwise? Mohammad Beh. has performed a very deserving task by putting together the first dictionary of torturer slang, *The Argot of the victim.* It is shocking reading, but necessary for the understanding of the plague of our century: torture.

Professor Bent Sørensen, MD
Member of the IRCT Council,
Member of CAT (United Nations' Committee Against Torture), and 1st Vice President of the CPT (The Council of Europe's Committee for the Prevention of Torture)

The cultural background of the Middle East torture victims, their individual experiences, and the torture to which they have been exposed are of course essentially different from what RCT is used to dealing with in victims under treatment, even though the purpose of torture is the same all over the world. Many of the torture methods were unknown at RCT. Some of these methods have a cultural, religious, or climatic background different from the better known ones.

Attached to these methods are naturally some new words and expressions that are used in the prisons by the torturers and their victims.

The victim's contact with the therapist at RCT takes place via the interpreter, and his role as go-between is therefore very important for the outcome of the treatment. To make the interpretation correct and avoid misunderstandings and/or misinterpretations, both the interpreter and the therapist must have a certain knowledge of the victim's culture and situation, and of the methods of torture to which he has been exposed. An incorrect interpretation or a misunderstanding between the client, the interpreter, and the therapist may have serious consequences for the outcome of the treatment.

Since interpretation for torture victims is a new and very sensitive area, both the interpreter and the therapist must be as well prepared as possible. The torture victim's vocabulary, and the way he uses the language, may cover – often using the characteristics of everyday language – concepts and meanings totally different from what is used in ordinary interpretation. It is therefore important for the therapist and the interpreter to be extremely aware of these words and concepts during the conversation.

The use of new words, sentences, or expressions by the victim when talking with the therapist can be taken for their ordinary primary meaning, but they may have a completely different secondary meaning which in the situation in reality is the primary. If the interpreter and/or the therapist do not know these expressions or sentences, which are therefore open to misinterpretation, it is necessary to ask the client about their meaning; one may at best get an explanation. It is sometimes difficult for the client to explain the meaning of each single word of prison jargon. A torture victim will often refrain from telling about previous horrors.

The prisoners and their torturers create a language with new words and expressions so that they can talk about various things without being under-

고문의 증거

남아프리카에서의 정치적 탄압과 인권 유린

레슬리 런던, BSc(hons)
테런스 L. 다우돌, MA(Clin Psych)#

"모든 인간은 삶과 자유, 개인의 안전에 대한 권리를 가진다."
"어느 누구도 임의적으로 체포, 또는 구금, 추방당할 수 없다."
"모든 인간은 누구나 자신의 권리와 의무, 그리고 자신에 대한 형사상 고발이 결정되는 과정에서 독립적이고 공정한 법정이 행하는 공평한 공청회를 가질 권리를 가진다."

수많은 남아프리카공화국인들은 아직도 인권선언의 이 세가지 조항이 자국에서 실현될 날을 기다리고 있다.

1977년 스티브 비코씨가 남아프리카 보안경찰에게 심문을 받다가 부상당하고 구금 상태에서 죽은 사실은 남아공과 남아공 의학계로 하여금 국제 인권의 주목을 끌게 만들었다.

경찰 보호하에서의 죽음은 곧, 극악한 정치 이데올로기에 대항하는 광범위한 정치적 반대를 억누르기 위해 아파르트헤이트 정부가 발전시켜온 전략의 체계화를 극단적으로 선언한 것일 뿐이다. 재판도 받지 않은 상태에서의 구금은 오랫동안 남아공에서 정치 탄압의 중심 역할을 해왔다.

그러나 1985년부터 1990년까지의 기간에 남아공 정부에 의한 긴급 상황이 연속됨에 따라 전례없이 많은 사람이 임의로 구금당하고 체포되었다. 특히 긴급법 하에서 구금당한 사람 중 어린이가 10~25%를 차지한다.

인권위원회는 1960년 이래 적어도 73,000여 건의 구금이 있었다고 추산했는데, 이 가운데 70%가 1984년 이후의 사건이다. 이는 단지 정치 지도자뿐 아니라 모든 계층 성원에게 해당되었으며 이들은 남아공의 억압받는 사회 조직 내에서 큰 영향력을 가진 사람들이었다. 이 사회에서 직접, 또는 가족이나 친구들이 구금당한 경험을 갖지 않은 사람을 찾기란 사실상 불가능하다.

동시에, 무제한의 경찰력 손에 있었다는 이 기간에 폭행, 구타, 고문을 당했다는 주장은 매우 많다. 이같은 폭력은 단지 피구금자에게만 제한되는 것이 아니라 전체 성원에 영향을 끼친다.

피구금자의 83%가 육체적 고문을 받았다는 보고

남아공에서의 고문의 증거는 특히 남아공 정부를 당황하게 하고 있는데, 이들은 탄압적인 법을 통해, 그리고 인권 조직을 금지하면서 어떻게 해서든지 이러한 사실이 발표되는 것을 막으려 한다. 그러나 구금경험자들과 정치범을 상대로 행한 여러 연구는 남아공에서 고문이 체계적으로 실행되어왔다는 사실을 확인시켜주었다. 포스터와 샌들러(케이프타운 대학교 범죄학 연구소)는 1974~84년 사이에 구금당했던 표본자들의 83%가 구금 기간에 육체적 고문을 당했다고 보고했다(표1).

131명의 구금경험자를 대상으로 한 1987년 NAMDA(국립 의·치과 협회) 회의에서의 한 연구는 72%가 구금 기간 동안 육체적인 고문을 받았다고 주장했으며 이들 중 75%가 석방될 당시에까지 고문 내용과 일치하는 육체적 증거를 지니고 있었다고 한다. 심리적인 폭행은 구금 경험자 중 79%가 당했다고 보고되었으며 63%는 구금과 관련해 정신 이상을 보였다고 한다(표1).

표1. 남아공에서 구금경험자와 정치범이 겪은 고문

인명	포스터/샌들러	NAMDA/브로드	윈즐로
피구금자 또는 죄수 수	176	131	23
연구대상기간	1974~84 석방자	1984~86 석방자	1990~91 석방자
육체적 고문 경험	83%	72%	89%
육체적 고문의 유형	구타 비정상적 자세 강제훈련 전기충격 묶어두기 수갑채우기 성기학대 발바닥치기	구타 질식시키기 비정상적 자세 전기충격	구타 질식시키기 발가벗기기 성폭행 음식 뺏기
정신적 고문 경험	83%	9%	78%
정신적 고문의 유형	협박 폭언 거짓 기소 고문장면 보여주기 강제로 옷 벗기기 잠 안재우기	협박 심문 굴욕감주기 신체 손상시키기	협박 폭언 살해시늉 감각 없애기 잠 안재우기
독방감금	79%	34%	알려진 바 없음
사후 심리적 영향	우울증 24% 대인관계 장애 35% 과민 31%	PTSD* 21% 불안 7% 우울증 12% 기타 23%	알려진 바 없음

*PTSD: 심적외상후스트레스장애, 외상후스트레스 장애. 정상적인 인간의 경험범주를 벗어나는 충격적 외상, 즉 강간이나 폭행, 전쟁에서 격전, 또는 시민의 폭격, 천재나 끔찍한 사고, 고문, 사형옥 등의 사건이 원인이 되어 생기는 정신장애.

이러한 사실은 1990~91년 로빈아일랜드에서 석방된 죄수들에 의해 보고된 구금경험에 관한 최근의 연구와 비슷한 점이 있다. 고문에 관한 이같은 주장들은 1985년 포트엘리자베스에서 지역의사로 근무하면서 닥터 웬디 오어가 제출한 진술서의 내용으로 뒷받침된다. 그녀의 진술서에는 정치범에 대한 폭행과 고문에 관한 증거가 축적되어 있다.

그녀는 폭행을 당했다고 호소한 286명의 피구금자중 153명이 불법적인 상해를 당한 증거를 갖고 있음을 발견했다.

60명이 얼굴에 상처가 있었으며 8명은 고막이 파열되었고 26명이 채찍으로 맞은 것과 같은 흔적과 물집이 있었다.

남아공 안전법의 결정적인 측면은 세계적으로 알려진 고문의 한 형태로 무기한 독방감금을 행해온 데 있다. 국가안전법 29조에 따르면 피구금자에 대해 행한 모든 질문에 만족할 만한 대답을 얻을 때까지는 심문을 목적으로 무기한 독방감금할 수 있도록 되어 있다. 구금중인 어린이들도 종종 독방에 감금되는데, 유감스럽게도 남아공에서는 아직도 이 29조가 습관적으로 행해지고 있다.

독방감금 상태에서 얻어진 자백은 남아공 법정에서 무조건적으로 받아들여져 결국 이 관습의 계속적 시행을 수월하게 한다. 보통 죄수나 구금자가 완전히 고립되어 혼자 있는 상태에서 가장 심한 육체적 · 정신적 학대가 가해진다.

1980년대말로 접어들면서 정치적 억압은 다른 양상으로 전개되기 시작해 자경단의 등장과 함께 암살, 습격 등 비공식적 탄압으로 바뀌었다. 이것은 석방된 피구금자들에 대한 제약에 새로운 전략을 제시한 것과 때맞춰 일어났다.

이 제약을 받은 사람들은 의문의 타격대의 암살 목표가 된다. 여러 가지 면에서 남아공에서 탄압의 성격 변화는 다른 체제에서 사용되었던 탄압 기술의적용 또는 개량을 반영하는 것이며 아울러 다른 체제의 모범으로 쓰일 법한 새로운 기술의 '개척자'로서 나타난다.

1990년 2월 민족주의 정부에 의해 선언된 정치 조직 금지 해제 및 정치 활동 공간의 전반적 완화에 따라 자경단과 비공식적 폭력은 이전의 경험에 비추어 엄청나게 증가했다. 암살, 납치, 대량학살이 이미 가난의 타격을 받은 남아공의 도시와 농촌에서 거의 매일 일어났다.

