Extended Literature List

The following literature list is a selection of publications in health care sciences journals published between 2008 and 2012 (see also the standard database for medical literature http://www.ncbi.nlm.nih.gov/pubmed, where you can also find earlier publications). Further science based literature can be found in databases such as google scholar (http://scholar.google.at/). We recommend using citation managers such as the free Zotero (http://www.zotero.org/) to find additional literature. As most literature and original abstracts at present are in English, PUBMED lists in some cases translated abstracts to cover Non- English journals in their database.

Publications in Scientific Journals

2008 – 2012

Abadia, B. C., et al. (2012). "[Neoliberalism in health: the torture of the health care workers of the Bogota s Instituto Materno Infantil (child and maternity hospital)]." Rev Salud Publica (Bogota) **14 Suppl 1**: 18-31.

> Objectives To link, from a historical point of view, the most significant transformations of the Instituto Materno Infantil (IMI) [the oldest child and maternity hospital of the country] during its process of crisis, closure and liquidation with the experiences of the hospital workers. To find experience-based and theoretical elements that can interconnect the process of health care privatization of the country with the workers' experiences of resistance and pain/suffering. Methods Critically-oriented ethnography based on continuous collective field work, historical research (primary and secondary sources) and semi-structured interviews with 5 women who worked at the IMI for more than 15 years.Results: A time line of 4 main periods: Los anos de gloria [The golden years] (up to 1990); Llega el neoliberalismo [Neoliberalism arrives] (1990-2000); La crisis y las resistencias [Crisis and resistances] (2001-2005); and Liquidacion [Liquidation (2006-20??)]. The narratives of the interviewed women unveil multiple aggressions that have intensified since 2006, have caused pain and suffering and are examples of violations of human and labour rights. Discussion We suggest to analyze the links between the different kinds of violence and pain and suffering as torture. This category is defined as the set of violent actions that cause physical and emotional pain, which are performed by actors in positions of power over other people who challenge that power and are part of modern States' ideological principles around a defined moral social

order. For the IMI workers' case, the ideological principle that is being challenged is health care neoliberalism. From the analyses of bureaucracy, confinement, torturing agents, and the breaking-off of the body-mind unit we conclude that this relationship between neoliberalism and torture aims to eliminate the last health care workers of the country who had job stability and full-benefits through public labour contracts. Their elimination furthers the accumulation of capital generated by increasing over-exploitation of labour and commodification of health care.

Adenauer, H., et al. (2010). "Is freezing an adaptive reaction to threat? Evidence from heart rate reactivity to emotional pictures in victims of war and torture." Psychophysiology **47**(2): 315-322.

The influence of past traumatic experiences on the defense cascade in response to affective pictures was examined in survivors of war and torture. Trauma-exposed refugees with and without Posttraumatic Stress Disorder (PTSD) as well as healthy individuals viewed 75 pictures that varied in emotional content. Heart rate (HR) was recorded during the flickering stimulation of affective pictures in the context of a steady-state experiment. Whereas healthy controls showed the typical orienting response to aversive stimuli, PTSD patients reacted with an almost immediate increase in HR toward unpleasant pictures. Trauma-exposed participants without PTSD showed an indiscriminate orienting response regardless of picture category. The present findings argue for a faster flight/fight response to threatening cues in PTSD. In contrast, trauma-exposed controls seem to exhibit a state of permanent alertness toward a wide range of stimuli.

Afana, A. and L. J. Kirmayer (2010). "Psychiatry and the prevention of torture." Can J Psychiatry **55**(4): 268; author reply 268-269.

Afana, A. H. (2009). "Weeping in silence: the secret sham of torture among Palestinian children." Torture **19**(2): 167-175.

Agger, I., et al. (2012). "Testimony ceremonies in Asia: integrating spirituality in testimonial therapy for torture survivors in India, Sri Lanka, Cambodia, and the Philippines." Transcult Psychiatry **49**(3-4): 568-589.

This study explores the therapeutic implications of including culturally adapted spiritual ceremonies in the process of testimonial therapy for torture survivors in India, Sri Lanka, Cambodia, and the Philippines. Data were collected through an action research process with Asian mental health and human rights organizations, during which the testimonial method was reconceptualized and modified to include four sessions. In the first two sessions, community workers assist survivors in the writing of their testimony, which is their narrative about the human rights violations they have suffered. In the third session, survivors participate in an honour ceremony in which they are presented with their testimony documents. In the fourth session, the community workers meet with the survivors for a reevaluation of their well-being. The honour ceremonies developed during the action research process came to employ different kinds of symbolic language at each site: human rights (India), religious/Catholic (Sri Lanka), religious/Buddhist (Cambodia), and religious/Moslem (Philippines). They all used embodied spirituality in various forms, incorporating singing, dancing, and religious purification rituals in a collective gathering. We suggest that these types of ceremonies may facilitate an individual's capacity to contain and integrate traumatic memories, promote restorative self-awareness, and engage community

support. Additional research is needed to determine the method's applicability in other sociopolitical contexts governed by more Western-oriented medical traditions.

Agger, I., et al. (2009). "Testimonial therapy. A pilot project to improve psychological wellbeing among survivors of torture in India." Torture **19**(3): 204-217.

INTRODUCTION: In developing countries where torture is perpetrated, there are few resources for the provision of therapeutic assistance to the survivors. The testimonial method represents a brief cross-cultural psychosocial approach to trauma, which is relatively easy to master. The method was first described in Chile in 1983 and has since been used in many variations in different cultural contexts. In this project the method has been supplemented by culture-specific coping strategies (meditation and a delivery ceremony). METHODS: A pilot training project was undertaken between Rehabilitation and Research Centre for Torture victims (RCT) in Copenhagen, Denmark, and People's Vigilance Committee for Human Rights (PVCHR) in Varanasi, India, to investigate the usefulness of the testimonial method. The project involved the development of a community-based testimonial method, training of twelve PVCHR community workers, the development of a manual, and a monitoring and evaluation (M&E) system comparing results of measures before the intervention and two to three months after the intervention. Twenty-three victims gave their testimonies under supervision. In the two first sessions the testimony was written and in the third session survivors participated in a delivery ceremony. The human rights activists and community workers interviewed the survivors about how they felt after the intervention. FINDINGS: After testimonial therapy, almost all survivors demonstrated significant improvements in overall WHO-five Well-being Index (WHO-5) score. Four out of the five individual items improved by at least 40%. Items from the International Classification of Functioning, Disability and Health (ICF) showed less significant change, possibly because the M&E questionnaire had not been well understood by the community workers, or due to poor wording, formulation and/or validation of the questions. All survivors expressed satisfaction with the process, especially the public delivery ceremony, which apparently became a "turning point" in the healing process. Seemingly, the ceremonial element represented the social recognition needed and that it re-connected the survivors with their community and ensured that their private truth becomes part of social memory. DISCUSSION: Although this small pilot study without control groups or prior validation of the questionnaire does not provide high-ranking quantitative evidence or statistically significant results for the effectiveness of our version of the testimonial method, we do find it likely that it helps improve the well being in survivors of torture in this particular context. However, a more extensive study is needed to verify these results, and better measures of ICF activities and participation (A&P) functions should be used. Interviews with human rights activists reveal that it is easier for survivors who have gone through testimonial therapy to give coherent legal testimony.

Akinsulure-Smith, A. M., et al. (2012). "Responding to secondary traumatic stress: a pilot study of torture treatment programs in the United States." J Trauma Stress **25**(2): 232-235.

Providers who care for torture survivors may be at risk for secondary traumatic stress, yet there has been little documentation of the effects of repeated exposure to traumatic issues on their emotional health or exploration of the support systems and resources available to address their emotional needs. This study assessed the secondary stress experiences of service providers (N = 43) within the National Consortium of Torture Treatment Programs in the United States and examined the supports offered by their organizations. The study found a significant correlation between rates of anxiety and depression among providers, $r(34) = .49$, $p = .003$. Although these participants reported that their work with survivors of torture

was stressful, 91% indicated that their organizations offered a variety of stress-reduction activities. Overall, participants reported that their own personal activities were the most-effective stress reducers. The results are discussed in light of challenges that professionals who work with this population face and the effectiveness of support systems available to support their work.

Alayarian, A. (2009). "Children, torture and psychological consequences." Torture **19**(2): 145-156.

Torture is a strategic means of limiting, controlling, and repressing basic human rights of individuals and communities that is often covert and denied by authorities. Deliberate infliction of pain and suffering or intimidation or coercion on children to obtain a confession or information, for punishment of real or perceived offences on the basis of discrimination about race, ethnic or political affiliation, is practiced in many places around the world. Impact of torture on children may vary depending on the child's coping strategies, cultural and social circumstances. We at Refugee Therapy Centre provide psychotherapy and associated treatments to people who have been tortured, giving priority to children. While our main objective is provision of clinical services, our focus is also to influence policy and practice by searching for evidence and demonstrating solutions to improve the lives, homes and communities of children disadvantaged by torture and the services that support them. We seek to provide some remedies to children of refugees who are suffering the consequence of trauma that they experienced and demonstrate good practice. In this paper I will give a brief introduction of our work at the RTC. I then discuss and reflect on children and torture. I will present a vignette and some examples of clinical intervention.

Ali, S. (2008). "Troubling times: a comment on Judith Butler's 'Sexual politics, torture and secular time'." Br J Sociol **59**(1): 35-39.

Allhoff, F. (2012). "Doctors and torture." Hastings Cent Rep **42**(1): 8.

Amone P'Olak, K. (2009). "Torture against children in rebel captivity in Northern Uganda: physical and psychological effects and implications for clinical practice." Torture **19**(2): 102-117.

BACKGROUND: Although torture in adults is well documented, studies that document its use against children, especially during war, are rare. This study documented the use of torture against children and its physical and psychological consequences during the war in Northern Uganda. METHODOLOGY: Changes to the skin were examined by medical assistants, photographs taken, and allegations of torture verified in an interview and the case histories filed upon admission to the rehabilitation centres. The sample included 183 children aged 12 to 18 (mean age 14.8, SD 2.9) of which 60 were physically examined in two rehabilitation centres. The impact of torture was assessed using the Impact of Event Scale Revised (IES-R) in a multiple regression model. RESULTS: Medical examinations showed visible evidence of physical trauma. Torture methods included burns, beatings, carrying heavy objects, gunshots, cuts with bayonets and machetes, long distance treks, etc. resulting into scars and keloids in different parts of the body. The scars were consistent with injuries inflicted on purpose. The children scored highly on the subscales of IES-R indicating severe symptoms of posttraumatic stress. The experience of torture explained between 26 to 37 per cent of the variance in symptoms of posttraumatic stress. CONCLUSIONS: The physical trauma is consistent with histories and reports filed upon admission to the rehabilitation centres indicating that the children were indeed tortured. As a result of the torture, the children were psychologically distressed. The challenge for clinicians is to employ a holistic approach

of treating survivors of torture by recognising not only the physical complaints but stress symptoms as well. This is because the mental states of debilitation, dependency, dread and disorientation that is induced in victims may have long-lasting consequences just like the physical and psychological consequences.

