TORTURE

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D J Pounder, University of Dundee, Dundee, UK

Introduction

There is no simple definition of torture. The word is derived from the same root as "distort," and originally it referred to the distortion of the human body on the rack or some other instrument. In modern law the three essential elements which constitute torture are: (1) the infliction of severe mental or physical pain or suffering; (2) the intentional or deliberate infliction of pain; and (3) the pursuit of a specific purpose, such as gaining information, punishment, or intimidation. The distinction between torture and other types of ill-treatment is made on the basis of a difference in the intensity of the suffering inflicted. The severity or intensity of the suffering inflicted can be gauged by reference to its duration, physical and mental effects, the sex, age, and state of health of the victim, and the manner and method of its execution. Torture is further characterized by being a deliberate form of inhuman treatment. The purposive element of torture is recognized in the definition of torture in the 1987 United Nations Convention which states that:

> the term torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind.

Ill-treatment that is not torture, in that it does not have sufficient intensity or purpose, will be classed as inhuman or degrading if it attains the required minimum level of severity. The assessment of the minimum level of severity is relative: it depends on all the circumstances of the case, such as the nature and context of the treatment or punishment, the duration of the treatment, its physical and mental effects, the manner and method of its execution, and in some cases, the sex, age, and state of health of the victim.

The notion of inhuman treatment covers at least treatment, which deliberately causes severe suffering, mental or physical, which in the particular situation is unjustifiable. Degrading treatment is that which arouses in its victims feelings of fear, anguish, and inferiority, capable of humiliating and debasing them. This has also been described as involving treatment which would lead to the breaking down of the physical or moral resistance of the victim, or driving the victim to act against his/her will or conscience. Relative factors such as the age and sex of the victim can have a greater impact in assessing whether treatment is degrading, in contrast to whether treatment is inhuman or torture, as the assessment of whether an individual has been subjected to degrading treatment is more subjective. It may well be sufficient that the victim is humiliated in his/her own eyes, even if not in the eyes of others. In this hierarchy of torture, inhuman treatment, and degrading treatment, it is axiomatic that all torture must be inhuman and degrading treatment, and all inhuman treatment must also be degrading.

The starting point for assessing whether ill-treatment has taken place is a determination of whether or not physical force has been used at all against the detainee. Recourse to physical force, which has not been made strictly necessary by the detainee's own conduct, is in principle an infringement of the prohibition of ill-treatment. The most obvious evidence of the use of physical force will be the presence of injuries or observable psychological trauma. If a detainee shows signs of injuries or ill-health, either upon release from detention or at any stage during the detention, then the burden will be on the detaining authorities to establish that the signs or symptoms are unrelated to the period or fact of detention. The burden of proof is firmly on the detaining authorities to provide a plausible account of how injuries occurred.

Torture Methods

The first global survey of torture, published by Amnesty International in 1973, showed that 72 out of 168 countries practiced torture systematically. A survey in 1997 reported torture and maltreatment in

115 out of 215 countries. There are clear differences between regions and countries and even between police forces within countries in the frequency of the various methods of torture. Psychiatric abuse was almost unique to the Soviet Union; falanga (beatings on the sole of the feet) was frequent in Greece; shaking is practiced mostly in Israel; whipping is more frequent in the Middle East and Africa and almost unknown in Latin America; hanging by the feet or ankles is more universal than the "parrot's perch" type of hanging which is more frequent in Brazil and Ethiopia. Soviet and Chinese techniques involved the use of solitary confinement, sleep deprivation, exposure to heat and cold, uncertainty, threats to family, starvation, offers of rewards, and the creation of a sense of hopelessness. The Israelis use prolonged sleep deprivation, blindfolding or hooding, forced prolonged maintenance of body positions that grow increasingly painful, confinement in closet-like spaces, exposure to temperature extremes, prolonged toilet and hygiene deprivation, degrading treatment, such as forcing detainees to eat and use the toilet at the same time, and verbal threats and insults. The techniques of hooding, sleep deprivation, and positional abuse, which the British employed in Northern Ireland, had also been used by them in Aden, Borneo/Malaysia, British Cameroons, British Guiana, Brunei, Cyprus, Kenya, Malaya, Palestine, and the Persian Gulf.

Torture methods have been classified into physical and psychological but this distinction is artificial, as is well seen with respect to sexual torture. The physical methods of torture challenge any possible classification because of their number and variety. The Human Rights Commissions of El Salvador and Chile listed 40 and 85 different types of torture, respectively. The most frequent methods of physical torture are beating, electrical torture, stretching, submersion in a liquid, suffocation, suspension, burning, and sexual assault. Sexual torture can be defined widely as including violence against the sexual organs, the introduction of foreign bodies into the vagina or rectum, rape and other forced sexual acts, and mental sexual assault such as forced nakedness, sexual humiliation, sexual threats, and the forced witnessing of sexual torture. Using this wide definition of sexual torture, its prevalence is very high in torture victims. Psychological methods of torture include induced exhaustion and debility through food, water, and sleep deprivation; isolation by blindfolding, hooding, and solitary confinement; threats of death and threats to the family; sensory deprivation through limitation of movement, continuous noise, and darkness or alternatively facing bright lights; and witnessing the torture of other prisoners or family members.

Medical Examination

The physical manifestations of torture vary according to the method and its intensity, frequency, and duration, as well as the victim's ability to protect him/herself, and the physical health of the victim prior to torture. Many forms of torture produce no physical findings while some forms have very specific physical findings in the immediate aftermath or may be strongly associated with particular sequelae. Torturers may select methods of torture because they leave no physical evidence or may modify methods of torture to reduce the possibility of producing physical evidence. The role of the assessment of the physical evidence is to establish whether it is consistent or inconsistent with the history provided. Clearly in many instances an absence of physical findings will be the expected outcome of the examination of a torture survivor. Published epidemiological studies of torture may be useful in correlating regional practices of torture with individual allegations of abuse.