경찰이 이와 같은 사건에 공모하고 협력했다는 주장은, 정치 조직이 협상을 위한 과정에서 인력을 동원하거나 스스로를 효과적으로 구축하는 것을 방해하기 위해 경찰이 이러한 폭력을 자극하고 있다는 의견을 더욱 신뢰하게 한다. 동시에 작년 경찰의 구금 건수가 줄었다고는 하지만 아직도 구금이 계속되고 있다는 충분한 증거가 있으며, 특히 반투스탄에서 독방감금당한 피구금자들에 대해 행해지는 폭행과 고문은 고질적인 일이다.

더욱 걱정스러운 일은 정치 조직에 대한 경찰의 태도가 겉으로는 관대해졌음에도 불구하고 경찰의 손에 들어간 사람들은 계속 고문을 당하고 구금 기간에 죽는 일이 끊이지 않는다는 사실이다.

2번째로 높은 사법적 처형

남아공이 악명을 누리는 또다른 분야는 사형 집행이다. 남아공은 교수형에서 세계적인 명예를 투리고 있으며 이란에 버금가는 세계 2번째의 법적 처형률을 기록

하고 있다. '죽음의 열'에서 처형을 기다리는 죄수들의 상황은 여러 모로 일반 죄수들보다 훨씬 더 참혹하다.

1984년 이후 남아공 체제에 의해 합법적인 정치 활동으로 승인받지 못한 '정치적' 범죄를 이유로 점점 더 많은 처형이 이루어졌고 일반 형사범처럼 취급받았다. 지난 5년간 맹렬한 대중 운동은 죽음의 대열에 선 정치범의 곤경에 초점을 맞추었다. 어느 정도는 이러한 압력 때문에 남아공 정부는 처형을 연기할 수밖에 없었다.

그 결과 '죽음의 대열'에서 수년을 보낸 몇몇 핵심 인물이 지금은 석방되었으며 이를 지켜보던 불행한 다른 사람들은 처형되었다. 자신의 처형을 기다리던 상황을 경험하는 것은 겨우 몇 명만이 제대로 알아볼 그러한 고문이며 이를 상대하는 상담자가 취급해야 하는 여러 종류의 억압 요소들 중의 하나이다.

이 부분은 Torture Survivors - a new Group of Patients (1992, IRCT)의 Chapter 2 를 발췌 번역한 것임.

고문의 목적

이전에는 구타와 협박의 중요한 목적이 정보와 자백을 받아내기 위한 것이었지만 오늘날은 오로지 한 개인을 파괴시켜서 공동체에 공포를 만연시키기 위해 그를 이용하는데 그 목적이 있다. 고문을 행하는 자들은 고문이 사람을 죽이지 않고도 한 사람의 정신상태를 파괴시킬 수 있음을 알고 있다. 즉 고문후에는 개인적인 삶과 사회적인 삶 모두가 완전히 손상되어져서 이전과는 더 이상 같지 않도록 피해자의 퍼스낼리티를 파괴한다.

다른 방편을 통해서 비교적 쉽게 구해지는 정보일지라도 피해자에게서 정보를 얻어낼 때까지 고문을 멈추지 않으며 오로지 피해자가 "살아있는 송장"이 되어서야 목적은 달성되는 것이다.

고문은 사람에게 가해질수 있는 고통중 가장 나쁜 탄압이다. 고문을 사용해야할 필요성이 발견되는 사회는 테러정부로 몰락하는 것이다. 그렇게 될때 그 사회가 민주적인 사회로 불리우는 것은 모순이고 반대로 비인간적인 사회로 불리워져야만 한다.

고문의 역학

국제사면위원회는 세계의 인권침해에 관한 연례보고서를 펴냈는데 1992년 국제사면위원회 보고서에서 전년도인 1991년도에 조사된 144개국 중 65개국에서 정부에의한 고문이 발생하였음을 밝혔다.

오늘날 전세계 5대양 6대주에서 고문은 자행되고 있다.

많은 사람들이 고문이 존재하는 나라로부터 도망해서 1988년 자료에 의하면 서유럽과 스칸디나비아반도의 여러나라에서 피난민의 10 내지 30%가 고문을 경험한 것으로 추정된다. 이런 퍼센티지는 앞으로 계속 증가할것으로 보여진다.

고문의 신체적 및 심리적 결과들

이 부분은 The Breaking of Bodies and Minds - Torture, Psychiatric Abuse and the Health Professions. (1985, American Association for the Advancement of Science)의 Chapter 3 를 발췌 번역한것임.

중남미, 인도차이나, 중동및 아프리카를 포함한 전세계에서 매년 그들의 정부로 부터 고문을 당한 많은 사람들이 미국과 캐나다로 이주해온다.

고문의 직접적인 결과로 인해 이러한 사람들은 종종 직접적이고 장기간의 주의를 요하는 지독한 의학적 문제로 고통을 당하게된다. 신체적인 고통 뿐만 아니라 고문피해자들은 종종 수년간 지속적으로 그들의 일상생활을 해치는 광범위한 심리적 장애로 인해 고통당하게된다. 고문피해자가 직면하는 문제의 다음 한가지 사례는 수년이 지났음에도 그들이 당한 고문이 적절한 치료를 제공받아야할 필요성이 있음을 분명히 하고있다.

37살이고 결혼해서 5명의 자녀가 있는 Mr.R.S는 엘살바도르의 수도에있는 산 살바도르 대학교의 인문학부 교수였다. 18개월동안 갇혀지내던 감방에서 풀려나자 마자 그는 엘살바도르를 떠났다. 군사정권은 대학에서의 그의 강의 내용을 이유로 그를 잡아들였다.

감옥에서 그는 15일 간의 조직적인 고문을 당했고 여섯시간에서 10시간 까지 지속되는 심문과정이 있기 전에도 구타를 당했다.

고문은 주먹으로 때리고 발로 걷어차고 각목으로 때리고 입, 귀, 젖꼭지, 생식기에 전기가 흐르는 장치를 갖다대는 것으로 행해졌다. 또한 그는 손발을 등뒤로 묶인채 흔들리는 로우프에 메달리기도 했다.

모든 고문이 행해질때 그는 알몸이었다.

Mr.R.S는 지난번에 일하던 경리사무소의 지배인이과 관련된 일로 급작스레 잡혀들어간 것으로 믿고있다. 한번은 그의 평소 급료가 엄청나게 줄어들었다. 그래서 그는 평소받던대로 지급해줄것을 요구하자 지배인은 비웃으면서 "당신은 항상 덤벼들기만 하는 공산주의자들과 같구만" 이라고 하였다. 그런데 이말은 엘살바도르의 지배적인 분위기에서는 감옥으로 보내지거나 심지어 죽음의 위협을 느끼게하는 표현인것이다.

이후에 카나다에 와서 있었던 일이다. 정부에서 운영하는 영어수업 시간에 참석한 그는 선생이 라틴아메리카에 관한 토의시간에 한 이야기에 대해서 몇가지 이의를 제기했다. 그러자 선생은 그에게 "당신은 다른 사람의 견해에 반대하고 대들기를 좋아하는 사람같군요"라고 이야기 했다.

그당시 그는 건강하고 안정적인 상태였는데도 그말을 듣고 사흘동안 결석하여 집에서 거의 침대에 누워 우울한 기

분을 느끼며 심한 두통을 경험했다.
모르긴해도 그 선생의 말은 고문당하던 기억을 되살려 놓았던 것이다.

고문 피해자들과 관계가 있는 건강전문가,고용주 및 그밖의 사람들은 피해자들의 삶에 끼치는 고문의 결과를 인식하고 이해할 필요성이 있다. 그에대한 이해가 없다면 고문피해자들은 계속해서 오진과 부적절한 의료적.심리적치료,예방할수있는 직업적 스트레스와 차별대우,이혼과 가정파괴 및 피할수있는 자살의 피해자가 될것이다.

이러한 일어날수있는 비극적 사건으로 고문피해를 당하는 것을 막기위해 고문의 징후와 증상을 인식하고 효과적인 치료방법에 대해서 알아야한다.

여기서 이야기되는 것은 라틴아메리카에서 고문을 받고 북아메리카로 온 피난민들에 대한 두차례의 사례조사에서 밝혀진 것들이다.

이러한 연구는 추방당한 고문 피해자와 마주한 의료인들과 그밖의 사람들이 보고한 신체적이고 심리적인 문제들의 유형에 대한 것들이다.

미국의 경우

고문방법

<표- 1>은 사용된 고문의 방법과 해당 피해자의 분포를 나타내주고있다.

<표- 1> 미국의 경우 : 고문의 방법 (n =44)

방 법	n	%
구타	38	85
전기고문	29	66
parilla	7	16
stretching	5	11
submarino	12	27
불로지지는 고문	9	20
공중에 매다는 고문	9	20
성고문	5	1
강간	4	2
기타	4	9
Telefino	7	16
Planton	8	18
질식시키는 고문	5	11

※ Parilla는 일종의 전기고문으로써 철판위에 알몸으로 또는 젖은 옷을 입힌채 가죽끈에 묶인채 고문 피해자의 몸에 전기를 흘려 보내 가해지는 고문이다.

Submarino는 고문 피해자의 머리를 오물, 피, 똥, 오줌이 가득찬 욕조속에 집어 넣음으로써 거의 질식 상태에 까지 이르게 하는 고문이다.

Planoton은 몇시간 혹은 며칠동안 천정에서 내려진 줄에 손을 묶인채 서서 매달려 있게되는 고문이다.