Amris, K., et al. (2009). "Long-term consequences of falanga torture--what do we know and what do we need to know?" Torture **19**(1): 33-40.

The long-term consequences of falanga are probably the best described consequences of exposure to specific forms of physical torture. Theories about casual lesions in the peripheral tissues of the feet have been put forward based on clinical observations along with international guidelines for the clinical assessment, but still knowledge is needed in several areas. A review of the literature on falanga is presented, mainly focusing on the clinical aspects and possible lesions caused by this specific form of torture that may influence the overall management of the condition. Finally, the article closes with a call for future research, which is needed in order to advance a knowledge-based development of the applied clinical practice.

Anasarias, E. A., et al. (2012). "Human rights, human wrongs: torture prevention, documentation and prosecution in the Philippines." Torture **22 Suppl 1**: 30-38.

This article presents an overview of the challenges faced by human rights organizations and survivors of torture in seeking justice despite the availability of an anti-torture law in the Philippines. Several legal, political, and security-related impediments are cited here to raise the challenge to state agencies to undertake steps to break the culture of impunity in the country by making the anti-torture law an effective remedy to prevent torture and for the victims to obtain redress. This paper draws lessons and recommendations form the insights generated by the authors in the course of their participation in the IRCT-led FEAT project.

Anderson, K. T. (2010). "Holistic medicine not "torture": performing acupuncture in Galway, Ireland." Med Anthropol **29**(3): 253-277.

This article examines how the aesthetic design of clinics and interactive discourse and rituals construct the social reality of acupuncture sessions as a form of holistic medical therapy. Verbal and nonverbal interactions create an appealing medical environment but also help prevent the emergence of undesired counter-realities (e.g., pain, biomedical intervention). Based on observations of acupuncture sessions conducted in Galway, Ireland, I illustrate how ambiance and aesthetic elements of clinics create a complex medico-cultural environment that balances oppositional associations (Western/non-Western, exoticism/convention, medical alterity/medical professionalism). Patients interviewed continually referred to acupuncture as a natural and non-invasive form of medical treatment. This suggests that interpersonal discourse and aesthetic design play key roles in how patients define acupuncture treatment, and that these ephemeral agents may also influence how patients come to define efficacy.

Arie, S. (2011). "Doctors need better training to recognise and report torture." BMJ **343**: d5766.

Augustin, Y. S., et al. (2011). "Prevention of torture by doctors and organisations." Lancet **378**(9809): e22-23.

Bandeira, M., et al. (2010). "The land of milk and honey: a picture of refugee torture survivors presenting for treatment in a South African trauma centre." Torture **20**(2): 92-103.

> Intake data obtained from 55 refugee torture survivors accessing trauma treatment services at a centre in Johannesburg, South Africa, paints a picture of suffering beyond the torture experience. The intake forms part of a more comprehensive monitoring and evaluation system developed for the work done with torture survivors accessing psychosocial services. The diverse sample with different nationalities highlights that torture occurs in many countries on the African continent. It also highlights South Africa's role as a major destination for refugee and asylum seekers. However, "the land of milk and honey" and the process of arriving here, often poses additional challenges for survivors of torture. This is reflected in the high levels of Post Traumatic Stress Disorder (69%), anxiety (91%), and depression (74%) for our sample, all of which were significantly correlated. The loss of employment status from before the torture experience until the time of intake was great for this sample, impacting on their recovery. In addition the presence of medical conditions (44%), disabilities (19%), and pain (74%) raise serious questions regarding interventions that focus mainly on psychosocial needs. No significant gender differences were found. The paper begins to paint a clearer picture of the bio-psycho-social state of torture survivors accessing services in South Africa, as well as highlighting many of the contextual challenges which impact on recovery.

Barber, B., et al. (2011). "Electric shock ear torture: a rare cause of tympanic membrane perforation and mixed hearing loss." J Otolaryngol Head Neck Surg **40**(3): E22-25.

> Summary of case report findings: Picana (electric shock torture) is a globally used form of torture. This is the first documented case of picana applied to the tympanic membrane. Two other types of ear torture have been documented, including picana of the helix and telefono. Several types of head and neck torture are applied globally.

Basoglu, M. (2009). "A multivariate contextual analysis of torture and cruel, inhuman, and degrading treatments: implications for an evidence-based definition of torture." Am J Orthopsychiatry **79**(2): 135-145.

> Current thinking on what constitutes torture in a detention/interrogation setting focuses solely on particular procedures, without regard for contextual factors that mediate traumatic stress. The present study examined stressor interactions that determined severity and psychological impact of captivity stressors in 432 torture survivors in former Yugoslavia countries and Turkey. A principal components analysis of 46 captivity stressors measured by an Exposure to Torture Scale identified meaningful stressor clusters, which suggested that multiple detention procedures were used in combination to maximize their impact. Perceived torture severity related to 'cruel, inhuman, and degrading' treatments (CIDT) but not to physical torture. Posttraumatic stress disorder related to war-related captivity, deprivation of basic needs, sexual torture, and exposure to extreme temperatures, isolation, and forced stress positions but not to physical torture. CIDT increased posttraumatic stress disorder risk by 71%. Fear- and helplessness-inducing effects of captivity and CIDT appear to be the major determinants of perceived severity of torture and psychological damage in detainees. Considerations on what constitutes torture need to take into account the contextual processes in a captivity setting that mediate these effects.

Bean, J., et al. (2008). "Medical students' attitudes toward torture." Torture **18**(2): 99-103.

Torture, whether it be domestic or war related, is a public health issue of current concern. It is the position of the American Medical Association (AMA), The World Medical Association (WMA), the United Nations Declaration and the Geneva Convention, that torture is unethical, "morally wrong" and never to be condoned. The attitudes of medical students, our future physicians, will be critical in reducing the incidence of torture. The purpose of this investigation was to assess medical students' attitudes regarding the permissibility and ethics of the use of torture. A University of Illinois at Chicago College of Medicine's Institutional Review Board approved torture questionnaire was administered to 336 students of the University of Illinois College of Medicine. 35 percent of students agreed that torture could be "condoned" under some circumstances. Moreover, 24 percent of respondents disagreed that torture should "be prohibited" as a matter of state policy and a similar 24 percent disagreed that torture was "intrinsically wrong." It is concluded that most students felt that torture was "not permissible" and "intrinsically wrong", a disturbing 27 percent-35 percent felt that it could be permitted or condoned at times. Moreover, 27 percent felt that torture was not unethical. Given the strong condemnation of torture by the AMA, the WMA and the Geneva Convention these medical student attitudes, albeit by a minority of students, are disturbing. It is suggested that medical school curriculum committees review this matter.

Beynon, J. (2012). ""Not waving, drowning". Asphyxia and torture: the myth of simulated drowning and other forms of torture." Torture **22 Suppl 1**: 25-29.

The article will give a brief introduction to what we understand by the term Asphyxiation. The main focus will then turn to how Asphyxiation is used as a method of torture, (often euphemistically called a "method of interrogation") with an overview of wet methods such as immersion in water or the pouring of water over the mouth and nose, and dry methods such as the use of bags/sacks/masks and how exacerbating factors such as the use of contaminants or irritants are used. The recently published International Forensic Expert Group Statement on Hooding will be introduced and the notion will be explored that during socalled 'enhanced interrogation' asphyxiation or drowning can be "simulated."

Bracha, H. S. and K. Hayashi (2008). "Torture, culture, war zone exposure, and posttraumatic stress disorder Criterion A's bracket creep." Arch Gen Psychiatry **65**(1): 115-116; author reply 116-117.

Burns-Cox, C. J. (2011). "Doctors and torture in Israel. Why the secrecy?" BMJ **343**: d5792; discussion 5794.

Butler, J. (2008). "Sexual politics, torture, and secular time." Br J Sociol **59**(1): 1-23.

Byard, R. W. and B. Singh (2012). "Falanga torture: characteristic features and diagnostic issues." Forensic Sci Med Pathol **8**(3): 320-322.

Carinci, A. J., et al. (2010). "Chronic pain in torture victims." Curr Pain Headache Rep **14**(2): 73-79.

Torture is widely practiced throughout the world. Recent studies indicate that 50% of all countries, including 79% of the G-20 countries, continue to practice systematic torture despite a universal ban. It is well known that torture has numerous physical, psychological, and pain-related sequelae that can inflict a devastating and enduring burden on its victims. Health care professionals, particularly those who specialize in the treatment of chronic pain, have an obligation to better understand the physical and psychological effects of torture.

This review highlights the epidemiology, classification, pain sequelae, and clinical treatment guidelines of torture victims. In addition, the role of pharmacologic and psychologic interventions is explored in the context of rehabilitation.

Catani, C., et al. (2009). "Pattern of cortical activation during processing of aversive stimuli in traumatized survivors of war and torture." Eur Arch Psychiatry Clin Neurosci **259**(6): 340-351.

Posttraumatic stress disorder (PTSD) has been associated with an altered processing of threat-related stimuli. In particular, an attentional bias towards threat cues has been consistently found in behavioral studies. However, it is unclear whether increased attention towards threat cues translates into preferential processing as neurophysiological studies have yielded inconsistent findings. The aim of the present study was to investigate the neocortical activity related to the processing of aversive stimuli in patients with PTSD. 36 survivors of war and torture with PTSD, 21 Trauma Controls and 20 Unexposed Subjects participated in a visual evoked magnetic field study using flickering pictures of varying affective valence as stimulus material. Minimum norm source localization was carried out to estimate the distribution of sources of the evoked neuromagnetic activity in the brain. Statistical permutation analyses revealed reduced steady-state visual evoked field amplitudes over occipital areas in response to aversive pictures for PTSD patients and for Trauma Controls in comparison to unexposed subjects. Furthermore, PTSD patients showed a hyperactivation of the superior parietal cortex selectively in response to aversive stimuli, which was related to dissociative symptoms as well as to torture severity. The results indicate a different pattern of cortical activation driven by aversive stimuli depending on the experience of multiple traumatic events and PTSD. Whereas, a decreased visual processing of aversive stimuli seems to be associated with trauma exposure in general, the superior parietal activity might represent a specific process linked to the diagnosis of PTSD.