A medical examination should be undertaken regardless of the length of time since the torture, but if it is alleged to have happened within the past 6 weeks, such an examination should be arranged urgently before acute signs fade. The history is a vital part of the examination because upon it rests the ability to match the account of the alleged abuse to the physical findings, and also to gain an idea of the psychological trauma that the victim has suffered. The history taken should include the prearrest psychosocial history, a summary overview of the detention and abuse, the circumstances of detention, conditions of detention, and methods of torture and ill-treatment. A torture survivor may have difficulty in recounting the specific details of the torture for several reasons, including fear, lack of trust in the questioner, the psychological impact of the trauma and impaired memory, protective coping mechanisms such as denial and avoidance, cultural factors, and factors during the torture itself such as blindfolding, drugging, and lapses of consciousness. The medical history should include any history of injuries sustained before the period of detention and any possible after effects. A description of acute injuries and symptoms resulting from the specific methods of abuse, and their evolution, and resolution or residual effects should be recorded. Chronic symptoms which the survivor believes were associated with the ill-treatment should also be noted.

The general examination should include the entire body surface to detect signs of generalized skin disease such as vitamin deficiency, pretorture lesions, and lesions inflicted by torture. The latter should be described by their location, shape, size, color, and surface characteristics. The documentation of scars should be carried out together with the subject's attribution of each separate one. Care should be taken to identify scars, which have been produced by tribal markings, traditional medicine, accident, or self-mutilation. Scars, while not in themselves specific, may be found in unusual locations, which conform to the description of the torture, thus corroborating the account. Otoscopy is necessary because trauma to the ears and rupture of the tympanic membrane are frequent consequences of heavy beatings. A common form of torture, known in Latin America as teléfono, is a hard slap of the palm of the hand to one or both ears, rapidly increasing pressure in the ear canal, and thus rupturing the eardrum. Prompt examination is necessary to detect these tympanic membrane ruptures less than 2 mm in diameter, which may heal within 10 days. The examination of the head and neck should include the oropharynx and gingiva. Referral for a dental examination may be appropriate in the light of the history of the torture methods.

Complaints of musculoskeletal aches and pains are very common in torture survivors, and may be the result of repeated beatings, suspension, other positional torture, or the general physical environment of detention. Although nonspecific, they should be documented. The physical examination of the musculoskeletal system should include testing for mobility of joints, the spine, and the extremities. Pain with motion, contractures, strength, evidence of compartment syndrome, fractures with or without deformities, and dislocations should be noted. Radiography is the appropriate investigation for bony lesions but injuries to tendons, ligaments, and muscles are best evaluated with magnetic resonance imaging (MRI). In the acute stage, MRI can detect intramuscular hemorrhage, but since muscles usually heal completely without scarring later imaging studies can be expected to be negative. Denervated muscles and chronic compartment syndrome will be imaged as muscle fibrosis. A detailed neurological examination is necessary. Radiculopathies, other neuropathies, cranial nerve deficits, hyperalgesia, paresthesias, hyperesthesias, and changes in position and temperature sensation, motor function, gait, and coordination may all result from trauma associated with torture. Individuals who report having being suspended should be examined for evidence of brachial plexopathy. A history of dizziness and vomiting should prompt a vestibular examination and a note of any nystagmus present.

Blunt-Force Injuries

The known methods of torture cover the entire spectrum of forms of physical trauma seen in general forensic practice and the principles applied to their documentation and interpretation are the same. Almost every torture session begins with a "softening up" of punching, kicking, and hitting with truncheons, rifle butts, or whatever weapons come to hand. Beatings and other forms of blunt-force trauma result in bruises, abrasions, and laceration whose overall pattern may be indicative of assault, but with generally nonspecific individual injuries. The dating of fresh injuries may establish that they occurred during the period of detention. However, beatings may be restricted to the first few days of detention so that injuries will have faded before the victim has to appear in court or is released from custody. Most blunt-force injuries heal within about 6 weeks, leaving no scars or nonspecific scars. Whips of barbed wire or thorn branches, or belts which have metal studs as well as heavy metal buckles, may leave a combination of linear scars and ragged scars where skin has been gouged out. Prolonged application of tight ligatures as a tourniquet (the garrotte of the Inquisition) may leave a circumferential linear zone of scarring around the arm or leg, typically at the wrist or ankle, an appearance that is diagnostic. More focal areas of hypo- or hyperpigmentation on the medial and lateral aspects of the wrists result from tight restraint. The tramline bruising characteristic of blows from a linear weapon with a circular cross-sectional shape, such as a truncheon or a cane, may resolve to leave tramline hyperpigmented scarring. Lacerations heal as scars, and multiple depigmented, often hypertrophic, linear scars, with marginal hyperpigmentation are characteristic of whipping. The only differential diagnosis is plant dermatitis.

In the north of India, in the Punjab, a torture known as ghotna involves rolling a wooden log up and down the thighs, while the log is weighted by one or two policemen standing on it. This causes exquisite pain and often unconsciousness and the victim is unable to walk for several weeks. The long-term effect is permanent pain on walking and abnormal tenderness on squeezing the quadriceps muscles. The ghotna may also be applied by placing it behind the knees and then forcibly flexing the legs over it. After this, there is permanent pain around the knee joints and tenderness in the popliteal fossae.