모든 조사 대상자들은 1가지 형태 이상의 고문을 당하였다. 44명중에 38명이 구타를 당했고 2/3가 전기쇼크를 입었으며 적지만 상당한 수의 사람이 화상을 입거나 메어 달리고 물속에 잠겨 질식하는 고통을 당하였다. 거의 모든 사람들이 처음 붙잡혀 들어 와서는 눈가리개로 눈을 가리웠고 두건 같은 것으로 얼굴을 덮혀 아무것도 보지못하는 상태였다. 이때 피해자들은 움직이는것 조차 매우 엄격히 제한 받았으며 심지어 사슬이나 수갑같은 것으로 의자나 침대 또는 벽 같은데 묶였으며 앉거나 눕기에 힘들 정도로 좁은 감방에 갇혀 지냈다. (적어도 72시간 동안)음식과 (적어도 48시간동안)물을 마시지 못하거나 (적어도 24시간동안) 잠을 못자게 하는 것은 보통이었다.

모든 피해자들은 개인적인 권강권이 무시당했고 심문 받는 장소에서는 대부분 벌거 벗기웠다. 피해자와 그 가족들은 죽음의 위협을 자주 느꼈고 17명(46%)은 수치스러운 일을 당하기도 하였다. 진정제나 수면제같은 약물은 9명에게 도움을 주었는데 그들 중 6명은 정맥주사로 맞기도 했다.

모든 피해자들은 심리적 고통을 경험한다.<표- 2>에서는 심리적 고통을 가져오는 폭행에 대해서 보여주고 있다.

<표- 2> 미국의 경우 : 심리적 폭행(n=37)

방 법	n	%
(독방에)고립 시키는 것	25	68
기진맥진 시키기		
음식을 주지 않고	24	65
물을 "	23	62
잠을 재우지 않고	20	54
극심한 추위나 더위를 느끼게 하는 상태	14	38
차가운 물을 덮어쓰게	9	24
사람을 멍하게 하는 방법		
꼼짝달싹 못하게 만들어	17	46
눈을 가리워서	34	92
강렬한 빛에 노출 시킴으로써	6	16
시끄러운 음악을 듣게함으로써	9	24
위협		
죽음의 위협	23	62
가족에 대한 위협	8	22
보다더 강도높은 고문이 주어질 것이라는	9	24
수치심을 자극하는 위협	17	46
다른 사람이 고문당하는 것을 보게하여 고문의 위협을 느끼게 하는것	24	65
체면손상		
personal hygiene preuented	37	100
프라이버시를 무시	37	100
욕설, 폭언	37	100
과밀공간에 가둠	12	32
음식물에 배설물을 집어넣음	3	8
(이, 바퀴벌래가 득실대는)불결한곳에 가둠	5	13
옷을 벗김	27	73
가끔씩 베풀어지는 관대한 심문자의 태도변화	7	19
약물을 통한 조정		
정맥주사, 나트륨 마취제	4	11
정맥주사, 알려지지 않은 약물	2	5
구강	3	8

고문의 영향

신체적인 영향으로 인해 피부에 나타나는 표시는 가장 분명했다. 조사가 있었던 기간 1년전에 고문을 당했던 4명을 포함한 9명의 피해자들은 눈으로 볼수있는 외상을 가지고 있었다. 이들 중에는 담배불로 인한 화상과 전기쇼크에 의한 고문으로 인한 눈에띄는 흉터를 가지고 있었다.

7명의 부인들에게 있어서 산부인과적인 문제는 당연스런 것이다.

임신한 상태로 구금되었던 한 여성은 자궁내 전기쇼크를 당했다. 그녀는 결국 유산을 했으며 석달동안 하혈을 하였지만 병원치료는 거의 받지 못했고 굴욕적 이었다.

또다른 여성은 구금된 동안 강간을 당했으며 풀려난뒤 아이를 낳게 되었다. 그당시 그녀는 몇차례의 낙태시도를 했다.

또다른 세명의 여성은 구금기간 동안 성적인 학대를 받았다. 세명의 여성은 구금기간 동안 멘스를 하지 못했으며 그중의 두명은 풀려나서도 멘스가 생기지 않았다. 일곱명 중의 3명은 생리통이 새로운 문제가 되었다.

telefone 피해자의 3/4이 조사기간에 청각손상을 이야기 했다. 2/3는 등뒤로 손이 묶인채 메달리는 고통을 당했다.

최근에 고문을 당했던 피해자들은 일반적으로 가장 많은 수의 고문의 증상과 신체적 증후를 예상했던 대로 나타내고 있다. 특별히 눈에띄는 것은 정형외과적인 문제로써 구타로인한 폭넓은 타박상, 불에 데인 흔적과 상처 그리고 수갑에 채이거나 묶여서 난 찰과상등이 있다.

어떤 특수한 고문방법에 의해 자행되지는 않았지만 일반적인 고통을 느끼는 하나가 요통이다.

고문당하기 전에는 요통이 없었지만 조사기간에 이런 상태에 처해 있었던 사람이 20%였다. 또한 55%의 피해자가 고문직후에 두통을 느꼈다. 조사기간에는 30%까지 줄어들기도 했다.

고문의 신체적 증상이 경감하는 경향이 있고 시간이 지남에 따라 그 고통이 줄어들지라도 심리적 증상은 지속되었고 대부분의 조사대상자들에게 고문을 경험한 이후 수년이 지나서도 그것이 심한 우울증의 원인이 되었다.

피해자들이 다양한 형태의 신체적, 심리적 고문을 당했기 때문에 심리적 고통이 특별한 형태로 나타나지는 않는다.

대부분의 응답자들은 불안의 고통을 밝힌다. 많은 사람이 고문받을 때의 악몽이 되살아남을 느끼고 일상적인 충격을 통해서도 그것을 기억하게 된다.

다수는 외부세계 와의 반응이 줄어듦을 경험했다. 표3은 조사기간 동안 응답자들이 밝힌 고문의 심리적 결과를 나타낸 것이다.

조사 대상자의 38%(44명 중 17명)가 미국정신의학협회의 정신진단분류편람에 의해 외상후 스트레스 장애로 진단을 내릴수있는 기준을 충족시키고 있었다.

〈표- 3〉 조사기간의 심리적 증상

심리적 증상	n	%
과거의 일에 고착되어		
새로운 대인관계를 맺는게 힘듬	12	32
사건을 회상하게 되는 것	15	41
다른 사람을 믿지 못함	14	38
타인과의 관계가 호전됨	7	19
다른 사람들로부터 배제당함	7	19
정 동		
안절부절함		
불안	14	38
흥분	12	32
정서불안	10	27
긴장		
긴장을 풀지못함	16	43
공포	15	41
우울한 기분		
삶을 즐기지 못함	9	24
무감정, 냉담함, 무관심	8	22
감정이 메말라짐	10	27
수면장애	23	62
쉬 피곤을 느낌	16	43
지적인 면		
집중력 저하	22	59
기억력 저하	22	59
신체적인 면		
전환장애(심신증상)	11	30

이런 장애의 특징적인 증상은 외상을 입었던 사건의 재경험과 외부세계

에 대한 반응의 둔화와 관계의 감소 그리고 (불안, 불만 또는 신체적 불편과 같은 비정상적인 기분을 느끼는)인지적 증상등이다.

DSM-Ⅲ 에서 이야기하는 바에 의하면 스트레스가 자연스런 발생이기 보다 외부의 음모에 의할때 그 장애가 보다 더 심각하고 오래동안 지속된다고 한다. 예를들면 고문피해자들은 곤혹스런 일을 겪게되는 경향이 있다. 그들은 총살대 앞에서 총소리를 듣게되고 총살형을 위해 많은 사람들이 줄지어 서있는 것을 보게된다. 이후 피해자들은 그들의 감방으로 돌아와서 계속해서 총살대 앞에서의 일들만을 기억하게 되었다.

위에서 든 예들은 지진이나 홍수와같이 사람이 저질러서 생기는 스트레스가 아니기 때문에 자연적인 재해로 발생한 피해자들과는 다르다.

조사대상자의 50% 미만이 외상후 스트레스 장애의 기준을 충족시킨다고 할지라도 연구자들은 실제로는 훨씬 높으리라고 생각한다.

카나다의 경우

고문방법

체포된 다음 피해자들은 주로 눈을 가리운채 비위생적이고 형편없는 음식을 넣어 주는 군영창에 수감되었다.

그들 모두는 신체적 폭행을 당했고 거의 전부 심리적 폭행도 당했다. 대부분이 따귀를 맞았고, 발로 채이고 총개머리판, 곤봉, 채찍과 눈에 드러나는외상을 최소화하기 위해 젖은 천으로 둘둘말은 쇠파이프 같은 여러가지 도구로 구타를 당했다.

피해자 중 거의 2/3가 직접적으로 손가락, 발가락, 머리 그리고 생식기에 전극을 꽂이는 전기고문을 당했거나 전기가 흐르는 침대 스프링위에 눕혀져 당했다.

조사대상자중 거의 절반 정도의 남녀가 강간, 추행, 옷벗김을 포함한 성적인 폭행을 당했다. 그밖의 고문형태로써는 오랜시간 강렬한 빛에 노출시키는 것과 머리를 플라스틱 봉투로 뒤집어씌운다거나 손, 발톱을 뽑히는 등의 것이 있다.

5명이 담배불, 끓는 물, 인두 및 화학적인 것에 의해 화상을 입었다고 밝혔다. 굶기는 것(48시간 이상 물이나 음식의 공급을 차단) 역시 보편적인 것이다.

고문의 영향

세명을 제외한 전부는 고문에 의한 신체적 증상들을 보였다. 다수는 악몽이 반복됨으로 인한 불면증이나 심각한 신경증으로 고통을 당한다. 많은 사람이 불안, 우울 또는 명시되지 않는 알수없는 공포로 고통을 당한다. 31명은 열상과 화상의 흔적, 귀먹음, 떨어진 시력, 체중감소, 골절상등의 신체적 손상을 당한 객관적인 증거를 보여준다.

피해자의 절반이 행동과 성격의 변화 주체할수없는 감정의 격발, 충동적

인 행동, 사회적 고립을 호소했다.