Chaney, S. (2011). ""A hideous torture on himself": madness and self-mutilation in Victorian literature." J Med Humanit **32**(4): 279-289.

This paper suggests that late nineteenth-century definitions of self-mutilation, a new category of psychiatric symptomatology, were heavily influenced by the use of self-injury as a rhetorical device in the novel, for the literary text held a high status in Victorian psychology. In exploring Dimmesdale's "self-mutilation" in The Scarlet Letter in conjunction with psychiatric case histories, the paper indicates a number of common techniques and themes in literary and psychiatric texts. As well as illuminating key elements of nineteenth-century conceptions of the self, and the relation of mind and body through ideas of madness, this exploration also serves to highlight the social commentary implicit in many Victorian medical texts. Late nineteenth-century England, like mid-century New England, required the individual to help himself and, simultaneously, others; personal charity and individual philanthropy were encouraged, while state intervention was often presented as dubious. In both novel and psychiatric text, self-mutilation is thus presented as the ultimate act of selfish preoccupation, particularly in cases on the "borderlands" of insanity.

Charles, L. L. (2012). "Producing evidence of a miracle: exemplars of therapy conversation with a survivor of torture." Fam Process **51**(1): 25-42.

This article illustrates the termination sessions of a therapy case with a survivor of torture, displaced to the United States after facing targeted persecution in his home country. Using methods of qualitative research in the naturalistic paradigm, I examine the case of the client's torture rehabilitation experience through his descriptions and evaluation of the

therapy process. Excerpts from the dialogue of the final 2 sessions, during which we discussed the client's past and future through the miracle question, are highlighted in this article. A case is made for further multimodal qualitative analyses of therapy conversation with this population.

Chaudhry, M. A., et al. (2008). "Pattern of police torture in Punjab, Pakistan." Am J Forensic Med Pathol **29**(4): 309-311.

A total of 1820 victims of alleged police torture were examined at the office of Surgeon Medicolegal Punjab Lahore during a period of 5 years. Most of the victims at the time of examination were showing visible evidence of Physical trauma. Victims were mainly men. Examination was conducted on the directions of various courts (Judicial Magistrates, District and Session Judges, and Lahore High Court). A wide range of different types of injuries of different durations were observed on various parts of the body. Blunt trauma was most frequent. Psychologic element of torture was also seen in some victims.

Cooper, M. and P. Cotton (2010). "Two cases of the use of snakes in psychological torture in East Africa." Torture **20**(1): 53-54.

Cooper, M. and P. Cotton (2011). "Torture documentation inside detention centres." Torture **21**(3): 195-196.

Cooper, M. J. (2011). "Near-death experience and out of body phenomenon during torture--a case report." Torture **21**(3): 178-181.

A case of a near death experience (NDE) associated with an "Out of body" phenomenon in an African man as a result of torture is presented. Although NDEs occur in approximately ten per cent of survivors of cardiac arrest, case reports emerging from the medical examination of torture victims are lacking. This may be due to cultural/linguistic barriers and fear of disbelief. Low NDE incidence during torture would suggest that torture techniques rarely induce the critical brain ischaemia considered necessary to provoke an NDE. Alternatively psychological or physical characteristics of torture may render NDE harder to recall. Proof of low incidence during torture would counter the theory that NDEs are a psychological response to perceived threat of death. NDEs often induce transformational benefits in patients' lives and for this reason the author urges physicians to consider the possibility of NDE amongst torture victims under their care. A request for information about similar cases is made.

Cooper, M. J. (2012). "Presenting evidence of torture at immigration tribunals in the United Kingdom." Torture **22**(1): 60-61.

Crosby, S. S. (2012). "A doctor's response to torture." Ann Intern Med **156**(6): 471-472.

Crosby, S. S., et al. (2010). "Head and neck sequelae of torture." Laryngoscope **120**(2): 414-419.

OBJECTIVES/HYPOTHESIS: To increase awareness of torture among otolaryngologists, and to describe methods and complications of head and neck torture. STUDY DESIGN: Retrospective review. METHODS: Five cases of survivors of torture were evaluated in an otolaryngology

practice in an urban hospital setting. RESULTS: The subjects presented with widely variable symptoms and physical manifestations related to the head and neck as a result of torture, in addition to psychiatric disease. Documentation of head and neck findings were essential to the asylum claim. CONCLUSIONS: Otolaryngologists serving immigrant and refugee populations must be familiar with methods and manifestations of torture involving the head and neck.

de Fouchier, C., et al. (2012). "Validation of a French adaptation of the Harvard Trauma Questionnaire among torture survivors from sub-Saharan African countries." Eur J Psychotraumatol **3**.

BACKGROUND: To date no validated instrument in the French language exists to screen for posttraumatic stress disorder (PTSD) in survivors of torture and organized violence. OBJECTIVE: The aim of this study is to adapt and validate the Harvard Trauma Questionnaire (HTQ) to this population. METHOD: The adapted version was administered to 52 French-speaking torture survivors, originally from sub-Saharan African countries, receiving psychological treatment in specialized treatment centers. A structured clinical interview for DSM was also conducted in order to assess if they met criteria for PTSD. RESULTS: Cronbach's alpha coefficient for the HTQ Part 4 was adequate (0.95). Criterion validity was evaluated using receiver operating characteristic curve analysis that generated good classification accuracy for PTSD (0.83). At the original cut-off score of 2.5, the HTQ demonstrated high sensitivity and specificity (0.87 and 0.73, respectively). CONCLUSION: Results support the reliability and validity of the French version of the HTQ.

Deal, J. L. (2010). "Torture by Cieng: ethical theory meets social practice among the Dinka Agaar of south Sudan." Am Anthropol **112**(4): 563-575.

Here I detail violence in South Sudan by first discussing a specific Dinka Agaar practice alongside existing discourses on the social aspects of violence and universal human rights, then I show how these acts had meaning and purpose using data from personal accounts of violence. I posit that the violence described was consistent with Dinka Agaar concepts of justice and basic human rights and that it cannot be judged against any universal human rights standard, devoid of local context or of an overarching metanarrative. These events highlight conflicting subjectivities, ethical norms, and the painful difficulties inherent to advocacy in areas of conflict. Viewed from the perspective of the larger social unit, it is easy to see how violence was required to end violence. However, witnessing punitive violence purposefully enacted on innocent individuals to achieve peace has the potential to create conflicting positions that modern anthropological discourse cannot reconcile.

Dello Russo, N. M. (2009). "The terrors of torture." J Am Dent Assoc **140**(4): 399.

den Otter, J. J., et al. (2013). "Documentation of torture and cruel, inhuman or degrading treatment of children: A review of existing guidelines and tools." Forensic Sci Int **224**(1-3): 27-32.

The documentation of individual cases of child torture is of paramount importance to bring justice to, and help heal, individuals and sensitize societies. Our objective is to systematically review medical guidelines for the recording of individual cases of child torture or cruel, inhuman or degrading treatment (CIDT). We searched CINAHL, Embase, the Guidelines International Network, Lilacs, Medline, the National Guideline Clearinghouse, PsychInfo and all websites of the organizations participating in the updating of the Istanbul Protocol for

guidelines or studies on how to document torture, CIDT or abuse in persons under 18 years. We did not find a comprehensive guideline that encompassed all aspects of the documentation of child torture, as does the Istanbul Protocol for adults. An expert opinion guideline on how to document sexual torture in children was found, and in addition we identified 13 consensus-based guidelines for the evaluation of abuse in children or specific aspects thereof. We strongly recommend a child specific, comprehensive guideline on the documentation of torture and CIDT in children.

Devi, S. (2010). "Healing the scars of torture." Lancet **376**(9752): 1527-1528.

Elsass, P., et al. (2010). "[Spirituality as coping in Tibetan torture survivors]." Ugeskr Laeger **172**(2): 137-140.

INTRODUCTION: There is solid documentation for the positive relationship between spirituality and health, but few examples of how this link may be used in projects of rehabilitation after war, civil conflicts and natural disasters. One such example is the Danida funded Tibetan Torture Program in India. This study aims to provide evidence of the Tibetan torture survivors' degree of traumatisation and their use of spirituality to overcome their difficult situation. MATERIAL AND METHODS: The study consists of an assessment and a rehabilitation part. A total of 102 Tibetan torture survivors were interviewed about their coping mechanisms in overcoming trauma. In all, 36 of these survivors were receiving counselling and both the clients and their 16 professionals were interviewed after the treatment with open-ended questions about what was helpful and not helpful. RESULTS: The torture survivors had symptoms of severe traumatisation (Hopkin's Symptom Checklist), but probably not as extensive as torture survivors from other cultures. CONCLUSION: The Tibetan torture survivors use Tibetan Buddhism as an important coping mechanism. Most clients expressed satisfaction with counselling, but criticised the crudeness of our methods.

Elsass, P., et al. (2009). "Questioning western assessment of trauma among Tibetan torture survivors. A quantitative assessment study with comments from Buddhist Lamas." Torture **19**(3): 194-203.

Our study falls in line with the numerous studies providing a critique of the use of western diagnostic instruments for assessing trauma in a cross-cultural context. Our purpose has been to give evidence for the Tibetan torture survivors' degree of traumatisation and for their use of spirituality to overcome their difficult situation. In addition we wanted to question the use of our western methods in an Asian context. 102 tortured refugees attended a formalised needs assessment including neuropsychological and psychological measures of Post Traumatic Stress Disorder (PTSD) and the Hopkins Symptom Checklist 25 (HSCL-25). Even though significant correlations between the amount of the measures of organized violence and neuropsychological and psychological distress were found in our data, the division of the material into different subgroups according to e.g. religious and non-religious groups did not have an influence on the level of distress. After the assessment study, eight Tibetan lamas were interviewed about their views on our methods and results. They questioned the validity of our western rating scales and explained that our results might be influenced by the Tibetan culture, which among other things can be characterized as having a view and articulation of suffering much more complex than the units of our study's rating scales.