Injury to the mouth and jaws may be coincidental to beatings or there may be specific use of dental torture. Facial trauma may result in temporomandibular joint syndrome with pain in the joint and limitation of lower-jaw movement. Dental torture may include breaking or extracting the teeth and the application of electric current to the teeth.

Falanga

Blunt-force trauma applied to the soles of the feet, or rarely to the palms of the hands or the hips, is known as falanga, or falaka, or basinado. A truncheon, rubber hose, baseball bat, or similar weapon is typically used. The resultant injuries are usually confined to the soft tissues with bruising, edema, and tissue disruption. The physical examination in the acute phase should be diagnostic. After the initial swelling and bruising have subsided there usually remains little external evidence. Sometimes, especially if a rough or jagged weapon has been used to beat the soles of the feet, there may be scarring. However, roughness, scarring, and pigmentation of the soles of the feet are often found normally in populations who habitually go barefoot or have lived in rough terrains. Fractures of the carpals, metacarpals, and phalanges can occur but are uncommon. Several complications and syndromes may occur, the most severe being closed-compartment syndrome, resulting in vascular obstruction and muscle necrosis, which may be complicated by gangrene of the distal foot or toes or fibrosis and contractures. However, permanent deformities of the feet are uncommon following falanga.

Falanga may be complicated by crushed anterior foot pads and crushed heels. Disruption of these fibrofatty subcutaneous tissue pads results in loss of their cushioning effect and consequently pain on walking. The heel is no longer a firm smooth elastic pad but rather spreads under weight-bearing and on palpation feels thin with the underlying bone easily palpable. Rupture of the plantar aponeurosis results in loss of support for the arch of the foot with consequent difficulty in walking. Passive extension of the big toe may establish whether the aponeurosis has been torn. Normally the start of tension in the aponeurosis is palpable when the big toe is dorsiflexed to 20° and higher values suggest injury to the attachments of the aponeurosis. This clinical finding is rarely seen.

The chronic effects of falanga are pain and difficulty on walking and survivors may be quite unable to run. In bed at night the added warmth causes burning pain deep in the calves and often as far up as the knees. The sole of the foot is tender on pressure over the metatarsal heads and squeezing the heel is abnormally painful. The whole length of the plantar aponeurosis may be tender on palpation. Pressure on the sole of the foot and dorsiflexion of the great toe may elicit pain. The more extreme complications described above are less often seen. In a victim of falanga, MRI is the preferred radiological examination to detect soft-tissue injury.

Suspension

Suspension is a common form of torture that can produce extreme pain and leaves little, if any, visible evidence of injury. The strappado of the Inquisition now tends to be called "Palestinian hanging," but the origin of this more modern terminology is obscure. For the strappado the victim's hands were tied behind the back and then he was hoisted up by his wrists to a pulley on the ceiling. Weights could be attached to his legs for greater effect or he could be suddenly allowed to drop but be brought up with a sharp jerk that dislocated his arms at the shoulders. Other forms of suspension torture are the cross, with the arms tied to a horizontal bar; butchery suspension, by the wrists above the head; reverse butchery suspension, by the feet in a head-down position; and the parrot's perch, with the knees flexed, the wrists tied to the ankles, and suspension by a bar passed behind the knees. The parrot's perch may produce tears in the cruciate ligaments of the knees.

Strappado is so painful that the victim usually loses consciousness within a few minutes and has to be revived before it is repeated. Beatings and electric-shock torture are often carried out at the same time. The immediate result is total freezing of the shoulders and it may be weeks or months before the arms can be used again. Strappado and crucification can both produce brachial plexus damage because this is the shoulder region structure that is most sensitive to traction injury. In the acute period following suspension, the complications include weakness of the arms and/or the hands, pain and paresthesias, numbness, insensitivity to touch, to superficial pain, and to position, and tendon reflex loss. The intense deep-muscle pain may mask the muscle weakness. Raising the arms or lifting a weight may cause pain, numbness, or weakness, or may simply not be possible. Tears of the ligaments of the shoulder joints, dislocation of the scapulae, and muscle injury in the shoulder region may all occur. Damage to the long thoracic nerve or dislocation of the scapula may result in a winged scapula, with a prominent vertebral border of the scapula visible.

Any brachial plexus injury manifests itself in motor, sensory, and reflex dysfunction. The most common finding on motor examination is asymmetrical muscle weakness more prominent distally, but

assessment may be difficult in the acute phase due to pain. With severe injuries muscle atrophy may be seen in the chronic phase. Complete loss of sensation or paresthesias along the sensory nerve pathways are common in the acute phase and, if still present after 3 weeks, then appropriate electrophysiological studies should be performed. A decrease in reflexes or a difference between the two extremities may be present. The neurological injury from brachial plexus traction in strappado results from posterior hyperextension of the arms and typically implicates the lower plexus and then the middle and upper plexus fibers. In crucification-type suspension with hyperabduction without hyperextension, it is the middle plexus fibers that are likely to be damaged first. Additionally the neurological injury is usually not the same in both arms as a result of the asymmetry of suspension. Damage to the lower plexus is reflected in weakness of the forearm and hand muscles with sensory deficiencies on the forearm and the ulnar nerve distribution on the medial aspect of the hand. Damage to the middle plexus is reflected in forearm, elbow, and finger extensor muscle weakness with weakness on pronation and radial flexion of the forearm. Sensory deficiency is of the forearm and the radial nerve distribution of the hand. Triceps reflexes may be lost. Damage to the upper plexus causes weakness of the shoulder muscles with deficiencies in abduction of the shoulder, axial rotation, and forearm pronation–supination. Sensory deficiency is in the deltoid region and may extend to the arms.