피해자들중 18명이 정신적 기능에 있어서의 변화를 이야기한다: 이들 중 13명이 집중력 상실과 생각이 순서대로 되지 못함을 밝혔다.

12명이 기억곤란을 그리고 5명이 일상생활의 혼란을 이야기 했다.

ORGANISATION MONDIALE CONTRE LA TORTURE
WORLD ORGANIZATION AGAINST TORTURE
ORGANIZACION MUNDIAL CONTRA LA TORTURA
WELTORGANISATION GEGEN DIE FOLTER

CONCLUSIONS AND RECOMMENDATIONS

From 27 to 29 May 1993, about 50 delegates from some 10 Anglophone countries in Africa came together in Mombasa, Kenya at the invitation of the World Organisation Against Torture and the Kenyan Section of the International Commission of Jurists in a Symposium to discuss the issue

Towards economic policies for the prevention of serious human rights violations

The participants heard reports on the human rights situations in the various countries represented and in particular testimonies about some vulnerable sectors such as women, children, journalists, trade unionists, political opponents, farmers & etc. The Symposium benefitted from the expertise of eminent specialists - including the Chairman of the African Commission on Human and Peoples Rights, a representative of the United Nations Centre for Human Rights, a representative of the International Labour Organisation, a representative of the World Bank, a representative of the Commission of the European Communities and the Attorney General of Kenya.

The participants in the symposium reaffirmed the universality and interdependency of human rights.

As a result of its deliberations the participants elaborated a strategy of action based on the following conclusions:-

1/ That education is fundamental to the promotion of human rights and the consolidation of democracy and therefore public education needs to be reinforced in all African countries;

2/ That some members of the medical profession and doctors bear a share of the responsibility in the perpetration of human rights violations; in particular with respect to the torture of prisoners, for example, in the cover up of torture, in the denial of medical care and by their refusal to treat political prisoners;

3/ That members of the legal and other possibly concerned professions do not always abide by the ethical principles governing their professions opposing torture and human rights violations;

4/ That human rights violations affect not only the direct victims themselves but also traumatise members of their families;

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5/ That effective mechanisms are needed for the protection of vulnerable members of society such as women and children, against sexual abuse, violence and discrimination;

6/ That female circumcision continues and that authorities do not take the necessary measures to educate the public against this practice and to protect the health of this sector of the population;

7/ That displaced persons and refugees continue to be a particularly disturbing factor in most African countries;

8/ That an adequate mechanism for direct compensation and rehabilitation needs to be established for the victims of human rights abuses, in particular torture, sexual abuse and other forms of violence;

9/ That independent civil society institutions are required in order to reinforce the democratic process on the African continent;

10/ That prison conditions in African countries are totally appalling and must be improved;

11/ That networking among NGOs on the African continent is needed to reinforce concerted action for the promotion of human rights;

12/ That Attorneys General in Africa have a vital role to play in the protection of human rights and the enforcement of democracy and the rule of law;

13/ That the independence of the judiciary is one of the best guarantees of democracy and needs to be strengthened in Africa;

14/ That a human rights court (HRC) needs to be established within the framework of the African Charter on Human and Peoples Rights;

15/ That all African governments should ratify the international human rights conventions, incorporate the norms contained in these conventions into their domestic law to make them justiciable for the individual;

16/ That special mechanisms are needed for the protection of vulnerable sectors of society when SAP programmes are adopted for African countries;

17/ That civil society institutions and in particular NGOs should be involved in the preparation of state reports to international human rights and economic institutions;

18/ That NGOs should be accorded some cooperative relationship by the international financial institutions, in particular the World Bank, and other donors similar to the example of the policies adopted by the Commission of the European Communities in some specific cases;

19/ That governments should provide for national dialogue fora in which NGOs, international agencies, involved with economic programmes and the governments concerned, can exchange views during the formulation of economic policies;

20/ That the explanation often invoked by States that the scarcity of resources accounts for some of the obstacles to the implementation of policies for the protection of vulnerable groups of a society is not a tenable excuse;

21/ That governments are responsible for the well-being of their populations and that as a result they should re-allocate funds from certain less vital sectors of the budget such as military expenditure, towards addressing problems affecting human rights.

RECOMMENDATIONS

On the basis of the above, the participants in the Symposium agreed upon the following recommendations and strategies:-

1/ African governments should ratify the international and regional human rights conventions - in particular the Convention Against Torture, Cruel, Inhuman and Degrading Treatment or Punishment - and incorporate and implement the norms contained in these conventions into their domestic law to make them justiciable for the individual;

2/ African governments should adopt effective mechanisms for the protection of vulnerable members of society such as women and children against sexual abuse, violence and discrimination and to put in place special mechanisms to protect people from torture;

3/ African governments should adopt preventive mechanisms and developmental programmes to ensure proper protection of the rights of the child:

4/ African governments should guarantee the independence of the judiciary and the independence of the office of the Attorney General;

5/ African governments should refrain from using the scarcity of resources excuse, and reallocate funds from certain less vital sectors of the budget, such a military expenditure, towards addressing problems affecting certain vulnerable groups of the population;

6/ International institutions and donors should grant NGOs some co-operative relationship similar to the example of the policies adopted by the Commission of the European Communities in some specific cases;

7/ African governments should provide for national dialogue fora in which NGOs, international agencies, involved with economic programmes and the governments concerned, can

exchange views during the formulation of economic policies to study the short term effects of such policies;

8/ NGOs should hold similar regional meetings with a view to forging further links between NGOs at the continental level and between NGOs and the donor institutions at the international level;

9/ International Institutions, donors and governments should regard the social dimension and policies they may have, as human rights issues.

Mombasa, Kenya 29 May 1993

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The Physical and Psychological Sequelae of Torture

Symptomatology and Diagnosis

Anne E. Goldfeld, MD; Richard F. Mollica, MD; Barbara H. Pesavento, MSW; Stephen V. Faraone, PhD

We present a review of the international literature on the medical and psychological effects of torture. Our review reveals that certain tortures and their physical and emotional sequelae are more prevalent than previously appreciated. They include the common occurrence of sexual violence during the torture of women and female adolescents and the high frequency of head injury and associated neuropsychiatric consequences. We recommend the use of standardized diagnostic criteria in the evaluation of patients who have survived torture; this will facilitate patient care and the documentation of human rights violations.

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OF THE more than 11 million displaced persons throughout the world, it is estimated that greater than 1 million refugees have been resettled in the United States since 1975.[1,2] Many of these individuals have experienced war trauma, including torture, and are fleeing from countries where torture is a widespread practice. Torture, which has been documented to occur in 98 countries worldwide, has been compared to an epidemic.[3] Therefore, it is with increasing frequency that health care providers in countries of asylum such as the United States are confronting patients who have survived torture.

The documentation of torture is often difficult. Not only is it often actively concealed by its perpetrators, modern torture is characterized by a technological sophistication that can leave few physical traces. Nonetheless, groups such as Amnesty International (AI) have provided convincing proof of the occurrence of torture in numerous countries. Such reports are based on multiple lines of corroborating evidence that may include testimony of victims, witnesses, former torturers, local human rights groups, investigative missions, and medical examination findings.[3]

Health care providers have in the past been unresponsive to the medical and psychiatric problems that may arise from situations of human brutality.[4] The tendency for individuals, including health professionals, to withdraw from survivors of violence has been well documented in practitioners caring for concentration camp survivors,[4] Cambodian survivors of the Khmer Rouge regime,[5] Vietnam veterans,[6] and Chilean survivors of torture.[7] The medical and psychiatric interviewer is often emotionally unprepared to listen to the horrifying experiences of the survivor of torture.[4,6] Patients themselves frequently will not reveal the torture experience to the physician[6-8]; they may fear reprisals, be overwhelmed by humiliation, be reluctant to retrieve painful memories, and fear stigmatization to themselves and their families. Therefore, familiarity with the injuries caused by torture, sensitivity to the psychological and social issues confronting the tortured patient, and awareness of the personal difficulty health practitioners may have in caring for this group of patients are all necessary to provide optimal care.

Despite the recognition that torture may cause serious physical and emotional impairments, information about the medical effects of torture is not readily available. This information is limited for several reasons. First, there have been few systematic investigations of survivors of torture. In addition, much of the information that has been published is relatively inaccessible because it is spread throughout foreign language journals or is privately circulated by clinics to avoid the danger of public attention to both practitioner and patient.

In this article, we review published and privately circulated international reports on the physical and psychological sequelae of torture. The goals of this review are threefold: (1) to make this information and its sources readily accessible to the medical community; (2) to make available the current experience of medical providers actively engaged in treating survivors of torture; (3) to determine effective diagnostic approaches to clinically significant symptoms in this expanding group of patients.