Fabri, M. R. (2011). "Best, promising, and emerging practices in the treatment of trauma: what can we apply in our work with torture survivors?" Torture **21**(1): 27-38.

Ferguson, R. (2009). "Information, not opinion. In reference to the May 2009 Digital Edition of RN, specifically "Red Cross: healthcare workers involved in torture"." RN **72**(7): 10; discussion 10.

Fincanci, S. K. (2008). "The role of jurisdiction on persistence of torture in Turkey and public reflections." Torture **18**(1): 51-55.

Torture still is a serious problem in Turkey. There has been a very effective struggle against torture, particularly for effective documentation by health professionals. The Istanbul Protocol has been taken into consideration by the ministry of health, and procedural safeguards with standardized medicolegal documentation had been a part of daily medicolegal practice. However, measures taken on the basis of effective documentation is not sufficient without effective investigation of which the role of jurisdiction is most prominent. Impunity is highly responsible for the persistence of torture, although procedural safeguards on medical examination and medicolegal documentation have had an influence for the decrease of the total number of cases. The Anatolia Agency had distributed information on the total number of punishments in 2007, which drew a more hopeful picture with 5,082 punishments among 33,000 law enforcement officials who had been taken to court. Nevertheless, a press conference held by the Human Rights Foundation of Turkey revealed that this information was not true. They revealed that the cases taken to the court were mostly because of ill treatment instead of torture, and a great majority of these officers had been acquitted between the years 1989-2005. Administrative measures had also been highly insufficient, and among 922 personnel who had been under investigation, only 8 of them had had punishment. The Human Rights Association has had a research on impunity, and only 15% of law enforcement officials who had been taken to the court were ever convicted of their crimes, and all of these punishments had been suspended. Research on cognitive behaviour of judges and prosecutors revealed that they think human rights might threaten the security of the state. This result only clarifies the cause of impunity, thus persistence of torture. The Istanbul University Istanbul Faculty of Medicine, Department of Forensic Medicine, has an outpatient clinic in which torture survivors are examined, and alternative medicolegal documentation is carried out. These patients who were able to have a medicolegal document are observed to benefit from psychotherapy, thus impunity should not only be surmounted for the eradication of torture, but also the healing of the wounds of torture survivors.

Furtmayr, H. and A. Frewer (2010). "Documentation of torture and the Istanbul Protocol: applied medical ethics." Med Health Care Philos **13**(3): 279-286.

The so-called Istanbul Protocol, a Manual on the Effective Investigation and Documentation of Torture and other Cruel, Inhumane or Degrading Treatment or Punishment was adopted by the United Nations soon after its completion in 1999 and since then has become an acknowledged standard for documenting cases of alleged torture and other forms of severe maltreatment. In 2009 the "Forum for medicine and human rights" at the Medical Faculty at the University Erlangen-Nuremburg has provided the first German edition of this manual. The article traces back the development of the protocol taking into account the general background as well as the factual occasion of its initiation. The main ethical and legal principles of the manual are introduced as well as the projects for implementing the rules provided in the protocol that have been carried out so far. From this the urgent need for implementation of the Istanbul Protocol guidelines also in Europe and in German-speaking countries and here not exclusively but especially within asylum procedures becomes clear.

Gadit, A. A. (2009). "Torture and doctors: an ethical dilemma?" J Pak Med Assoc **59**(8): 573-574.

Gawande, A. (2009). "Hellhole: the United States holds tens of thousands of inmates in long-term solitary confinement. Is this torture?" New Yorker: 36-45.

Gharib, B., et al. (2012). "Physical punishment, abuse, torture or revenge? A case report." Acta Med Iran **50**(8): 580-582.

Child maltreatment happens in all countries and cultures. Children as the vulnerable part of the societies are subject to rage, abuse and maltreatment and need special multidisciplinary attention to get proper protection and care. Appropriate legislation, community education, advocacy in media and attention of care givers and children health providers may alter the trend of child abuse in communities. In order to raise awareness about child abuse for healthcare professionals, in this report we introduce a disastrous case of 4 years old boy who was attacked by his father which presented to Children's Medical Center in Tehran. The living environment of the victim was a dysfunctional family and an addict father as the risk factors of dangerous circumstances for a child.

Gola, H., et al. (2012). "Victims of rape show increased cortisol responses to trauma reminders: a study in individuals with war- and torture-related PTSD." Psychoneuroendocrinology **37**(2): 213-220.

Studies investigating cortisol responses to trauma-related stressors in patients with posttraumatic stress disorder (PTSD) have yielded inconsistent results, demonstrating that cortisol responses were enhanced or unaffected when confronted with trauma reminders. This study investigated the effect of the type of trauma experienced on both salivary and plasma cortisol responses during confrontation with trauma-related material. Participants were 30 survivors of war and torture, with and without rape among the traumatic events experienced. Participants of both groups (raped vs. non-raped) fulfilled DSM-IV criteria of PTSD. Plasma and salivary cortisol levels were measured at three time points during a standardized clinical interview: once before and twice after assessing individual traumatic experiences. Results show that groups did not differ in basal plasma and salivary cortisol levels. However, differential salivary cortisol responses were observed in PTSD patients who had been raped compared to those who had not been raped ($p<.05$) but had experienced an equal number of traumatic events and showed equally high PTSD symptom severity. Whereas salivary cortisol levels decreased in the course of the interview for the group with no past experience of rape ($p<.05$), those PTSD patients who had been raped showed a significant cortisol increase when reminded of their traumatic events ($p<.001$). This effect was not found in plasma cortisol. Our results indicate that the type of traumatic stress experienced contributes to cortisol responses during the confrontation with trauma-related material. We hypothesize, that the nearness of the perpetrator during the traumatic event might shape later psychophysiological responding to trauma reminders.

Gray, A. E. (2011). "Expressive arts therapies: working with survivors of torture." Torture **21**(1): 39-47.

Green, D., et al. (2010). "Defining torture: a review of 40 years of health science research." J Trauma Stress **23**(4): 528-531.

The current review critically examines the body of torture research (N = 209), focusing on the definition and operationalization of the primary construct. Almost three-quarters (69.9%) of

the studies reviewed did not reference any definition of torture. Few studies identified important contextual variables related to defining torture such as identities and motivations of perpetrators and severity of abuse. Definitional ambiguity further impacted how individuals were queried about their experiences and the extent to which torture was distinguished from other forms of maltreatment. Although there are notable exceptions, the methods used in the torture literature are variable and often undefined, impacting the interpretation of findings of risk factors, consequences, and treatment of torture events.

Grodin, M. A., et al. (2008). "Treating survivors of torture and refugee trauma: a preliminary case series using qigong and t'ai chi." J Altern Complement Med **14**(7): 801-806.

OBJECTIVES: This paper seeks to explore the potential value of qigong and t'ai chi practice as a therapeutic intervention to aid in the treatment of survivors of torture and refugee trauma. DESIGN: The common effects of torture and refugee trauma are surveyed with a focus on post-traumatic stress disorder. An alternative theoretical framework for conceptualizing and healing trauma is presented. Evidence is reviewed from the scientific literature that describes how qigong and t'ai chi have been used in studies of the general population to alleviate symptoms that are also expressed in torture survivors. Observations are presented from a combined, simplified qigong and t'ai chi intervention with a convenience sample of four refugee survivors of torture. RESULTS: Preliminary observations from four cases and a review of the literature support the potential efficacy of incorporating qigong and t'ai chi into the treatment of survivors of torture and refugee trauma. CONCLUSIONS: The incorporation of qigong and t'ai chi into the treatment of torture survivors, within a new framework for healing trauma, merits further investigation.

Gulland, A. (2011). "Doctors in Israeli detention facilities are complicit in torture, says report." BMJ **343**: d7200.

Guy, K. M. (2009). "Child soldiers as zones of violence in The Democratic Republic of Congo: three cases of medico-legal evidence of torture." Torture **19**(2): 137-144.

This article sets medico legal light on torture of three former child soldiers by comparing torture methods, consequences of torture and medical observations. It is focused on these child soldiers as representatives of the many abuses of children as soldiers in armed groups. The three persons were child soldiers during 12 years in The Democratic Republic of Congo (DRC) as members of three different armed groups. They were exposed to armed conflict events, experienced torture, and participated in atrocities, sexual abuse and traditional rituals during their role in armed conflict. They were psychologically distressed with unhealthy physical and mental states. The principles for working with child soldiers are described. The model addresses basic items: The confluence of the dimensions of the items will determine the specifics of medico legal evidence of torture in child soldiers, taking into consideration inputs that are required at the macro, community and individual levels. A primary goal is to prevent violence from occurring in child soldiers. Thus, much more deliberate effort is made to address the underlying causes of recruitment of children in armed groups in DRC and to invest more resources in conflict resolution before there is an outbreak of violence. Peace education tends to be introduced too late and does little to alleviate the use of children in armed conflict in DRC.

Hall, P. (2011). "Doctors and torture, victims and justice." Lancet **378**(9809): e26.

Halvorsen, J. O. and A. Kagee (2010). "Predictors of psychological sequelae of torture among South African former political prisoners." J Interpers Violence **25**(6): 989-1005.

> The present study investigated potential predictors of the psychological sequelae of torture among 143 former political activists who had been detained during the apartheid era in South Africa. Using multiple regression analyses, the authors found that the number of times detained for political reasons, negative social support, strong religiousness, female gender, and number of days detained significantly predicted psychological distress and symptoms of traumatization as measured by the Harvard Trauma Questionnaire (adjusted R(2) = .183) and the Hopkins Symptom Checklist-25 (adjusted R(2) = .152). The number of times detained for political reasons, negative social support, strong religiousness, and female gender emerged as salient risk factors for psychological distress, whereas duration of imprisonment appeared to protect against posttraumatic symptoms. This article discusses these results in terms of the current research on factors associated with traumatization.

Hardi, L. and A. Kroo (2011). "Psychotherapy and psychosocial care of torture survivor refugees in Hungary: "a never-ending journey"." Torture **21**(2): 84-97.

Hensel-Dittmann, D., et al. (2011). "Treatment of traumatized victims of war and torture: a randomized controlled comparison of narrative exposure therapy and stress inoculation training." Psychother Psychosom **80**(6): 345-352.