The most constant long-term finding following strappado is tenderness and tension in the trapezius and scapular muscle groups, pain on raising the arms, often with limitation by pain, and especially extreme pain on internal rotation. Brachial plexus lesions, including winging of the scapulae and X-ray changes in the shoulder joints, are less common.

In addition to the various forms of suspension there are many forms of positional torture, all of which restrain the victim in contorted, hyperextended, or other unnatural positions that cause severe pain and may produce injuries to ligaments, tendons, nerves, and blood vessels. Characteristically, these forms of torture leave few, if any, external marks or radiological findings despite the frequency of severe chronic disability that follows. Dependent upon the specific forced position adopted, complaints are characterized by pain in the respective region of the body and limitation of joint movement. In north India the police seat a victim on the floor, pulling the head back by the hair and with a knee in the back, while the legs are pulled apart up to 180° until the adductor muscles are torn off their origins, resulting in an audible tearing sound. This torture is given the name of cheera, which means tearing in Punjabi. The immediate result is massive bruising in the groins. The later effects include permanent tenderness over the origin of the adductors and extreme pain on attempts at abduction of the hips with great difficulty in walking.

Burning and Electrical Torture

Burning is the method of torture that most frequently results in permanent skin changes, which can be of diagnostic value. Cigarette burns leave well-defined 5–10-mm circular or ovoid scars with a hyperpigmented thin indistinct margin enclosing a scar of hypopigmented tissue-paper appearance with a thickened center. Burning by the application of hot metal objects produces a branding effect, with the resultant burn reflecting the shape of the causative object. The shaped, sharply demarcated atrophic scar has a thin hyperpigmented marginal zone. Burning with a flame or a liquid, such as melted rubber from a tire, produces more irregular patterns. Any burning of dark-skinned persons may result in hypertrophic or keloid scars. Burning of the soles of the feet using lighted kerosene is a method of torture found in the Indian subcontinent.

Electrical torture is carried out by attaching electrodes to the body and connecting them to a power source. The most common sites selected are the hands, feet, fingers, toes, ears, nipples, mouth, lips, and genitals. The power source may be a hand-cranked or gasoline generator, domestic electricity, a stun gun, a cattle prod, or any other electrical device. Since the electric current will follow the shortest route between the two electrodes the symptoms will reflect this, as all muscles along the route are tetanically contracted. Moderately high currents may lead to dislocation of the shoulder and produce lumbar and cervical radiculopathies. Electrical burn marks at the sites of application of the electrodes are usually red-brown circular lesions between 1 and 3 mm in diameter, which resolve to leave fine scars which may be hyperpigmented. Such lesions are not easily identifiable and need to be searched for carefully. When bare wires or needles have been used to apply electrical current, as in the Latin American technique of picana, there may be permanent pinpoint scars which can be identified if they are in clusters. Electrodes which have been clipped to the skin of the earlobe or scrotum may leave sharply defined scarring which is distinctive. To avoid leaving evidence of electrical burn marks, torturers may extend the electrical contact surface area through the use of water or gels. In the acute phase there may be myoglobinemia and myoglobinuria resulting from the tetanic contraction of muscles. The usefulness of skin biopsies in the

diagnosis of the electrical burns is controversial because the histopathological changes, although specific, are not universally present and the procedure is intrusive.

Asphyxia

Asphyxiation by a variety of methods is an increasingly common type of torture. It usually leaves no marks, produces a death experience with loss of consciousness, and recuperation is rapid. This method of torture was so widely used in Latin America that its Spanish name submarino became part of the human rights vocabulary. Wet submarino involves forcible immersion of the head into water, often contaminated with urine, feces, vomit, or other foul material. Dry submarino may be simply achieved by the use of a plastic bag placed over the head, a common practice of an antiterrorist section of the Spanish police. Other methods include forced closure of the mouth and nose, ligature pressure around the neck, or suspension by a ligature, i.e., hanging, and forced inhalation of dusts, cement, hot peppers, and other irritants.

General Findings

Sexual torture including rape produces the range of physical findings found in rape victims in other settings.

The extreme nature of the torture event is powerful enough on its own to produce mental and emotional consequences regardless of the individual's pretorture psychological status. There are clusters of symptoms and psychological reactions that have been observed and documented in torture survivors with some regularity. Since there is such a strong psychological element in the aftermath of torture, the borderline between physical and psychosomatic symptoms is certain to be blurred. There are almost universal symptoms, such as headache, and a form of backache which is characteristically most severe in the cervical and lower thoracic areas. Many attribute this to the actual blows received, but its physical cause is more likely to be the extreme movements induced by struggles to avoid the beating and prolonged forced imposition of extremes of posture. There is often muscle tension and altered posture of a psychological nature. Other common psychosomatic symptoms are palpitations and hyperventilation.

Although acute torture-related injuries may be characteristic of the alleged ill-treatment, most injuries heal within about 6 weeks, leaving no scars or nonspecific scars. Many forms of torture leave no physical evidence. Consequently, a completely negative physical examination does not rule out torture.

See Also

History of Torture; **Injury, Fatal and Nonfatal:** Blunt Injury; Burns and Scalds; **Sexual Offenses, Adult:** Injuries and Findings after Sexual Contact; **Torture:** Psychological Assessment

Further Reading

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Psychological Assessment

K Allden, Dartmouth Medical School, Hanover, NH, USA

Introduction

The psychological assessment of torture survivors and those who allege torture present physicians, clinicians, and social scientists with the challenge of evaluating individuals who have survived crises of life-threatening proportions. For many who have survived torture, the experience can cause profound effects at a deeply personal level that can persist and fluctuate for many years. Psychological consequences develop in the context of personal meaning and personality development; consequences will vary over time and are shaped by cultural, social, political, interpersonal, biological, and intrapsychic factors that are unique for each individual. In recent decades much has been learned about psychological, biological, and neuropsychiatric responses to extreme stress, including torture, and clusters of typical symptoms have emerged that are recognized across cultures. Recognizing these considerations, this article focuses on the psychological assessment of those who allege torture.