THE PHYSICAL SEQUELAE OF TORTURE

Between 1979 and 1985, six patient series reported the physical examination findings and symptoms in a total of 319 survivors of torture who had sought refuge in Canada, Denmark, and Hol-

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Table 1.—Types of Torture Reported by Torture Survivors in Six Investigations, 1979 to 1985[4-9]

Torture Types	No. of Cases (N=319)
Beating, kicking, striking with objects (to torso and/or genitalia and/or head)	410*
Threats, humiliation	246
Application of electricity (to torso, genitalia, mouth) with pointed electrodes, cattle prods, or shock baton	149
Blindfolding	105
Mock execution	89
Made to witness others being tortured	72
Submarino—submersion of head in water (often filthy or polluted with excreta) with near drowning	54
Isolation (for >48 h)	50
Starvation (for >48 h)	50
Sleep deprivation	49
La bandera—suspension from a rod by hands and feet	45
Rape—mutilation of genitalia, insertion of foreign bodies into vagina or rectum	44
Burning—application of cigarettes, electrically heated rods, hot oil, quicklime, corrosive acid	42
Falanga—beating the soles of the feet with rods	31
Rope bondage—tightening of ropes over hours	30
Telephono—striking of blows at the victim's ears	23
Forced standing (for >48 h)	19
Throwing of urine or feces at victim	16
Medicine administration (nontherapeutic)	12
Traction alopecia—lifting by hair	8
Needles under toenails or fingernails	8
Deprivation of water—providing only filthy, salty, or soapy water	5
Forced extraction of teeth	5
Prevention of urination and defecation	4
Deprivation of medical care	4

*An individual patient may have sustained blows to three areas.

land.[9-14] Five of these studies used semistructured questionnaires that were based on an interview schedule developed by the Danish medical group of AI.[9,10,12-14] These questionnaires are not described in detail in any of the studies, but reportedly focus on the description of torture and on the health status of the patient before and after torture. The sixth study presented case histories of six patients.[11] The length of time between torture and evaluation was not consistently noted in the studies. General physical examinations and simple laboratory tests were done and roentgenograms were obtained in all six studies when possible. The majority of interviews and examinations were conducted in the country of refuge. However, in the Danish study by Wallach and Rasmussen,[13] 18 Chilean nationals were examined in their own country. In the other Danish study by Rasmussen and Lunde,[10] of 135 subjects evaluated, 35 from Greece, 32 from Spain, and five from Northern Ireland were all examined in their own country and 13 from Argentina were examined in Rome.[10]

The majority of patients evaluated in the six studies were Chilean, comprising 191 of the total of 319 cases. Other nations represented in the studies were Greece, Northern Ireland, Uruguay, South Africa, El Salvador, Spain, Argentina, Ethiopia, Algeria, Bolivia, Morocco, Bangladesh, and Romania. The majority of interviews were conducted by physicians, although consistent documentation of where, when, and by whom the examinations were conducted was not provided.

Table 1 summarizes the tortures to which the 319 individuals evaluated in the six patient series were subjected. The most common physical symptoms reported included headache, impaired hearing, gastrointestinal distress, and joint pain. The most common physical findings were scars on the skin and bone dislocations and fractures. No medical diagnoses were reported in any of these studies.

In the patient series cited previously, physical symptoms and findings were frequently correlated with specific tortures. However, detailed medical historical data and descriptions of physical findings necessary to establish such associations were not consistently presented. For example, in one of the Canadian studies,[14] the authors note that ten of 12 patients who complained of hearing loss had been subjected to *telephono*, a torture consisting of beating the ears with a hard object. In this same study, however, there is no documentation of physical findings suggestive of head trauma or of audiometric measurements that could establish the diagnosis of hearing loss secondary to *telephono*. In another example, Rasmussen and Lunde[10] report that 32% of 135 patients evaluated suffered from gastrointestinal complaints and 22% suffered from cardiovascular complaints. Yet, they present no historical descriptive data or physical findings that could help decipher the etiology of these general symptoms and their connection to torture.

Other human rights and case reports provide more detailed descriptions of physical findings and symptoms after torture. Furthermore, they suggest that certain tortures and their medical sequelae are more prevalent than appreciated in the patient series cited previously. Danielsen and Aalund[15] describe certain types of electrical and burning tortures that may produce distinctive scarring patterns in the skin. *Picana*, a type of electrical torture in which an electrically charged needle is applied to areas of heightened sensitivity such as nipples, genitals, eyes, tongue, and teeth, typically produces 1- to 2-mm reddish macular scars in clusters.[15,16] Characteristic scars have also been described resulting from burning with cigarettes,[15,16] molten rubber,[17] corrosive liquids,[18] and tight ropes[15,16,19] and after beating with blunt instruments.[15] A diagnostically promising finding has been the description of calcium salt deposition that may be found in a punch biopsy specimen of the dermis beneath an area that has been shocked by an electrical cathode during torture.[20-22]

Skeletal and soft-tissue abnormalities secondary to beatings and suspension during torture are frequently described. Occult fractures, lumbosacral spine injuries,[9,23] dislocation of vertebrae, and paraplegia[24] have been reported after prisoners had been beaten or hung by one extremity during torture. Other reports detail massive swelling that causes vascular compromise of the lower legs after *falanga*, a torture method consisting of blows to the sole of the foot.[25-27] Additional reported effects of *falanga* include aseptic necrosis of a toe,[28] necrotic ulcers of the leg (L. Danielsen, MD, unpublished data, 1985), chronic venous incompetence of the legs,[26,27] and pain on walking.[27]

Although not emphasized in the patient series reviewed, numerous observations from health practitioners worldwide reveal that sexual abuse and rape figure prominently in the torture of women.[17,24,29-39] For example, in investigations of Cambodian, Laotian, and Vietnamese refugees, histories of rape and sexual abuse during torture and detention are widespread.[30-32] In Uganda, group rape of female detainees by military guards is reported to be frequent and resistance to rape to result in shooting or stabbing of the victim.[17] Similarly, the sexual abuse of female prisoners has been described in Chile,[33,34] El Salvador,[35,36] Poland,[24] and Nicaragua.[37]

Neither youth nor pregnancy serve as a deterrent to torture. A recent Helsinki Watch Committee report from the Ukraine describes 15 cases of rape of female children younger than 14 years old whose parents were members of ethnic or religious minorities (E. Brantley, JD, oral communication, 1986). Sexual abuse and detention of female children has also been documented in El Salvador.[36] Kicking pregnant women in the abdomen to precipitate spontaneous abortion during torture is described in Uganda[17]; in Chile, beating and electrical torture of pregnant women is reported.[34] The mutilation of female genitalia, pregnancy, venereal disease, infertility, miscarriage, and serious social and psychological impairments are reported to be common consequences of the torture of women.[29,33,34,40]

Table 2.—The Percent Distribution of Psychiatric Symptoms of Torture Survivors by Clinical Survey, 1979 to 1985

	Allodi and Cowgill,[43] 1982 (N=42)	Rasmussen and Lunde,[10] 1980; Lunde,[33] 1982 (N=135)	Domovitch et al,[14] 1984* (N=98)	19 Case Studies†
Cognitive symptoms				
Confusion/disorientation	5 (12%)	...	...	1 (5%)
Memory disturbance	12 (29%)	61 (45%)	37 (38%)	6 (32%)
Impaired reading	...	...	...	2 (11%)
Poor concentration	13 (32%)	61 (45%)	46 (60%)	8 (42%)
Psychological symptoms				
Anxiety	36 (88%)	32 (24%)	87 (94%)	12 (63%)
Depression	29 (71%)	26 (19%)	57 (66%)	13 (68%)
Irritability/aggressiveness	...	40 (30%)	53 (66%)	2 (11%)
Emotional lability	...	...	21 (30%)	12 (63%)
Self-isolation/social withdrawal	...	13 (10%)	53 (63%)	5 (26%)
Neurovegetative symptoms				
Lack of energy	26 (63%)	19 (14%)	32 (41%)	7 (26%)
Insomnia	28 (68%)	...	81 (83%)	16 (84%)
Nightmares	14 (34%)	29 (20%)	66 (78%)	16 (84%)
Sexual dysfunction	5 (12%)	...	27 (57%)	...

*The number of cases examined for each symptom ranged from 53 to 98.
†Case studies from Amnesty International Human Rights Missions to Uganda, Greece, Chile, Iraq, Egypt, and Northern Ireland.

Sexual abuse of male detainees appears to be less prevalent; however, in two reports from Denmark, sexual dysfunction (decreased libido and impotence) and testicular atrophy are described as sequelae of genital torture of men.[41,42] Application of electricity to, and beating and pulling of, the penis and testicles as well as testicular crushing with cattle gelding instruments have all been described in Uganda.[17] In Chile, a former detainee interviewed by an American Committee for Human Rights mission described genital torture of male inmates (J. Fine, MD, oral communication, 1986). Repeated rape of a male torture victim in Latin America is described by Allodi and Cowgill.[43]

THE PSYCHOLOGICAL SEQUELAE OF TORTURE

Table 2 summarizes the psychological symptoms associated with the torture experiences documented in three studies by Danish and Canadian groups that evaluated a total of 275 survivors of torture.[10,14,33,43] The Danish study by Lunde[33] reports the psychological findings in the group of patients studied by Rasmussen and Lunde.[10] This study and the Canadian study by Domovitch et al[14] assessed the psychological symptoms associated with the torture experience by use of semistructured interview schedules that were not described in detail in their reports. The 41 patients that compose the Canadian study by Allodi and Cowgill[43] were from three Latin American countries. They were examined in Canada from a few months to several years after their torture experience by the same Spanish-speaking psychiatrist using a semistructured interview format.[43] In addition, we reviewed 19 case reports from AI human rights missions to Uganda, Greece, Chile, Egypt, Iraq, and Northern Ireland. These findings are also summarized in Table 2.[17,44,48] One hundred ninety-seven of the 275 survivors of torture evaluated for psychological symptoms were from Latin America. All cases presented in Table 2, except for AI case reports, were evaluated in countries of asylum. The time interval between torture and evaluation was not generally noted. The most common psychological symptoms reported included insomnia and nightmares, memory loss, and poor concentration. The psychiatric diagnoses of these patients were not indicated in any of the reports.