> BACKGROUND: The aim of the present randomized controlled trial was to compare the outcome of 2 active treatments for posttraumatic stress disorder (PTSD) as a consequence of war and torture: narrative exposure therapy (NET) and stress inoculation training (SIT). METHODS: Twenty-eight PTSD patients who had experienced war and torture, most of them asylum seekers, received 10 treatment sessions of either NET or SIT at the Outpatient Clinic for Refugees, University of Konstanz, Germany. Posttests were carried out 4 weeks after treatment, and follow-up tests were performed 6 months and 1 year after treatment. The main outcome measure was the PTSD severity score according to the Clinician-Administered PTSD Scale (CAPS) at each time point. RESULTS: A significant reduction in PTSD severity was found for NET, but not for SIT. A symptom reduction in the NET group occurred between pretest and the 6-month follow-up examination, the effect size being d = 1.42 (for SIT: d = 0.12), and between pretest and the 1-year follow-up, the effect size being d = 1.59 (for SIT: d = 0.19). The rates and scores of major depression and other comorbid disorders did not decrease significantly over time in either of the 2 treatment groups. CONCLUSIONS: The results indicate that exposure treatments like NET lead to a significant PTSD symptom reduction even in severely traumatized refugees and asylum seekers.

Hexom, B., et al. (2012). "Survivors of torture: prevalence in an urban emergency department." Acad Emerg Med **19**(10): 1158-1165.

> OBJECTIVES: Torture has been documented in 132 countries, and approximately 400,000 survivors of torture reside in the United States. It is unknown if torture survivors seek medical care in emergency departments (EDs). The authors set out to estimate the prevalence of survivors of torture presenting to an urban ED. METHODS: A cross-sectional survey of ED patients was performed by convenience sampling from October 2008 to September 2009 in a large urban teaching hospital in New York City. ED patients not of a vulnerable population were consented and entered into the study. Participants were asked two screening questions to ascertain if they were self-reported survivors of torture. For

exploratory purposes only, these individuals were further queried about their experiences. The detailed responses of these self-reported survivors of torture were compared to the United Nations Convention Against Torture (UNCAT) definition by a blinded, independent panel. RESULTS: Of 470 study participants, 54 individuals (11.5%, 95% confidence interval [CI] = 8.6% to 14.4%) self-reported torture. Nine (16.7%) had ongoing physical disabilities, 30 (55.6%) had recurrent intrusive and distressing memories, 42 (77.8%) never had a physician inquire about torture, and only eight (14.8%) had requested political asylum. Of these self-reported survivors of torture, 29 (53.7%) met the UNCAT definition, for an adjudicated prevalence of 6.2% (95% CI = 4.3% to 8.7%). CONCLUSIONS: Self-reported survivors of torture presented to this urban ED, and a significant proportion of them met the UNCAT definition of a torture survivor. Continuing torture-related medical and psychological sequelae were identified, yet there was a low rate of asylum-seeking. Only a minority were previously identified by a physician. These data suggest an unrecognized public health concern and an opportunity for emergency physicians to intervene and refer survivors of torture to existing community resources.

Highfield, E. S., et al. (2012). "Acupuncture and traditional Chinese medicine for survivors of torture and refugee trauma: a descriptive report." J Immigr Minor Health **14**(3): 433-440.

Refugees with trauma histories are a difficult medical population to treat. Acupuncture care has gained acceptance in many mainstream hospitals in the United States, but research on acupuncture and refugee populations is limited. Herein, we report our experiences with 50 refugees (total acupuncture treatments = 425) at a major tertiary teaching hospital. Patients often reported extreme trauma including physical torture, rape and witnessing the same in family members. Patients represented 13 different countries, with about half the patients being Somali. The primary complaint of all patients was pain (100%). Using the Wong-Baker Faces Pain scale, 56% patients reported pain decreases. Patient acceptance of acupuncture was high. We provide three case histories as illustrative examples. Further research is warranted.

Hinshelwood, G. (2009). "Dedicated charities for survivors of torture and organized violence." Nurs Ethics **16**(1): 3-4.

Hoffman, S. J. (2011). "Ending medical complicity in state-sponsored torture." Lancet **378**(9802): 1535-1537.

Hollifield, M., et al. (2011). "Is torture reliably assessed and a valid indicator of poor mental health?" J Nerv Ment Dis **199**(1): 3-10.

Torture is thought to confer worse mental health than other war-related traumatic events. However, reliability of torture assessment and validity of torture constructs as indicators of poor mental health have not been systematically evaluated. Study aims were to assess the psychometric properties of 2 common torture constructs. Refugees were assessed for having experienced torture by 1 subjective and 1 objective criterion. A subset was interviewed about definitions and effects of torture. Reliability and validity of torture constructs were assessed with general linear models. Interview data were analyzed for consistency of themes. Reliability of torture constructs was moderate, which paralleled inconsistencies in interview themes. Both torture criteria had similar dose-dependent relationships to mental health. Multivariate analyses showed that torture was not an independent predictor of poor mental health when controlling for the number of war-related events. Further work is

needed to define torture from distinct medical and legal perspectives to improve reliability and validity.

Holst, E. (2012). "Don't let torture victims fall through the cracks. Interview by Fiona Fleck." Bull World Health Organ **90**(3): 166-167.

Hont, G. (2008). "[Nobody punish physicians participating in forced interrogations and torture]." Lakartidningen **105**(19): 1417-1420.

Human Rights, W. (2009). "In a time of torture." Reprod Health Matters **17**(34): 173-179.

Husain, M. (2011). "Contributory torture." Torture **21**(3): 192-194.

Husain, M., et al. (2010). "A study to determine whether targeted education significantly improves the perception of human torture in medical students in India." J Indian Med Assoc **108**(8): 491-494.

This study was undertaken to find out the knowledge of torture in MBBS students. A fair comparison was done by selecting two groups of medical students; one, to whom torture was not taught ie, pretaught group (PrTG, n = 125), and second, to whom torture was taught in classroom ie, post-taught group (PoTG, n = 110) in more than one sessions. The topic on torture was taught under many headings maximising the effort to cover as much as possible; namely, definition, geographical distribution, types of torture (physical, psychological and sexual), post-torture sequelae, sociopolitical environment prevailing in the country, doctors' involvement in torture, rehabilitation of torture victims and the UNO's role in containment of torture. In all a questionnaire was designed having MCQ types on these aspects. It was found that significant level of difference in perception and knowledge about torture existed amongst the groups, and this was further accentuated in medical and non-medical intratopics. 'P' value of each question was computed separately. It was found that the study was statistically significant and reestablished the need of fortifying the gossameric firmament of education specific to torture.

Iacopino, V., et al. (2011). "Ethics. Bad science used to support torture and human experimentation." Science **331**(6013): 34-35.

Iacopino, V. and S. N. Xenakis (2011). "Neglect of medical evidence of torture in Guantanamo Bay: a case series." PLoS Med **8**(4): e1001027.

BACKGROUND: In the wake of the September 11, 2001 attacks on the US, the government authorized the use of "enhanced interrogation" techniques that were previously recognized as torture. While the complicity of US health professionals in the design and implementation of US torture practices has been documented, little is known about the role of health providers, assigned to the US Department of Defense (DoD) at the US Naval Station Guantanamo Bay, Cuba (GTMO), who should have been in a position to observe and document physical and psychological evidence of torture and ill treatment. METHODS AND FINDINGS: We reviewed GTMO medical records and relevant case files (client affidavits, attorney-client notes and summaries, and legal affidavits of medical experts) of nine individuals for evidence of torture and ill treatment and documentation by medical personnel. In each of the nine cases, GTMO detainees alleged abusive interrogation methods

that are consistent with torture as defined by the UN Convention Against Torture as well as the more restrictive US definition of torture that was operational at the time. The medical affidavits in each of the nine cases indicate that the specific allegations of torture and ill treatment are highly consistent with physical and psychological evidence documented in the medical records and evaluations by non-governmental medical experts. However, the medical personnel who treated the detainees at GTMO failed to inquire and/or document causes of the physical injuries and psychological symptoms they observed. Psychological symptoms were commonly attributed to "personality disorders" and "routine stressors of confinement." Temporary psychotic symptoms and hallucinations did not prompt consideration of abusive treatment. Psychological assessments conducted by non-governmental medical experts revealed diagnostic criteria for current major depression and/or PTSD in all nine cases. CONCLUSION: The findings in these nine cases from GTMO indicate that medical doctors and mental health personnel assigned to the DoD neglected and/or concealed medical evidence of intentional harm.

International Forensic Expert, G. (2012). "Statement on access to relevant medical and other health records and relevant legal records for forensic medical evaluations of alleged torture and other cruel, inhuman or degrading treatment or punishment." Torture **22 Suppl 1**: 39-48.

Jaffe, H. (2008). "How to deal with torture victims." Torture **18**(2): 130-138.

Jaranson, J. M. and J. Quiroga (2011). "Evaluating the services of torture rehabilitation programmes: history and recommendations." Torture **21**(2): 98-140.

Jesper, S. (2008). "Doctors' involvement in torture." Torture **18**(3): 161-175.

Doctors from both non-democratic and democratic countries are involved in torture. The majority of doctors involved in torture are doctors at risk. Doctors at risk might compromise their ethical duty towards patients for the following possible reasons: individual factors (such as career, economic or ideological reasons), threats, orders from a higher ranking officer, political initiatives, working in atrocity-producing situations or dual loyalty. In dual loyalty conflicts, factors that might compromise doctors' ethical obligations towards detainees/patients are: ideological totalitarianism, moral disengagement, victim blame, patriotism, individual factors or threats. Another important reason why doctors are involved in torture is that not all doctors are trained in addressing human rights issues of detainees. Torture survivors report that they have experienced doctors' involvement in torture and doctors themselves report that they have been involved in torture. Testimonies from both torture survivors and doctors demonstrate that the most common way doctors are involved is in the diagnosis/medical examination of torture survivors/prisoners. And it is common before, during and after torture. Both torture survivors and doctors state that doctors are involved during torture by treatment and direct participation. Doctors also falsify journals, certificates and reports. When doctors are involved in torture it has devastating consequences for both torture survivors and doctors. The consequences for the survivors can be mistrust of doctors, avoidance of seeking doctors' help and nightmares involving doctors. Mistrust and avoidance of doctors could be especially fatal to the survivor, as it could mean a survivor who is ill may not seek medical attention. When the unambiguous role of the doctor as the protector and helper of people is questioned, it affects the medical profession all over the world.