In 1999, the United Nations (UN) High Commissioner for Human Rights endorsed the first comprehensive set of guidelines for the medicolegal investigation and documentation of torture. The document is the *Principles and Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, also known as the Istanbul protocol. The UN annexed the principles in April 2000 in resolution E/CN4/RES/2000/32. The Istanbul protocol is the result of 3 years of collaborative analysis by a committee of forensic physicians, medical specialists, psychologists, human rights specialists, and lawyers who represented 40 organizations and institutions from 15 countries. This important reference is now the internationally recognized standard on evaluating those who allege torture. The reader is urged to refer to these guidelines. The document contains a model protocol for legal investigations of torture with a description of procedures for determining an appropriate investigative body, interviewing alleged victims and witnesses, obtaining consent, safety concerns, use of interpreters, securing physical evidence, developing a commission of inquiry, choosing experts, performing the physical and psychological exam, interpretation of findings and recommended content, and format of final reports.

In 1984, the UN Convention Against Torture defined torture as:

> any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.

This definition acknowledges that mental suffering is often the intention of the torturer. The goal of torture is not simply to physically incapacitate the victim, but, as several authors have described, the goal is to reduce the individual to a position of helplessness and distress and break his/her will. At the same time, torture sets horrific examples to those who come into contact with the victim, and can profoundly damage intimate relationships between spouses, parents, and children, and other family members, as well as relationships between the victims and their communities. In this way, torture can break or damage the will and coherence of entire communities.

Evaluating the psychological consequences of torture presents two paradoxes. First, although psychological wounds are the most personal, intimate, and enduring consequences of torture and can affect not only the victim but also his/her family and community, there are no objective signs, measurable parameters, lab tests, or X-rays that document psychological wounds. The second paradox is that, despite the fact that torture is an extraordinary life experience capable of causing a wide range of psychological suffering, extreme trauma such as torture does not always produce psychological problems. Therefore, if an individual does not have mental problems, it does not mean that he/she was not tortured. When there are no psychological findings, this does not refute or support whether torture actually occurred.

Psychological Torture

Recent terrorist events have led world leaders and the public to ponder the question of whether torture is ever justified. A utilitarian argument has been raised to address what to do about a "ticking bomb," that perhaps torture may be justifiable under extreme circumstances to extract information from a suspected terrorist. Under this argument, a suspected terrorist is a threat, not by what he/she has done but what he/she could do. The subjective judgments that would be made under these circumstances, however, could lead to a "slippery slope" of increasing force being applied to a wider network of suspects. The discussion goes on to ask: once torture is permitted for some suspects, how is it stopped?

Ultimately, this examination leads to the further discussion of what pressure can be utilized during interrogation without "crossing the line" into torture. Torture is not permitted under international humanitarian law. What constitutes physical torture is rarely disputed: it includes blunt trauma (beating, whipping, kicking, punching), positional torture, crush injuries, stabbing, burning, electric shock, and sexual assault. What constitutes psychological torture is under dispute by some, even though the UN definition of torture clearly states that torture includes mental suffering. The following is a very abbreviated list of methods that have been used as psychological torture: conditions of detention (small, overcrowded, or filthy cells), solitary confinement, forced nakedness, deprivation of normal sensory stimulation (light, sound, hooding, sense of time), deprivation of physiologic needs (food, water, toilet, bathing), sleep deprivation, social isolation, humiliation, threats of harm or death to family, threats of future torture, techniques to break down the individual such as forced betrayals, learned helplessness, contradictory or ambiguous messages, violation of cultural taboos,

behavioral coercion (forced to harm others, destroy property, or betray someone), and being forced to witness atrocities.

Medical, psychiatric, and psychological practitioners recognize that the distinction between physical and psychological impact of torture is blurred; consequences can and do overlap. Psychological torture has physical and psychological consequences. Physical torture has psychological and physical consequences. One needs only to consider the consequences of sleep deprivation to see how blurred the overlap is. The effects of sleep deprivation include cognitive impairment, disorientation, heightened sensitivity to pain, horizontal nystagmus, mild tremor, electroencephalographic changes, visual and tactile hallucinations, disturbances of perception, mood changes, paranoia, and even seizures. For further reading concerning the legal debate about what constitutes torture, the reader is referred to former UN Special Rapporteur on Torture Sir Nigel Rodley's book, *The Treatment of Prisoners under International Law.*

Social, Political, and Cultural Considerations

There are three complimentary approaches for understanding the psychological impact of torture. The personal approach is the individual's story as told through testimony, oral history, literature, and art. The clinical approach utilizes a medical and psychological paradigm and relies on clinical history, physical exam, and mental status exam. The community approach involves epidemiological studies of traumatized groups and populations. In combination these approaches provide a broad and in-depth understanding of the impact of torture on human beings.

Each approach requires consideration of the context of torture. Torture has unique cultural, social, and political meanings for each individual. These meanings will influence an individual's ability to describe and speak about his/her experiences. Similarly, these factors contribute to the impact that the torture inflicts psychologically and socially. Cross-cultural research reveals that phenomenological or descriptive methods are the best approaches when attempting to evaluate psychological or psychiatric reactions and disorders because what is considered disordered behavior or a disease in one culture may not be viewed as pathological in another. The World Health Organization's multicenter cross-cultural study of depression conducted in the 1980s provides a helpful guiding principle. That is, while some symptoms may be present across differing cultures, they may not be the symptoms that concern the individual the most. Therefore, the clinician's inquiry has to include the individual's beliefs about his/her experiences and meanings of the symptoms, as well as evaluating the presence or absence of symptoms of trauma-related mental disorders.