In two of the studies summarized in Table 2, authors state that they have found evidence of a psychological syndrome specific to the survivor of torture.[10,43] Allodi and Cowgill[43] state, "All patients suffered from a homogeneous disorder characterized by extreme anxiety, insomnia and nightmares . . . somatic symptoms of anxiety, phobias, suspiciousness and fearfulness." They felt this symptom complex constituted a torture syndrome. Rasmussen and Lunde,[10] in their 1980 report, suggested that a psychological syndrome secondary to head trauma may exist. They also observed that 14% of their study group of 135 patients had a "mental disturbance." The diagnostic criteria on which their conclusions were based were not described. In a 1984 follow-up study of 22 of the original 135 subjects who had been studied by Rasmussen and Lunde, Abildegaard et al[49] indicated that eight (39%) of 22 had a "chronic organic psychosyndrome," also called by them, "post-traumatic cerebral syndrome." Survivors of torture qualified as having this disorder if they had three or more of the following symptoms: impaired memory, headaches, intolerance to alcohol, and sleep, marital, or emotional disturbances.[49]

In each of the studies presented in Table 2, a high percentage of patients were beaten or kicked in the head. It is not known whether head trauma accounted for any of the symptoms described previously, because none of the studies reported the results of neuropsychological testing, neurological examinations, or related laboratory studies (eg, electroencephalography or computed tomography), which might establish this link. The relationship between head injury and mental disturbance such as memory loss, headache, and impaired concentration has been well documented[50,51] and may account for the occurrence of similar cognitive symptoms in survivors of torture. The 1982 documentation by computed tomography of cerebral atrophy in five young men who had been tortured two to six years before neurological investigation[52,53] also suggests a possible organic basis for psychological symptoms in these patients.

COMMENT

Sexual Violence and Head Injury During Torture and Detention

In gathering and summarizing the research and clinical experiences of health practitioners and clinics working with survivors of torture, it is apparent that certain tortures and their physical and

emotional impact are more significant than previously appreciated. These tortures include sexual violence among tortured women and female adolescents and head injury. Although the true prevalence of sexual violence and head injury in this patient population is as yet unknown, it is clear from the material reviewed that they may be the cause of significant emotional and physical injury among survivors of torture. Therefore, in our current state of knowledge about survivors of torture such emphasis is important to orient health care providers to symptom complexes they might anticipate. Additionally, although a torture syndrome has been claimed by some investigators to occur after torture, lack of reference to standardized psychiatric diagnostic criteria, as well as incomplete descriptions of the psychological meaning and impact to the victim of torture, gives little clinical usefulness and meaning to this term.

Sexual violence is often associated with the torture and detention of women and female adolescents. The problem of security and protection against sexual violation and rape is therefore essential to the well-being of those in refugee camps, in areas devastated by war, and in countries where torture is practiced. Furthermore, the true magnitude of this problem is likely to be underappreciated because women who have been sexually violated during torture frequently hide their experience from physicians and families to avoid the shame and stigma of the experience.[54] Despite the complex and sensitive nature of this problem, health care providers must be aware of the likelihood of its occurrence and anticipate the potential physical and emotional injury that may result from sexual violence.

Similarly, physicians should be alerted to the frequent occurrence of head trauma among this patient population. Such injuries are frequently associated with neuropsychological deficits and impairments in social functioning.[50,51] Despite the clear documentation of head injury in survivors of torture (Table 1), there has been no systematic evaluation of the neurological and/or neuropsychiatric deficits that may be related to head injury in these patients. Therefore, psychological symptoms displayed by survivors of torture may be secondary to organic central nervous system dysfunction rather than to the psychological effects of the torture experience.

Improving Medical Evaluations of Survivors of Torture

It is apparent from the studies reviewed that the medical and psychiatric evaluation of survivors of torture presents unique problems to the clinician. Difficulties that may be encountered include assessment of the accuracy of the torture survivor's trauma story (especially if physical findings are subtle or absent), cultural and linguistic barriers to clinical evaluation, and the emotional resistance by practitioner and patient to discuss the torture event. In addition, special problems of confidentiality and trust are raised in the care of survivors of torture. Care must be taken not to stigmatize these individuals further by labeling them prematurely with syndromes that may then become sensationalized. Assignment of medical and psychiatric diagnoses based on supportive historical data and physical findings could help ameliorate some of these difficulties by establishing links between particular tortures and their medical and psychological consequences.

Medical diagnoses were not reported in any of the investigations or case studies reviewed herein. Such information could help orient physicians to disorders they can anticipate in their evaluation and treatment of survivors of torture and help them uncover even subtle physical findings. It could also improve communication about the medical effects of torture among health care professionals. Use of adequate diagnostic criteria in assigning psychiatric diagnoses is also important, because as numerous epidemiologic studies have documented, the presence of emotional symptoms is not identical to a diagnosis of a mental disorder. For example, a survivor of torture may feel sad and hopeless, but may not be suffering from a major depression.

In the studies reviewed in this article, many of the symptoms associated with the diagnosis of posttraumatic stress disorder (eg, recurrent thoughts or memories of the traumatic event, hyperalertness, reliving the traumatic event, sleep disturbance, etc[55]), as well as major affective disorder (eg, dysphoric mood, poor appetite, feelings of worthlessness[55]), were not systematically assessed. Therefore, it is not known if any of the psychological symptoms described were associated with either of these disorders or secondary to head trauma. Furthermore, patients who have been tortured may carry more than one psychiatric diagnosis.[31] Before a new syndrome, such as a torture syndrome, is applied to these patients it should be determined whether the symptoms they display meet established diagnostic categories. These distinctions have important impact on therapeutic approach, including the appropriate use of psychotropic medications.

In addition, individual differences, including gender, age, and education, and many other cultural traits and personality characteristics can have significant impact on an individual's interpretation of the social and psychological meaning of their torture experience.[56] For example, the subjective experience of a rape trauma during detention may be considerably different for a Cambodian woman than the psychological distress following a Chilean political prisoner's mock execution. Yet, both may suffer from symptoms consistent with the diagnosis of posttraumatic stress disorder. Description of these differences in clinical studies would provide meaningful information about the psychiatric disorders associated with torture.

CONCLUSIONS

Emphasis on a rigorous medical approach to torture is in no way meant to detract from the understanding of torture as a social and political phenomenon. Rather, our hope is that the careful documentation of symptoms and physical findings associated with human rights abuses will focus attention on the occurrence of torture and hasten its elimination. The reporting of a physical or emotional injury and the torture event that gave rise to it can provide evidence about who has been tortured, when, and how. Such knowledge can support the international medical and legal system in documenting human rights violations. This information could furthermore help establish legal refugee status for individuals seeking political asylum.

A comprehensive survey of the evaluation and treatment practices of health practitioners and clinics that serve patients who have been tortured would greatly enrich our understanding of the survivor of torture. Important insights into the similarities and differences between the psychological symptoms that follow torture and that characterize the posttraumatic stress disorder could be gained. Such a survey could also help clarify therapeutic issues such as the efficacy of specialized torture rehabilitation treatment centers vs mainstream primary care settings. It might also elucidate the differences between caring for refugee patients in countries of asylum vs caring for patients who live in the sociopolitical context in which the torture occurred.

Future research in this field should explore the prevalence and complications of sexual abuse and head injury in this patient population. The development and validation of culturally and linguistically pertinent screening in-

struments is necessary for appropriate psychiatric diagnosis and care.[5] Descriptions of where and by whom examinations were conducted, and the reporting of information in a format that would ideally include history, physical and psychological findings, and diagnosis would greatly improve communication between health professionals as well as facilitate the evaluation of information on this topic.

Health professionals are in a unique position to foster the prevention of torture. The medical verification of injuries caused by torture can provide powerful testimony to its occurrence. Such evidence can focus international attention on human rights abuses even when they are strenuously denied by the governments that commit them. Therefore, the application of a rigorous medical approach to the patient who has survived torture will not only provide these individuals with the best possible care, but will contribute to the international recognition and eradication of this inhumane practice.

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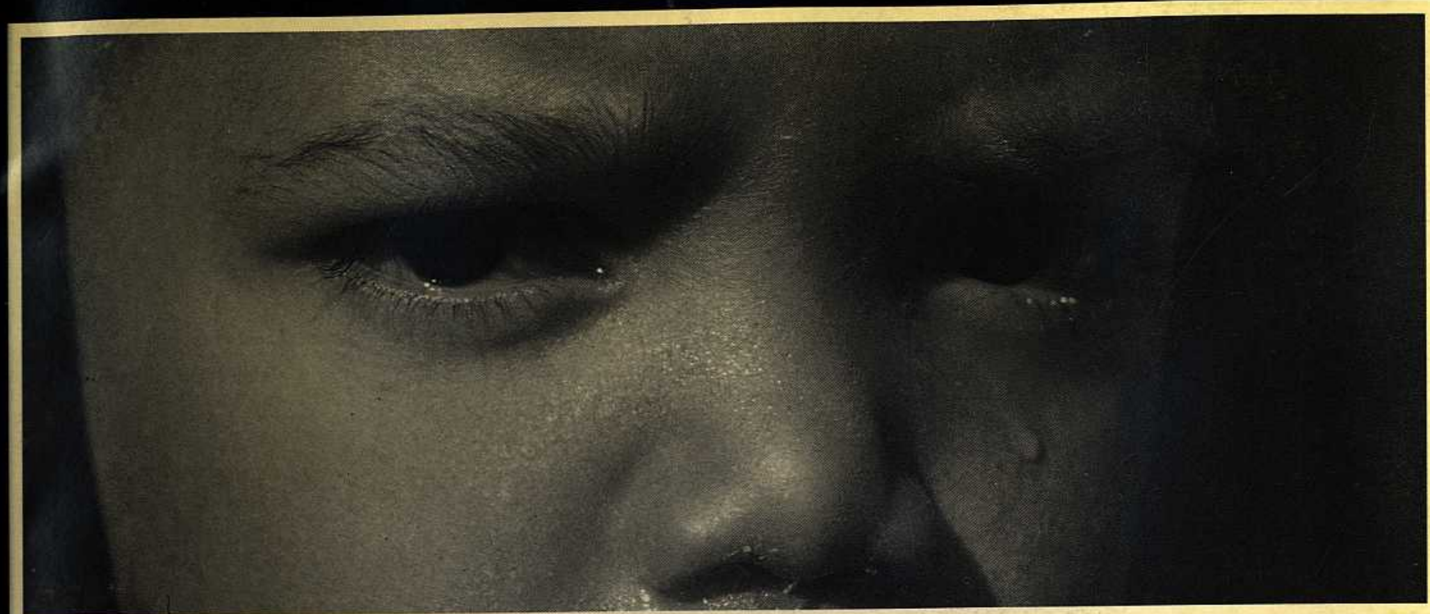

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Convention des Nations Unies relative aux droits de l'enfant

Introduction

"Parmi les innombrables messages diffusés dans le cadre des campagnes de sensibilisation à la torture, une affiche retient particulièrement l'attention par la sobriété de sa présentation et l'atrocité du message qu'elle transmet. Il s'agit de la photo d'un simple clou se détachant sur un fond blanc avec la légende expliquant que ce clou rappelle le cas d'une femme, Maria, que ses tortionnaires obligèrent à regarder son enfant à qui ils crevaient les yeux.