Johnson, H. and A. Thompson (2008). "The development and maintenance of post-traumatic stress disorder (PTSD) in civilian adult survivors of war trauma and torture: a review." Clin Psychol Rev **28**(1): 36-47.

This review provides a comprehensive and critical summary of the literature as to the development and maintenance of post-traumatic stress disorder (PTSD) following civilian war trauma and torture. Prevalence rates are reviewed and predictors are discussed in terms of risk factors, protective factors, and factors that maintain PTSD. Most epidemiologically sound studies found relatively low rates of PTSD. There is good evidence of a dose-response relationship between cumulative war trauma and torture and development and maintenance of PTSD. There is also some evidence that female gender and older age are risk factors in development of PTSD. Some refugee variables may exacerbate symptoms of PTSD and contribute to their maintenance. Preparedness for torture, social and family support, and religious beliefs may all be protective against PTSD following war trauma and torture. Applicability of the concept of PTSD to non-western populations and areas for much needed further study are discussed.

Kinzie, J. D. (2011). "Guidelines for psychiatric care of torture survivors." Torture **21**(1): 18-26.

Kira, I. A., et al. (2010). "Group therapy model for refugee and torture survivors." Torture **20**(2): 108-113.

The paper discusses the Center for Torture and Trauma Survivors' therapy group model for torture survivors and describes two of its variants: The Bashal group for African and Somali women and the Bhutanese multi-family therapy group. Group therapies in this model extend to community healing. Groups develop their cohesion to graduate to a social community club or initiate a community organization. New graduates from the group join the club and become part of the social advocacy process and of group and individual support and community healing. The BASHAL Somali women's group that developed spontaneously into a socio-political club for African women, and the Bhutanese family group that consciously developed into a Bhutanese community organization are discussed as two variants of this new model of group therapy with torture survivors.

Kira, I. A., et al. (2012). "Group therapy for refugees and torture survivors: treatment model innovations." Int J Group Psychother **62**(1): 69-88.

The paper discusses varieties of group therapies with refugees and torture survivors and the logic behind enhancing traditional group therapies to fit the unique experiences of refugees and torture survivors. It discusses some lessons learned from practice and from empirical research and some recommended adaptations. Finally, it discusses the Center for Torture and Trauma Survivors' therapy group model for torture survivors and describes two of its variants: The Bashal group for African and Somali women and the Bhutanese multi-family therapy group. Group therapies, in this model, extend to community healing. One of the essential and innovative features of the model is that it focuses not only on treating individual psychopathology but also extends to community healing by promoting the development of social clubs and organizations that promote the values and culture of the graduates of the therapy group and the continuation of social support. New graduates from the group join the club and become part of the social advocacy process and of group and community support and healing. This model adds an ecological dimension to the traditional group therapy.

Kira, I. A., et al. (2010). "The effects of gender discrimination on refugee torture survivors: a cross-cultural traumatology perspective." J Am Psychiatr Nurses Assoc **16**(5): 299-306.

Trauma developmental theory identifies gender discrimination (GD) as a type of persistent, ongoing trauma that has the potential for serious, negative effects on mental health. This study was conducted to examine the potential role of GD in the development of cumulative trauma disorders (CTD) and symptoms of posttraumatic stress disorder (PTSD) as well as the role of GD in mediating the effects of other traumas on these disorders. The sample included 160 female torture survivors from more than 30 countries. Measures of PTSD, CTD, and types of trauma exposure were acquired as part of a larger study on refugee torture survivors. Structural equation modeling was used to test several plausible models for the direct and indirect effects of GD on PTSD and CTD, within the context of other trauma exposure. Results suggest that GD mediates the effects of identity traumas on CTD and PTSD. GD also had direct effects on CTD, including relationships with dissociation, suicidality, and deficits in executive function. GD did not appear to directly influence the development of PTSD. The implications of these results for assessment and treatment of women's trauma-related disorders as well as strategies for their prevention are discussed.

Kjaerum, A. (2010). "Combating torture with medical evidence: the use of medical evidence and expert opinions in international and regional human rights tribunals." Torture **20**(3): 119-186.

Kolbet, P. R. (2008). "Torture and Origen's hermeneutics of nonviolence." J Am Acad Relig **76**(3): 545-572.

In a world where too many people continue to be tortured without recourse to legal protections, nonlegislative resources for preserving human dignity amid dehumanizing terror are much needed. This article analyzes the hermeneutical exercises constructed by the influential third century Christian intellectual, Origen of Alexandria, to prepare himself and others for torture and martyrdom. These exercises were designed to be a counter-asceticism that would strike at the root of violence both in the self and in society and enable his contemporary Christians to suffer at the hands of the Romans without losing sight either of their own humanity or that of their tormentors. Christians following Origen's practice were trained to resist not only the Roman Empire's violent disciplining of bodies, but the whole interpretation of the world that justified it as they embodied a nonviolent alternative to it. In this way, Origen provides resources for a particularly religious mode of resistance to torture that usefully supplements the contemporary human rights campaign and holds promise for overcoming some of its limitations.

Lazarus, C. (2012). "Imprisonment and torture of doctors in Bahrain." S Afr Med J **102**(6 Pt 2): 336.

Lincoln, H. S. and M. J. Lincoln (2010). "Role of the odontologist in the investigation of domestic violence, neglect of the vulnerable, and institutional violence and torture." Forensic Sci Int **201**(1-3): 68-73.

Dentists have a significant role to identify and intervene in domestic abuse, violence, and neglect of the vulnerable. Over 75% of abuse victims have injuries to the head, face, mouth, and neck and so dentists are often first responders. However, under recognition and under reporting of domestic abuse and violence is a particular problem among health care providers, including dentists. Forensic odontologists are well suited to lead the training of

their clinical colleagues in the various cultural determinants to abuse, including etiology, symptoms, physical signs of abuse, as well as appropriate reporting. In addition to leading their colleagues, forensic odontologists play an essential role as part of multidisciplinary teams that investigate conflict situations, serious crimes, exploitation of disadvantaged populations, and other serious violence and abuse. Whether in conflict zones or within private families, early detection and intervention is important to prevent establishment of abusive social and family patterns that perpetuate a "cycle of violence". This is especially true in young children, the most vulnerable population of all. To support this theory of early and effective intervention, this paper comprehensively reviews the most recent evidence concerning the etiology, detection, and prevention of violence and abuse.

Lockwood, J. A. (2012). "Insects as weapons of war, terror, and torture." Annu Rev Entomol **57**: 205-227.

For thousands of years insects have been incorporated into human conflict, with the goals of inflicting pain, destroying food, and transmitting pathogens. Early methods used insects as "found" weapons, functioning as tactical arms (e.g., hurled nests) or in strategic habitats (e.g., mosquito-infested swamps). In the twentieth century the relationship between insects and disease was exploited; vectors were mass-produced to efficiently deliver pathogens to an enemy. The two most sophisticated programs were those of the Japanese in World War II with plague-infected fleas and cholera-coated flies and of the Americans during the Cold War with yellow fever-infected mosquitoes. With continued advances, defenses in the form of insecticides and vaccines meant that insects were no longer considered as battlefield weapons. However, in recent times sociopolitical changes have put insects back into the realm of human conflict through asymmetrical conflicts pitting combatants from nonindustrialized regions against forces from militarily and economically superior nations.

Longacre, M., et al. (2012). "Complementary and alternative medicine in the treatment of refugees and survivors of torture: a review and proposal for action." Torture **22**(1): 38-57.

Survivors of torture and refugee trauma often have increased needs for mental and physical healthcare. This is due in part to the complex sequelae of trauma, including chronic pain, major depressive disorder, posttraumatic stress disorder (PTSD) and somatization. This article reviews the scientific medical literature for the efficacy and feasibility of some complementary and alternative medicine (CAM) modalities including meditation, Ayurveda, pranayama/yogic breathing, massage/body-work, dance/movement, spirituality, yoga, music, Traditional Chinese Medicine and acupuncture, qigong, t'ai chi, chiropractic, homeopathy, aromatherapy and Reiki specifically with respect to survivors of torture and refugee trauma. We report that preliminary research suggests that the certain CAM modalities may prove effective as part of an integrated treatment plan for survivors of torture and refugee trauma. Further research is warranted.

Luban, D. (2009). "Human dignity, humiliation, and torture." Kennedy Inst Ethics J **19**(3): 211-230.

Modern human rights instruments ground human rights in the concept of human dignity, without providing an underlying theory of human dignity. This paper examines the central importance of human dignity, understood as not humiliating people, in traditional Jewish ethics. It employs this conception of human dignity to examine and criticize U.S. use of humiliation tactics and torture in the interrogation of terrorism suspects.

Lueger-Schuster, B. (2010). "Supporting interventions after exposure to torture." Torture **20**(1): 32-44.

> A wide range of reactions as panic, demoralisation, feelings of being insecure and unsafe, hopelessness and any kind of dysfunction dominate after torture. The range of PTSD and other psychiatric disorders can be explained by variations in severity, frequency and duration of traumatic events. The advanced numbers of refugees and asylum seekers illustrate the need of people after the experience of torture to find a safe place for recovery. The various steps for immediate coping strategy after being tortured are evaluated. Stressors after torture, as pressure on families, decline of social and economic life, threats, feelings of guilt and shame and health problems due to torture act as remainders for the torture experience. Coping with exposure to torture starts immediately during the experience. A phase-oriented research, taking into consideration internal and external resources, risk factors and protective factors, as well as pre-trauma status, could help to understand more about the needs torture survivors have after being released from detention.

Malka, A. and C. J. Soto (2011). "The conflicting influences of religiosity on attitude toward torture." Pers Soc Psychol Bull **37**(8): 1091-1103.

> This research examines the thesis that religiosity has conflicting influences on Americans' attitudes about the use of torture on terrorism suspects: an organic influence favoring opposition to torture and a discursively driven influence favoring support of torture. In each of two national samples, religiosity had both a direct effect toward opposition to torture and an indirect effect-via conservative political alignment-toward support of torture. Multiple-group analyses revealed that the direct effect toward opposition to torture did not vary across Americans with differing levels of exposure to political discourse, whereas the indirect effect toward support of torture via conservative political alignment was much stronger among Americans highly exposed to political discourse. Among such individuals, the indirect effect was so strong that it completely counteracted the competing direct effect. Discussion focuses on the competing influences that a single nonpolitical psychological characteristic may have on a political preference.