Torture is powerful enough on its own to produce mental and emotional consequences, regardless of the individual's pretorture psychological status. Nevertheless, torture has variable effects on people because the social, cultural, and political contexts vary widely. Outcomes can be influenced by many interrelated factors that include, but are not limited to, the following:

- circumstances, severity, and duration of the torture
- cultural meaning of torture/trauma and cultural meaning of symptoms
- age and developmental phase of the victim
- genetic and biological vulnerabilities of the victim
- perception and interpretation of torture by the victim
- the social context before, during, and after the torture
- community values and attitudes
- political factors
- prior history of trauma
- preexisting personality.

For example, compare the consequences for a young woman who is raped during torture and is from a culture that attaches a severe negative stigma of impurity to a woman who has been raped, with a military officer who is held as a prisoner of war and suffers long-term solitary confinement and multiple beatings. Both types of torture are severe, yet the impact on the individual's life is vastly different. The young woman might be socially ostracized and condemned by her family and community. The former military officer may have brain damage from beatings to the head with resultant long-term cognitive impairment.

Self-Report and the Controversy about Traumatic Memory

Self-reports of trauma and torture are often not believed or felt to be distortions or exaggerations for purposes of obtaining asylum, compensation, or other benefits and secondary gain. Self-reported physical and psychological symptoms are often construed as fabrications or exaggerations for the same reasons. This is reflected in the skepticism many refugees and asylum-seekers encounter when confronted by government officials and others in authority. Much recent neuropsychological research has focused on memory distortion, reconstructing the past, and psychological trauma. Some studies suggest that with

increased psychological symptoms there will be exaggeration of traumatic events. Other studies document a direct dose effect between exposure to trauma and level of psychological symptomatology.

Contributing to this puzzle are descriptive clinical reports that reveal complaints of cognitive disturbances among diverse traumatized groups. Research about survivors of prisoner-of-war camps and Nazi concentration camps reveals neurocognitive deficits and suggests that physical insults, particularly starvation, vitamin deficiency, and beatings to the head, are major contributing factors. It is often underrecognized that many torture survivors have been subjected to physical injury to the brain from beatings to the head, suffocation, near drowning, and severe, prolonged nutritional deficiencies, and that these insults may lead to cognitive impairment in torture survivors.

Complicating the picture even more is the finding that depression and posttraumatic stress disorder (PTSD) affect cognition. There are multiple hypotheses about why this may be true, ranging from alterations in neuroendocrine systems, to neurotoxic effects of severe stress on hippocampal neurons, to psychoanalytic mechanisms.

Memory impairment as a result of these factors may affect the accuracy of the details a survivor is asked to provide about his/her torture. Despite these potential limitations, it is often of critical importance for a torture survivor to provide accurate details of his/her torture and trauma experiences because these details will be used in legal affidavits for political asylum, human rights investigations, and other legal and judicial purposes such as war-crime tribunals. The inability to produce detailed and precise recollections about dates, times, places, environmental descriptions, and descriptions of perpetrators can reflect negatively on the survivor's credibility and lead to severely deleterious consequences such as deportation of the survivor back to an extremely dangerous home country, denial of family reunification, prolonged detention, or failure to produce evidence to convict war criminals. Because of these grave outcomes, the clinician must take care to put the survivor's trauma history, clinical history, mental status exam, and physical exam together with knowledge of the political context of the country where the torture allegedly took place, cultural idioms and beliefs, social customs, and barriers to full disclosure of traumatic events. The clinician must attempt to obtain as complete a picture as possible of the individual's life experiences and the context in which they are experienced in order to vouch for the credibility of the story and the believability of the clinical symptomatology.

Risk Factors, and Natural History of Trauma and Torture-Related Disorders

Despite the variability due to personal, cultural, social, and political factors, certain psychological symptoms and clusters of symptoms have been observed among survivors of torture and other types of violence. Since 1980, the diagnosis of PTSD has been applied to an increasingly broad array of individuals suffering from the impact of widely varying types of violence. Although the utility of this diagnosis in nonwestern cultural groups has not been clearly established, evidence suggests that there are high rates of PTSD and depression symptoms among traumatized refugee populations from multiple different ethnic and cultural backgrounds.

The core symptoms and signs of severe trauma and torture across cultures have become increasingly clear. Many are physiological reactions that can persist for years. The main psychiatric disorders associated with torture are PTSD and major depression. One does not have to be tortured to develop PTSD and/or major depression because these disorders appear in the general population. Similarly, everyone who has been tortured does not develop PTSD and major depression.

The course of major depression and PTSD varies over time. There can be asymptomatic intervals, recurrent episodes, and episodes during which an individual is extremely symptomatic. Therefore, when conducting an evaluation of a torture survivor, one must consider the following questions:

1. What is the timeframe of onset of symptoms? Did symptoms occur immediately following the traumatic events or were they delayed for weeks, months, or even years?
2. Is there a history of recurring episodes of symptomatology?
3. How do problems and symptoms emerge over time?
4. Where is the survivor in the recovery process at the time of the assessment?

In considering who may be at heightened risk for developing psychological problems, one must evaluate both general/overall risk factors as well as those risk factors specific to traumatized populations, including how trauma affects family and social relationships and other natural supports. The general risk factors for developing mental illness are based on age, sex, education, social class, divorced/widowed status, history of mental illness, and family history of mental illness. Additional risk factors for torture survivors include war, political oppression, imprisonment, witnessing or experiencing atrocities,

loss of family and/or separation from family, and distortion of social relationships. If the torture survivor is also a refugee or asylum-seeker, he/she has the further risk factors of migration (loss of home, loved ones, and possessions), acculturation, poverty, prejudice, cultural beliefs and traditional roles, cultural and linguistic isolation, absence of adequate support systems, and unemployment or underemployment. The multiple layers of increasing risk present a clinical picture that has been described as one of cumulative synergistic adversity.