Si toutes tortures provoquent la répulsion, celles commises à l'encontre des enfants suscitent une horreur mêlée d'incrédulité. L'esprit se refuse à admettre qu'on puisse s'acharner avec une telle cruauté sur des êtres fragiles, vulnérables, incapables de se défendre et qui dans leur innocence même ne semblent pouvoir provoquer une telle haine à leur encontre. On s'attendrait à ce que le plus endurci des tortionnaires, prêt à faire subir les pires sévices à d'autres êtres humains que son aveuglement lui fait considérer comme des ennemis si dangereux et si pervers qu'ils ne méritent plus aucun respect, épargnerait les enfants que même sa folie ne peut lui présenter comme des adversaires à combattre par n'importe quels moyens.

Or il n'en est rien. Parmi les dizaines de milliers de victimes de tortures, de traitements cruels inhumains ou dégradants, d'exécutions sommaires ou de disparitions forcées recensés par notre organisation, nous enregistrons un grand nombre d'enfants, voire même de nourrissons. Dans certains pays, des escadrons de la mort se sont même organisés pour éliminer les gamins des rues.

Au Brésil, dans les années 60 et 70, une dictature implacable s'était donnée pour tâche d'annihiler toute opposition politique au nom d'une doctrine, dite de sécurité nationale. Pour parvenir à leur but, les militaires au pouvoir avaient eu recours de façon systématique à la torture et aux exécutions sommaires.

La démocratisation du régime dans les années 80 s'est traduite par un meilleur respect des droits de l'homme particulièrement à l'égard des membres de la classe politique pourchassés par la dictature. Mais les escadrons de la mort n'ont pas été complètement démantelés, loin s'en faut. Ces milices illégales, constituées de policiers appuyés de certains civils poursuivent leur croisade purificatrice. Aujourd'hui, dans les grandes villes du pays, les escadrons de la mort se consacrent à ce qu'ils appellent eux-mêmes le *"nettoyage 'social"*, c'est-à-dire l'élimination après torture et dans des conditions particulièrement ignobles destinées *"à faire un exemple"* de petits délinquants, de *"parasites sociaux"* parmi lesquels de nombreux enfants des rues.

En quelques années, on a recensé, au Brésil uniquement, plusieurs milliers d'enfants, victimes de ces atrocités. Le scénario est presque toujours le même: un gamin est arrêté illégalement, torturé à mort et son corps mutilé délibérément abandonné en pleine rue pour faire savoir aux autres gosses ce qu'il en coûte de se livrer aux trafics, d'importuner les touristes ou de voler des commerçants. Si cette véritable guerre aux enfants de la rue a pris une tournure particulièrement dramatique au Brésil, le phénomène ne touche hélas pas ce seul pays.

La crise économique qui frappe la plupart des pays du Sud, s'accompagne d'une vertigineuse croissance d'enfants abandonnés à leur sort, vivant comme ils le peuvent dans la rue. Organisés en bandes, souvent dangereux parce qu'ils ne connaissent que la loi de la jungle, ces gamins deviennent la cible d'organismes paramilitaires concevant le rétablissement de l'ordre par l'élimination des victimes les plus vulnérables du désordre existant. Mais les enfants de la rue ne sont pas les seuls à subir les atrocités commises par certains agents de l'Etat. Des mineurs sont torturés, exécutés ou disparaissent parce qu'ils appartiennent à des minorités ethniques ou religieuses, en conflit avec la majorité. Certains sont soumis à des exactions pour faire pression sur leurs parents, d'autres pour leur faire avouer ce qu'ils peuvent savoir des activités d'un groupe d'opposants. Il arrive ainsi que des enfants, témoins d'atrocités commises par l'armée ou la police, soient froidement abattus pour empêcher toute enquête.

Depuis le début des activités de l'OMCT/SOS-Torture, en 1986 et plus particulièrement depuis l'informatisation de

l'ensemble des données concernant les victimes, notre centrale d'alerte a pris conscience de l'ampleur et de la gravité des violences commises à l'encontre des enfants. L'Assemblée générale réunie à Manille en 1991, a estimé que des actions spécifiques devaient être entreprises au niveau international pour faire reculer ce fléau.

L'OMCT/SOS-Torture a décidé, en lien avec les organisations de protection des enfants et les organisations de défense des droits de l'homme, de mettre sur pied un programme d'action destiné à lutter contre ces pratiques.

En septembre 1992, le Conseil exécutif a approuvé une proposition du directeur, de conduire, avec les membres du réseau et d'autres organisations intéressées, une enquête sur les tortures, les exécutions sommaires et les disparitions forcées dont sont victimes les enfants.

Pour compléter les informations contenues dans notre base de donnée, dont les cas constituent le corps du présent rapport, un questionnaire a été envoyé à quelque 350 organisations internationales, régionales ou nationales. Malgré la diversité des sources et leur fiabilité, nous sommes conscients qu'une telle étude ne peut prétendre être exhaustive. Certaines situations n'ont pu être traitées faute d'informations suffisantes, alors que d'autres mieux documentées, sont présentées en détails. Il ne faut pas voir dans cette différence de traitement une volonté de mettre en lumière certains cas en laissant d'autres dans l'ombre.

En préparant ce dossier, notre souci a été d'attirer l'attention de la communauté internationale sur un problème particulièrement grave, qui devrait être une des priorités du travail de la Conférence mondiale des droits de l'homme de juin 1993.

Cette publication, par ailleurs, se veut la première étape d'une série d'initiatives, dont certaines sont actuellement à l'étude avec d'autres ONG, visant à mettre sur pied un programme mondial concerté d'actions destinées à faire reculer et, si possible, à éliminer des pratiques particulièrement abjectes.

Les droits de l'enfant sur le plan normatif

Le présent document étant consacré aux enfants victimes de très graves violations aux droits de l'homme relevant du mandat de l'OMCT/SOS-Torture, telles que torture, exécutions sommaires, disparitions forcées, il nous est apparu important de préciser quels sont les critères de définition retenus par les instruments internationaux en la matière.

Nous examinerons donc tout d'abord la manière dont les Nations Unies définissent l'enfant ainsi que les âges minima fixés pour établir la responsabilité pénale, la participation à des conflits armés, l'accès à l'emploi et le consentement à l'acte sexuel. Ces quatre questions sont en effet directement liées aux plus graves abus enregistrés.

La responsabilité pénale, admise par certains codes pénaux pour de très jeunes délinquants ou considérés comme tels, se traduit par des sanctions abusives ou des conditions de détention inacceptables souvent assimilables à des mauvais traitements ou de la torture.

La participation active à des conflits armés provoque la mort ou des traumatismes physiques et psychiques de nombreux enfants. Or nous verrons que dans ce domaine, la Convention relative aux droits de l'enfant a singulièrement manqué d'audace en acceptant que soient enrôlés dans des unités combattantes de très jeunes gens.

L'âge minimum pour l'accès à l'emploi est réglementé par onze Conventions de l'OIT qui précisent les conditions acceptables de travail des mineurs et protègent l'enfant contre une exploitation préjudiciable non seulement à son bien-être et à son éducation, mais aussi à sa santé et à sa vie.

Enfin l'âge minimum pour le consentement à l'acte sexuel permet de lutter contre la pratique particulièrement abjecte de la pédophilie et de la prostitution infantile. Comme nous le verrons il existe des provisions dans certains instruments internationaux interdisant la prostitution et notamment la prostitution infantile. Mais ces dispositions ne s'appliquent pas aux cas de relations sexuelles entre partenaires consentants en âge d'entretenir des relations sexuelles, à moins qu'il se soit avéré que l'un des deux se prostitue, ce qui est souvent difficile à prouver. La fixation d'un âge minimum pour le consentement sexuel reste donc la forme de protection la plus efficace contre la pédophilie qui se développe dans certains pays du Sud particulièrement vulnérables, en raison de leurs difficultés économiques.

Après avoir brièvement passé en revue les droits reconnus aux enfants, nous présenterons ensuite les définitions conventionnelles, lorsqu'elles existent, de la torture, de l'exécution sommaire et de la disparition forcée ; les instruments interdisant ces pratiques, notamment lorsque des enfants en sont les victimes et les mécanismes mis en place au niveau international pour lutter contre ces crimes.

Nous aborderons enfin l'interdiction, hélas peu respectée, de pratiques ayant des conséquences particulièrement graves sur les enfants, notamment le travail forcé en paiement d'une dette et de la prostitution.

1 - Définition de l'enfant

La Convention des Nations Unies relative aux droits de l'enfant stipule à son article premier :

"Au sens de la présente Convention, un enfant s'entend de tout être humain âgé de moins de dix-huit ans, sauf si la majorité est atteinte plus tôt en vertu de la législation qui lui est applicable".

Cet article a été un de ceux qui ont nourri les plus vifs débats lors de sa rédaction. La définition retenue appelle plusieurs commentaires.

On remarquera tout d'abord que les auteurs se sont abstenus de prendre parti sur la question de savoir quand commence l'enfance. Les travaux préparatoires avaient mis en lumière les divergences profondes et inconciliables entre ceux qui estimaient qu'il fallait retenir comme début

de l'enfance, la date de la conception et ceux qui considéraient que l'enfance ne saurait commencer avant la naissance.