Marcussen, H. (2011). "Torture in retrospect (1992-2000)." Torture **21**(3): 147-154.

Mason, D. J. (2010). "Nurses' possible participation in the torture and abuse of prisoners at Guantanamo." Nurs Outlook **58**(1): 5-6.

McColl, H., et al. (2012). "The role of doctors in investigation, prevention and treatment of torture." J R Soc Med **105**(11): 464-471.

> Doctors may assess and treat torture survivors; some may document crucial evidence of torture in medico-legal reports. However, there is a lack of education on torture and related ethical and legal issues at undergraduate and postgraduate level and many doctors are not aware of opportunities to work with organisations for the prevention of torture. This paper defines Torture, describes methods used, and sets out the human rights instruments and codes of ethical practice that mandate efforts to prevent torture. Medical complicity in torture is discussed and the need for national and international medical associations to prevent torture by both supporting doctors and recognising and tackling medial complicity. The paper offers guidance for assessing and documenting torture, and for providing health care for survivors of torture.

McColl, H., et al. (2010). "Rehabilitation of torture survivors in five countries: common themes and challenges." Int J Ment Health Syst **4**: 16.

BACKGROUND: Torture continues to be a global problem and there is a need for prevention and rehabilitation efforts. There is little available data on torture survivors from studies designed and conducted by health professionals in low income countries. This study is a collaboration between five centres from Gaza, Egypt, Mexico, Honduras and South Africa who provide health, social and legal services to torture survivors, advocate for the prevention of torture and are part of the network of the International Rehabilitation Council for Torture Victims (IRCT). METHODS: Socio-demographic, clinical and torture exposure data was collected on the torture survivors attending the five centres at presentation and then at three and six month follow-up periods. This sample of torture survivors is presented using a range of descriptive statistics. Change over time is demonstrated with repeated measures analysis of variance. RESULTS: Of the 306 torture survivors, 23% were asylum seekers or refugees, 24% were socially isolated, 11% in prison. A high level of traumatic events was experienced. 64% had suffered head injury whilst tortured and 24% had ongoing torture injury problems. There was high prevalence of symptoms of anxiety, depression, post traumatic stress as well as medically unexplained somatic symptoms. The analysis demonstrates a modest drop in symptoms over the six months of the study. CONCLUSIONS: Data showed that the torture survivors seen in these five centres had high levels of exposure to torture events and high rates of clinical symptoms. In order to provide effective services to torture survivors, health professionals at torture rehabilitation centres in low income countries need to be supported to collect relevant data to document the needs of torture survivors and to evaluate the centres' interventions.

McFarlane, C. A. and I. Kaplan (2012). "Evidence-based psychological interventions for adult survivors of torture and trauma: a 30-year review." Transcult Psychiatry **49**(3-4): 539-567.

In this paper we review research evidence on psychosocial interventions for adult survivors of torture and trauma. We identified 40 studies from 1980 to 2010 that investigated interventions for adult survivors of torture and trauma. Population subtypes include resettled refugees, asylum seekers, displaced persons, and persons resident in their country of origin. Settings include specialized services for torture and trauma, specialized tertiary referral clinics, community settings, university settings, as well as psychiatric and multidisciplinary mental health services. Interventions were delivered as individual or group treatments and lasted from a single session to 19 years duration. The studies employed randomized controlled trials, nonrandomized comparison studies and single cohort follow-up studies. In all, 36 of the 40 studies (90%) demonstrated significant improvements on at least one outcome indicator after an intervention. Most studies (60%) included participants who had high levels of posttraumatic stress symptomatology. Improvements in symptoms of posttraumatic stress, depression, anxiety, and somatic symptoms were found following a range of interventions. Little evidence was available with regard to the effect on treatment outcomes of the amount, type, or length of treatment, the influence of patient characteristics, maintenance of treatment effects, and treatment outcomes other than psychiatric symptomatology. The review highlights the need for more carefully designed research that addresses the shortcomings of current studies and that integrates the experience of expert practitioners.

McKinney, M. M. (2011). "Treatment of survivors of torture: spiritual domain." Torture **21**(1): 61-66.

Metalios, E. E., et al. (2008). "Teaching residents to work with torture survivors: experiences from the Bronx Human Rights Clinic." J Gen Intern Med **23**(7): 1038-1042.

INTRODUCTION: Despite the 1984 United Nations's Convention Against Torture calling to train doctors to work with torture survivors, many physicians are unaware of their obligation and few are taught the requisite clinical skills. AIM: To describe the development, implementation, and evaluation of a curriculum to teach residents to work with torture survivors. PARTICIPANTS: Medicine residents in New York City PROGRAM DESCRIPTION: A 2-component curriculum consisting of a series of workshops and clinical experiences, which provide content, skills, and practices regarding the medical, psychological, ethical, and legal aspects of evaluating and caring for torture survivors. CURRICULUM EVALUATION: All 22 trainees received surveys before and after training. Surveys assessed residents' relevant prior experience, beliefs, skills, and attitudes regarding working with torture survivors. At baseline, 23% of residents described previous human rights trainings and 17% had work experiences with torture survivors. Before the curriculum, 81% of residents reported doctors should know how to evaluate survivors, although only 5% routinely screened patients for torture. After the curriculum, residents reported significant improvements in 3 educational domains-general knowledge, sequelae, and self-efficacy to evaluate torture survivors. DISCUSSION: This curriculum addresses the disparity between doctors' obligations, and training to work with torture survivors. It is likely to achieve its educational goals, and can potentially be adapted to other residencies.

Meyers, A. and D. Summerfield (2011). "The campaign about doctors and torture in Israel two years on." BMJ **343**: d5223.

Miles, S. H. (2008). "Doctors' complicity with torture." BMJ **337**: a1088.

Miles, S. H. (2011). "Settled precepts: normative ethics, applied ethics and physician complicity with torture." Med Confl Surviv **27**(4): 191-196.

Miles, S. H., et al. (2010). "Punishing physicians who torture: a work in progress." Torture **20**(1): 23-31.

BACKGROUND: There are only a few anecdotal accounts describing physicians being punished for complicity with torture or crimes against humanity. A fuller list of such cases would address the perception that physicians may torture with impunity and point to how to improve their accountability for such crimes. METHODS: We performed a multilingual web search of the records of international and national courts, military tribunals, medical associations (licensing boards and medical societies), medical and non-medical literature databases, human rights groups and media stories for reports of physicians who had been punished for complicity with torture or crimes against humanity that were committed after World War II. RESULTS: We found 56 physicians in eight countries who had been punished for complicity with torture or crimes against humanity. Courts punish crimes. Medical societies punish ethics violations. Fifty-one physicians (85%) had been punished by the medical associations of five countries. Eleven (18%) had been punished by domestic courts. International courts had imprisoned two (3%) physicians. Several were punished by courts and professional associations. There are open cases against 22 physicians. CONCLUSIONS: Punishments against physicians for crimes against humanity are becoming institutionalized. Medical associations must lead in shouldering responsibility for self-regulation in this matter. Physicians have supervised torture ever since medieval "Torture Physicians" certified that

prisoners were medically capable of withstanding the torture and of providing the desired testimony. Revelations of sadistic medical experiments on prisoners during World War II turned the world against physician torturers and led to the "Doctor's Trial" at Nuremberg, a trial that held physicians accountable for crimes against humanity. This paper describes the largest case series of physicians who have been punished for abetting torture or other crimes against humanity committed after World War II. We wanted to: 1) describe and categorize the hearing procedures, 2) identify the roles of punished physicians, 3) categorize acts for which physicians are punished, and 4) describe the political cultures in which punishments arise. Our larger aim was to learn whether punishments against physicians for abetting torture or crimes against humanity occur under sufficiently diverse environments as to inform generalizable public policy to punish and perhaps to deter this kind of medical misconduct.

Miles, S. H. and A. M. Freedman (2009). "Medical ethics and torture: revising the Declaration of Tokyo." Lancet **373**(9660): 344-348.

Miles, S. H. and R. E. Garcia-Peltoniemi (2012). "Torture survivors: what to ask, how to document." J Fam Pract **61**(4): E1-5.

Miller, H. I. (2010). "The UN's water torture." GM Crops **1**(1): 13-15.

The United Nations is a bastion of corruption, profligacy and incompetence that is a particular threat to the inhabitants of poor nations. Its policies, programs and agencies have made a growth industry of the unscientific regulation of important technologies-of which gene-splicing [also known as recombinant DNA technology or genetic modification (GM)] is only one. The UN's actions regularly defy scientific consensus and common sense, instead pandering to extremists. The result is vastly inflated research and development costs, less innovation, and diminished exploitation of superior techniques and products that could offer monumental humanitarian and economic benefits.

Miller, I. (2009). "Necessary torture? Vivisection, suffragette force-feeding, and responses to scientific medicine in Britain c. 1870-1920." J Hist Med Allied Sci **64**(3): 333-372.

One of the primary aims of late nineteenth-century laboratory experimentation was to ground understandings of illness and disease within new regimes of science. It was also hoped that clinical practice would become increasingly complemented by discoveries and technologies accrued from emergent forms of modern medical enquiry, and that, ultimately, this would lead to improved diagnostic and therapeutic procedures that could be applied to a wide variety of medical complaints. This met with resistance in Britain. So far, analyses of the British reception to forms of scientific medicine have focused on a science versus intuition dichotomy. This article aims to address other aspects intertwined in the debate through an exploration of alternative representations of the medical scientist available and the relation of this to perceptions of clinical practice. Using new technologies of the stomach as a case study, I shall examine how physiologists approached digestion in the laboratory, the responses of antivivisectionists to this, the application of gastric innovations at the clinical level, and the impact of the use of the stomach tube in the suffragette force-feeding controversy.

Mills, E., et al. (2008). "Prevalence of mental disorders and torture among Bhutanese refugees in Nepal: a systemic review and its policy implications." Med Confl Surviv **24**(1): 5-15.