Conducting the Psychological Evaluation and Barriers to Full Disclosure

Psychological evaluations may take place in a variety of settings and contexts, resulting in important differences in the manner in which evaluations should be conducted and in the way symptoms are interpreted. The clinician should understand what the barriers preventing the alleged torture survivor from fully disclosing his/her story are. Barriers to obtaining the complete story include circumstances of the experience itself, such as blindfolding, drugging, and lapses of consciousness. In addition, due to threats during torture, the survivor may be afraid of placing self or others at risk. Whether or not certain sensitive questions can be asked safely will depend on the degree to which confidentiality and security can be assured. An evaluation by a clinician visiting a prison or detention center may be very brief and not allow for as detailed an evaluation as one performed in a clinic or private office that may take place over several sessions and last for several hours. Some symptoms and behaviors typically viewed as pathological may be viewed as adaptive or predictable, depending on the context. For example, diminished interest in activities, feelings of detachment, and estrangement would be understandable findings in a person in solitary confinement. Likewise, hypervigilance and avoidance behaviors may be necessary for those living under threat in repressive societies.

The clinician should attempt to understand mental suffering in the context of the survivor's circumstances, beliefs, and cultural norms rather than rush to diagnose and classify. Awareness of culture-specific syndromes and native language-bound idioms of distress is of paramount importance for conducting the interview and formulating the clinical impression and conclusion. When the interviewer has little or no knowledge about the victim's language and culture, the assistance of an interpreter is essential. An interpreter from the victim's country of origin will facilitate an understanding of the language, customs, religious traditions, and other beliefs that will need to be considered during the evaluation.

Clinicians should be aware of the potential emotional reactions that these evaluations may elicit in survivors; these reactions can present barriers to full disclosure. Fear, shame, rage, and guilt are typical reactions. A clinical interview may induce mistrust on the part of the torture survivor and possibly remind him/her of previous interrogations, thereby retraumatizing him/her. To reduce the effects of retraumatization, the clinician should communicate a sense of empathy and understanding. The victim may suspect the clinician of having voyeuristic and sadistic motivations or may have prejudices toward the clinician because he/she has not been tortured. The clinician is a person in a position of authority and for that reason may not be trusted with certain aspects of the trauma history. Alternatively, individuals still in custody may be too trusting in situations where the clinician cannot guarantee that there will be no reprisals for speaking about torture. Torture victims may fear that information that is revealed in the context of an evaluation cannot be safely kept from being accessed by persecuting governments. Fear and mistrust may be particularly strong in cases where physicians or other health workers were participants in the torture. In the context of evaluations conducted for legal purposes, the necessary attention to detail and the precise questioning about history are easily perceived as a sign of doubt on the part of the examiner. Under these pressures, survivors may feel overwhelmed with memories and affect or mobilize strong defenses such as withdrawal and affective flattening or numbing during evaluations.

If the gender of the clinician and the torturer is the same, the interview situation may be perceived as resembling the torture more than if the genders were different. For example, a woman who was raped and tortured in prison by a male guard is likely to experience more distress, mistrust, and fear when facing a male clinician than she might experience with a female. However, it may be much more important to the survivor that the interviewer is a physician regardless of gender so as to ask specific medical questions following rape and sexual torture about possible pregnancy, ability to conceive later, and future of sexual relations between spouses.

When listening to individuals speak of their torture clinicians should expect to have personal reactions and emotional responses themselves. Understanding these personal reactions is crucial because they can have an impact on one's ability to evaluate and address the physical and psychological consequences of torture. Reactions may include avoidance and defensive indifference in reaction to being exposed to

disturbing material; disillusionment, helplessness, and hopelessness that may lead to symptoms of depression or vicarious traumatization; grandiosity or feeling that one is the last hope for the survivor's recovery and well-being; feelings of insecurity in one's professional skills in the face of extreme suffering; guilt over not sharing the torture survivor's experience; or even anger when the clinician experiences doubt about the truth of the alleged torture history and the individual stands to benefit from an evaluation.

Diagnostic Considerations

It is prudent for clinicians to become familiar with the most commonly diagnosed disorders among trauma and torture survivors and to understand that it is not uncommon for more than one mental disorder to be present as there is considerable comorbidity among trauma-related mental disorders. The two most common classification systems are the *International Classification of Disease* (ICD-10), Classification of Mental and Behavioral Disorders, published by the World Health Organization, and the *Diagnostic and Statistical Manual*, 4th edition, of the American Psychiatric Association (DSM-IV). Clinicians, who are not full-time mental health professionals, such as internists and general practitioners who perform evaluations of torture survivors should be familiar with the common psychological responses to torture and be able to describe their clinical findings. They should be prepared to offer a psychiatric diagnosis if the case is not complicated. A psychiatrist or psychologist skilled in the differential diagnosis of mental disorders related to severe trauma will be needed for particularly emotional individuals, cases involving multiple symptoms or atypical symptom complexes, psychosis, or in cases presenting confusing clinical pictures.