Devant l'impossibilité de trouver un consensus les auteurs ont préféré ne rien mentionner. Le texte de surcroît ne renvoit pas non plus la question au législateur national en lui demandant d'établir une règle en la matière répondant à certaines exigences fixées internationalement, comme c'est souvent le cas lorsqu'il y a accord sur un principe mais divergence quant à son application.

On notera toutefois que le neuvième alinéa du préambule de la Convention sur les droits de l'enfant, fait référence à une protection juridique avant la naissance :

*"Ayant présent à l'esprit que comme indiqué dans la Déclaration des droits de l'enfant, adoptée le 20 novembre 1959 par l'Assemblée générale des Nations Unies, **l'enfant, en raison de son manque de maturité physique et intellectuelle, a besoin d'une protection spéciale et de soins spéciaux, notamment d'une protection juridique appropriée, avant comme après la naissance**".*

La question de l'âge maximum a suscité elle aussi certaines difficultés. Un compromis a été trouvé qui pose comme principe la limite maximale à 18 ans tout en prévoyant la possibilité de ramener la fin de l'enfance à un âge inférieur lorsque la législation nationale a prévu que la majorité est atteinte avant 18 ans.

Certes, en admettant que la législation nationale puisse fixer l'âge maximum en-dessous de ce que prévoit la Convention, les auteurs ont accepté la possibilité que certains Etats restreignent la portée de la protection que la Convention garantit à l'enfant. On notera toutefois que l'âge est fixé par la Convention et que l'on a écarté la solution, fréquente dans d'autres instruments, confiant au législateur national le soin de déterminer, à la lumière de certains critères, le seuil à retenir. C'est un point important vers une harmonisation internationale de la législation en faveur des enfants.

On remarquera que l'âge maximum a été fixé relativement haut et que contrairement à d'autres instruments internationaux ou à de nombreuses législations nationales, la Convention ne définit pas des catégories d'âges pour moduler les droits et devoirs. Là encore les différences culturelles ont joué un rôle important en ne permettant pas de définir des seuils identiques pour tous ; d'où cette catégorie unique qui comprend aussi bien des nourrissons incapables de s'alimenter par eux-mêmes que des jeunes gens déjà indépendants économiquement de leur famille.

En procédant de la sorte les auteurs de la Convention ont été contraints de s'en tenir à des principes généraux dans les domaines délicats où l'âge doit être pris en compte comme un critère essentiel pour la définition de l'étendue d'un droit ou de son exercice. Dans ces cas-là il convient, pour interpréter la règle générale de la Convention, d'examiner comment ces questions sont résolues par les instruments internationaux existant et par les législations nationales.

Ages minima retenus pour déterminer la responsabilité pénale des enfants délinquants

L'article 37a in fine de la Convention relative aux droits de l'enfant prévoit que :

"...ni la peine capitale, ni l'emprisonnement à vie sans possibilité de libération ne doivent être prononcés pour les infractions commises par des personnes âgées de moins de 18 ans".

Cet article rejoint en partie la teneur de la garantie n° 3 des *"Garanties pour la protection des droits des personnes passibles de la peine de mort"* adoptées par le Conseil économique et social par sa résolution 1984/50 du 25 mai 1984.

Cette interdiction de sanctions par trop lourdes à des enfants implique toutefois que ceux-ci, ou certains d'entre eux, peuvent et doivent être tenus pénalement responsables de leurs actes. Or la Convention ne dit rien quant à l'âge à partir duquel une telle responsabilité peut être admise.

L'*"Ensemble des règles minima des Nations Unies concernant l'administration de la justice pour mineurs (Règles de Beijing)"* adopté par l'Assemblée générale des Nations Unies le 29 novembre 1985, ne fixe pas non plus d'âge minimum en la matière.

Les articles 2. 2 et 4. 1 qui traitent de ce point sont accompagnés d'un commentaire officiel précisant que cette question ne peut relever que des législations nationales :

Article 2. 2

"Aux fins du présent Ensemble de règles, chaque Etat membre applique des définitions ci-après de manière compatible avec son système et ses concepts juridiques propres:

*a) Un **mineur** est un enfant ou un jeune qui, au regard du système juridique considéré, peut avoir à répondre d'un délit selon des modalités différentes de celles qui sont appliquées dans le cas d'un adulte ;*

*b) Un **délit** désigne tout comportement (acte ou omission) punissable par la loi en vertu du système juridique considéré ;*

*c) Un **délinquant juvénile** est un enfant ou un jeune accusé ou déclaré coupable d'avoir commis un délit".*

L'article 2. 2 définit les termes "mineur" et "délit" en tant qu'élément de la notion de "délinquant juvénile" qui fait l'objet principal du présent Ensemble de règles minima (voir aussi les articles 3 et 4). Il faut noter que les limites d'âges dépendent expressément de chaque système juridique et

tiennent pleinement compte des systèmes économiques, sociaux, politiques et culturels des Etats membres. Il s'ensuit que toute une gamme d'âges relève de la catégorie des jeunes allant donc de 7 à 18 ans ou plus. Cette disparité est inévitable en égard à la diversité des systèmes juridiques nationaux et ne diminue en rien l'impact du présent Ensemble des règles minima".

Article 4. 1

"Dans les systèmes juridiques qui reconnaissent la notion de seuil de responsabilité pénale, celui-ci ne doit pas être fixé trop bas eu égard aux problèmes de maturité affective, psychologique et intellectuelle".

L'article 4. 1 comme on le voit ne demande pas au législateur national de fixer un seuil de responsabilité pénale, il se contente de recommander aux Etats, dont le système juridique connaît cette notion, de veiller à ce l'âge qu'ils retiennent ne soit pas trop bas.

Il ressort de ce qui précède que sur le plan pénal, du moins dans de nombreux systèmes, une distinction est faite entre une catégorie d'enfants -irresponsables en raison de leur jeune âge- et des mineurs -pénalement responsables mais devant être traités différemment des adultes-. Si les instruments internationaux prévoient un traitement spécifique pour le délinquant mineur, en revanche aucune règle ne fixe d'âge minimum au-dessous duquel un enfant ne devrait pas être tenu pour pénalement responsable de ses actes.

Age minimum pour la participation active à un conflit armé

L'article 38 alinéa 2 de la Convention relative aux droits de l'enfant stipule :

"Les Etats parties prennent toutes les mesures possibles dans la pratique pour veiller à ce que les personnes n'ayant pas atteint l'âge de 15 ans ne participent pas directement aux hostilités".

Cette disposition, admettant qu'au-delà de 15 ans un enfant puisse être non seulement enrôlé dans les forces armées mais de surcroît amené à participer directement aux hostilités, a été vivement critiquée, notamment par les ONG.

On est d'autant plus surpris que l'article 37 interdit, comme nous l'avons vu précédemment, l'application de la peine capitale et l'emprisonnement à vie pour des infractions commises par des personnes âgées de moins de 18 ans. On aurait pu s'attendre à ce que la même limite soit fixée pour la participation active à un conflit armé.

En effet si l'on admet qu'avant 18 ans les actes d'un délinquant doivent être jugés avec moins de rigueur que ceux d'un adulte, c'est que l'on estime que le développement incomplet de sa personnalité doit être pris en compte dans la fixation de la peine. Dès lors, comment peut-on justifier que le même instrument prévoit que dans les cas de conflits armés une personne peut, dès 15 ans, prendre part activement aux combats qui l'exposent aux atrocités de la guerre comme victime, comme auteur et comme témoin.

La révision d'un dispositif prévu par une Convention internationale étant pratiquement impossible, il serait souhaitable qu'un autre instrument juridique international de même portée prévoit l'interdiction absolue d'impliquer activement les enfants de moins de 18 ans dans un conflit armé.

Ages minima pour l'accès à l'emploi

L'article 32 de la Convention relative aux droits de l'enfant fait obligation à l'Etat de protéger l'enfant contre l'exploitation économique, de prendre des mesures pour éviter qu'il soit astreint à un travail mettant en danger sa santé, son éducation ou son développement, d'établir des âges minima d'admission à l'emploi et de spécifier les conditions d'emploi.

Cet article en revanche ne prévoit pas d'âge minimum pour l'accès au travail. Dans ce cas-là toutefois, l'absence de cette mention peut s'expliquer par le fait que la question a fait l'objet d'une réglementation détaillée de l'Organisation internationale du travail depuis plus de soixante-dix ans.

En effet, c'est lors de sa première session en 1919 déjà que l'OIT approuvait la Convention initiale fixant l'âge minimum pour l'accès à l'emploi dans le domaine industriel à 14 ans (Convention no. 5). Depuis, dix autres Conventions sont venues compléter ce premier instrument, la dernière en date étant la Convention 138. Il n'est pas possible de détailler chacune d'entre elles.

Nous retiendrons :

- que les Conventions les plus récentes ont porté l'âge minimum à 15 ans pour l'accès à l'emploi ;
- qu'après le secteur industriel d'autres secteurs ont été réglementés comme les pêcheries et l'agriculture, et enfin
- que des dispositions spécifiques ont été élaborées pour le travail impliquant la manipulation de produits dangereux.

C'est ainsi que trois Conventions (no. 13, 136 et 152) interdisent certains emplois aux adolescents de moins de 18 ans, alors que la Convention 115 sur la protection des radiations interdit l'emploi de travailleurs de moins de 16 ans et prévoit que des niveaux distincts de radiation seront fixés pour les employés de moins de 18 ans et pour ceux de plus de 18 ans.

Ces diverses Conventions, admettent parfois certaines exceptions ou dérogations, mais elles établissent des règles précises qui devraient faire référence en matière d'emploi des mineurs. La portée de ces instruments est toutefois limitée