The diagnosis most commonly associated with torture is PTSD. Typical symptoms of PTSD include reexperiencing the trauma, avoidance, emotional numbing, and hyperarousal. Reexperiencing can take several forms: intrusive memories, flashbacks (the subjective sense that the traumatic event is happening all over again), recurrent nightmares, and distress at exposure to cues that symbolize or resemble the trauma. Avoidance and emotional numbing include avoidance of thoughts, conversations, activities, places, or people that arouse recollection of the trauma, feelings of detachment and estrangement from others, inability to recall an important aspect of the trauma, and a foreshortened sense of the future. Symptoms of hyperarousal include difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, and exaggerated startle response.

Depressive states are almost ubiquitous among survivors of torture. Depressive disorders may occur as a single episode or be recurrent. They can present with or without psychotic features. Symptoms of major depression include depressed mood, anhedonia (markedly diminished interest or pleasure in activities), appetite disturbance, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue and loss of energy, feelings of worthlessness and excessive guilt, difficulty concentrating, and thoughts of death, suicidal ideation, or suicide attempts.

A survivor of severe trauma such as torture may experience dissociation or depersonalization. Dissociation is a disruption in the integration of consciousness, self-perception, memory, and actions. A person may be cut off or unaware of certain actions or may feel split in two and feel as if he/she is observing him/herself from a distance. Depersonalization is feeling detached from oneself or one's body.

Somatic symptoms, such as pain and headache and other physical complaints, with or without objective findings are common problems among torture victims. Pain may shift in location and vary in intensity. Somatic symptoms can be directly due to physical consequences of torture, or may be of psychological origin, or both. Also, various types of sexual dysfunction are not uncommon among survivors of torture, particularly, but not exclusively, among those who have suffered sexual torture or rape.

Psychotic symptoms may be present, such as delusions, paranoia, hallucinations (auditory, visual, olfactory, or tactile), bizarre ideation, illusions, or perceptual distortions. Cultural and linguistic differences may be confused with psychotic symptoms. Before labeling something as psychotic, one must evaluate the symptoms within the individual's cultural context. Psychotic reactions may be brief or prolonged. It is not uncommon for torture victims to report occasionally hearing screams, his/her name being called, or seeing shadows, but not have florid signs or symptoms of psychosis. Individuals with a past history of mental illness such as bipolar disorder, recurrent major depression with psychotic features, schizophrenia, and schizoaffective disorder may experience an episode of that disorder.

The ICD-10 includes the diagnosis "enduring personality change." PTSD may precede this type of personality change. To make the ICD-10 diagnosis of enduring personality change, the following criteria must have been present for at least 2 years and must not have existed before the traumatic event or events. These criteria are: hostile or distrustful attitude toward the world, social withdrawal, feelings of emptiness or hopelessness, chronic feelings of "being on edge" as if constantly threatened, and estrangement.

Alcohol and drug abuse may develop secondarily in torture survivors as a way of blocking out traumatic memories, regulating affect, and managing anxiety. Other possible diagnoses include: generalized anxiety disorder, panic disorder, acute stress disorder, somatoform disorders, bipolar disorder, disorders due to a general medical condition (possibly in the form of brain impairment with resultant fluctuations or deficits in level of consciousness, orientation, attention, concentration, memory, and executive functioning), and phobias such as social phobia and agoraphobia.

Psychological Testing and the Use of Checklists and Questionnaires

If an individual has trouble expressing in words his/her experiences and symptoms; it may be useful to use a trauma event questionnaire or symptom checklist. These tools may facilitate disclosure of severely traumatic memories and reduce the anxiety often experienced in an unstructured interview. There are numerous questionnaires available; however, none is specific to torture victims. Much caution must be exercised in the interpretation of responses and scores because established norms do not exist for most nonmainstream western European and American populations. Similarly, there is little published information about the use of standard psychological and neuropsychological tests among torture survivors. Due to the fact that there is such wide cultural and linguistic diversity among this group, one should exercise extreme caution when requesting or employing psychological and psychometric tests of any kind, most of which have not been cross-culturally validated.

Formulating the Clinical Impression

Interpretation of the clinical findings is a complex task. The following questions from the Istanbul protocol will help guide the formulation of the clinical impression and diagnostic conclusions.

1. Are the psychological findings consistent with the alleged report of torture?
2. Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?
3. Given the fluctuating course of trauma-related mental disorders over time, what is the timeframe in relation to the torture events? Where in the course of recovery is the individual?
4. What are the coexisting stresses impinging on the individual (e.g., ongoing persecution, forced migration, exile, loss of family and social role)? What impact do these issues have on the victim?
5. What physical conditions contribute to the clinical picture? Pay special attention to head injury sustained during torture and/or detention.
6. Does the clinical picture suggest a false allegation of torture?

When writing reports, clinicians should comment on the emotional state of the person during the interview, symptoms, history of detention and torture, and personal history prior to torture. Factors such as the onset of specific symptoms in relation to the trauma, the specificity of any particular psychological findings, as well as patterns of psychological functioning should be noted. Additional factors such as forced migration, resettlement, difficulties of acculturation, language problems, loss of home, family, and social status, as well as unemployment should be discussed. The relationship and consistency between events and symptoms should be evaluated and described. Physical conditions such as head trauma or brain injury may require further evaluation.

It is possible that some people may falsely allege torture or exaggerate a relatively minor experience or symptoms for personal or political reasons. The clinician should keep in mind, however, that such fabrication requires a detailed knowledge about trauma-related symptoms that individuals rarely possess. Also, inconsistencies can occur for a number of valid reasons such as memory impairment due to brain injury, confusion, dissociation, cultural differences in perception of time, or fragmentation and repression of traumatic memories. Additional sessions should be scheduled to help clarify inconsistencies and, when possible, family or friends may be able to corroborate detail.

See Also

History of Torture; **Torture:** Physical Findings; **War Injuries**

Further Reading

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Torture, History of *See* **History of Torture**