> The mass expulsion and exile of Bhutanese de facto refugees to displaced camps in Nepal represents one of the world's most neglected humanitarian crises. We aimed to summarize the impact of the long-term displacement on refugee mental illness using systematic review techniques, a methodology seldom used in the humanitarian field. In order to examine the impact among the population and the association between tortured refugees over non-tortured refugees, we searched 11 electronic databases from inception to 12 May 2006. We additionally contacted researchers at the United Nations High Commission for Refugees (UNHCR) and at the Centre for Victims of Torture, Kathmandu, and searched the websites of Amnesty International, Human Rights Watch, Relief-Web, and the US State Department. We included any studies that use a pre-defined protocol to determine mental illness within this population. Six studies met our inclusion criteria. All were conducted amongst the Bhutanese populations residing in Nepalese refugee camps, and include a sub-sample of 2,331 torture survivors residing in the camps, identified in 1995. All studies report a dramatically high incidence of mental illness including depression, anxiety and post-traumatic stress disorder. Both tortured and non-tortured participants reported elevated rates of mental illness. Our review indicates that the prevalence of serious mental health disorders within this population is elevated. The reported incidence of torture is a possible contributor to the illnesses. The use of systematic review techniques strengthens the inference that systematic human rights violations were levied upon this population and that they continue to suffer as a result. The international community must resolve this protracted crisis.

Mirzaei, S., et al. (2011). "How to combat torture if perpetrators are supported by a religious "justification"." Torture **21**(3): 173-177.

> While there are some examples of legal cases which have resulted in the prosecution of perpetrators and successful reparation for survivors, in countries such as Iran such due procedure is close to impossible since torture is practiced by state officials mostly based on religious codes, and the legal system is controlled by practices that makes it close to impossible to achieve justice. This article discusses the implications of such a situation that also include health care professionals in third party countries who have an obligation to document evidence using the Istanbul Protocol based on a case example of a survivor exposed to different forms of torture.

Mollica, R. F. (2011). "Medical best practices for the treatment of torture survivors." Torture **21**(1): 8-17.

Mollica, R. F., et al. (2009). "Brain structural abnormalities and mental health sequelae in South Vietnamese ex-political detainees who survived traumatic head injury and torture." Arch Gen Psychiatry **66**(11): 1221-1232.

> CONTEXT: A pilot study of South Vietnamese ex-political detainees who had been incarcerated in Vietnamese reeducation camps and resettled in the United States disclosed significant mental health problems associated with torture and traumatic head injury (THI). OBJECTIVES: To identify structural brain alterations associated with THI and to investigate whether these deficits are associated with posttraumatic stress disorder and depression. DESIGN: Cross-sectional neuroimaging study. SETTING: Massachusetts General Hospital and McLean Hospital. PARTICIPANTS: A subsample of Vietnamese ex-political detainees (n = 42) and comparison subjects (n = 16) selected from a community study of 337 ex-political

detainees and 82 comparison subjects. MAIN OUTCOME MEASURES: Scores on the Vietnamese versions of the Hopkins Symptom Checklist-25 (HSCL) and Harvard Trauma Questionnaire for depression and posttraumatic stress disorder, respectively; cerebral regional cortical thickness; and manual volumetric morphometry of the amygdala, hippocampus, and thalamus. RESULTS: Ex-political detainees exposed to THI (n = 16) showed a higher rate of depression (odds ratio, 10.2; 95% confidence interval, 1.2-90.0) than those without THI exposure (n = 26). Ex-political detainees with THI had thinner prefrontotemporal cortices than those without THI exposure (P < .001 by the statistical difference brain map) in the left dorsolateral prefrontal and bilateral superior temporal cortices, controlling for age, handedness, and number of trauma/torture events (left superior frontal cortex [SFC], P = .006; left middle frontal cortex, P = .01; left superior temporal cortex [STC], P = .007; right STC, P = .01). Trauma/torture events were associated with bilateral amygdala volume loss (left, P = .045; right, P = .003). Cortical thinning associated with THI in the left SFC and bilateral STC was related to HSCL depression scores in THI-exposed (vs non-THI-exposed) ex-political detainees (left SFC, P for interaction = .007; left STC, P for interaction = .03; right STC, P for interaction = .02). CONCLUSIONS: Structural deficits in prefrontotemporal brain regions are linked to THI exposures. These brain lesions are associated with the symptom severity of depression in Vietnamese ex-political detainees.

Montgomery, E. and N. Patel (2011). "Torture rehabilitation: reflections on treatment outcome studies." Torture **21**(2): 141-145.

Moog, F. P. (2010). "[Therapy or torture: a treatment of gout misunderstood by Gregory of Tours]." Wurzbg Medizinhist Mitt **29**: 116-130.

Historiarum libri decem, a work written by St. Gregory, the bishop of Tours, is an important contemporary source for the study of the Merovingian times. In Book V 42 Gregory reports the story of Maurilio, the bishop of Cahors in the Southern Gaul, who was strongly suffering from gout. Maurilio treated the illness himself applying a hot iron to his foot and shank. This therapy is already mentioned in the Corpus Hippocraticum. It seems, however, that cauterization was not known to St. Gregory of Tours as a medical treatment of this particular illness. He simply saw in it a sanctifying practice in the sense of penitential mortification. Indeed, for Gregory this interpretation is an important part of his literary aim, as Maurilio is for him a brilliant example of a minister of the Church. Although Maurilio is well-known for his piety, knowledge, and uprightness in diocesan dealings, he voluntarily, as Gregory thinks, submits to ascetic self-castigation.

Mooney, H. (2011). "US doctors were complicit in Guantanamo Bay torture, report says." BMJ **342**: d2680.

Moreano, B. (2010). "[Psychological comorbidity in tinnitus. Noise in the ear - torture for the psyche]." MMW Fortschr Med **152**(41): 20.

Moreno, A. and V. Iacopino (2008). "Forensic investigations of torture and ill-treatment in Mexico. A follow-up study after the implementation of the Istanbul Protocol." J Leg Med **29**(4): 443-478.

Morentin, B., et al. (2008). "A follow up study of allegations of ill-treatment/torture in incommunicado detainees in Spain. Failure of international preventive mechanisms." Torture **18**(2): 87-98.

BACKGROUND: Proper documentation is an important factor in torture prevention, thus making systematic research studies necessary. According to international reports, torture/ill-treatment continues to exist in Spain in relation to Basque people arrested under anti-terrorist legislation (incommunicado detention). To improve the safeguards of these detainees, the European Committee for the Prevention of Torture (CPT) has visited Spain and published recommendations. However, the Spanish Government has not implemented these recommendations. The primary aims of this study were to analyze the methods of torture claimed by Basque incommunicado detainees during 2000-2005 and to compare them with the findings of a previous study (1992-1993), as well as to evaluate the impact of the CPT recommendations. The influence of variables related to police ill-treatment were also studied. METHODS: This retrospective study is based on the testimonies given voluntarily by 112 Basques held incommunicado during 2000-2005. Testimonies were collected by a non-governmental organisation. FINDINGS: Threats (91 percent) and beatings (89 percent) were the most frequent alleged methods, followed by suffocation, deprivation methods, forced body position, undressing and physical exercises (percentage between 49 percent and 29 percent). The frequency of suffocation, electricity, visual input reduced and threats was lower in 2000-2005 than in the 1992-1993 period. Different patterns of torture related to each police force were detected. The group arrested by the Guardia Civil alleged more severe torture methods, while the detainees arrested by Ertzantza alleged less severe ill-treatment. The prevalence of sexual torture was higher for women than for men. The present data are in consonance with the findings described for international organisms after their visits to Spain. INTERPRETATION: These findings, in addition to other evidence, suggest that torture is still a serious problem in Spain in relation with Basque incommunicado detainees. This fact shows that national and international (mainly based on CPT visits) measures of control/prevention have failed. This study supports the importance of scientific statistical analysis in the documentation of human rights violations and its potential use in order to improve the forensic evaluation of torture victims.

Morentin, B., et al. (2008). "A follow-up investigation on the quality of medical documents from examinations of Basque incommunicado detainees: the role of the medical doctors and national and international authorities in the prevention of ill-treatment and torture." Forensic Sci Int **182**(1-3): 57-65.

According to the United Nations and the European Committee for the Prevention of Torture (CPT), torture and ill-treatment continues to be a problem during incommunicado detentions in Spain. CPT has visited Spain and published recommendations for improvements of preventive medical examinations. However, no scientific assessment of the impact of such recommendations exists. The objectives of this study were to assess the quality of documents from preventive medical examinations and the prevalence of alleged ill-treatment and compare findings with similar data from a previous study. Documents issued by state employed doctors describing medical examination of Basques held incommunicado during 2000-2005 were reviewed. The analysis covered allegations of ill-treatment and existence and quality of information essential for medical appraisal of allegations of ill-treatment. The material was collected by a non-governmental organisation. Of 425 documents concerning 118 persons, 85% had no formal structure and the format recommended by CPT was never used. None of 127 documents, concerning 70 persons with allegations of ill-treatment had an overall conclusion on the likelihood of ill-treatment. Twelve to 68% of necessary data were totally missing, and only 13-38% of existing

information was sufficient. There was significant variation between the reporting of individual doctors, but in general the quality was unacceptable, although somewhat higher than in the previous study. The prevalence of allegations of ill-treatment was as high as previously. There were more reports of psychological ill-treatment and procedures of forced physical exhaustion, but fewer reports of beatings. In conclusion, there was no indication that the conditions of incommunicado detainees have improved substantially over the past 15 years and the standard of medical reporting was unacceptable. The Spanish authorities should give clear objectives and guidelines for medical examinations of detainees. An independent forensic specialist with the overall academic responsibility for preventive medical examinations of detainees should be employed to supervise state employed doctors. The present article shows the necessity for harmonization of medical practice in documentation of torture.

Morris, K. L. (2009). "Torture and attachment: conscience and the analyst's world-seeing eye." Psychoanal Rev **96**(5): 841-855.

Mostad, K. and E. Moati (2008). "Silent healers: on medical complicity in torture." Torture **18**(3): 150-160.

OBJECTIVE: To shed light on a large but neglected human rights issue that can be termed passive participation in torture. This is a response to the rising number of statements from torture victims who claim that during their incarceration, medical personnel cooperated with the interrogators by sharing medical documents, giving false statements, and providing other indirect assistance to the interrogator. METHOD: Cases studies are used to demonstrate the existence of passive participation, as well as situations where the passivity has been addressed and improved. Extracts of international instruments and actions undertaken by associations are used to help the reader address issues around the passive participation in torture. RESULT: By reading this article medical professionals will be made aware that action can be undertaken with the help of existing international laws and policies. CONCLUSION: In the conclusion of the article a range of bullet-points is made available for medical professionals who want to address the issue of passive participation.

Moszynski, P. (2008). "Medical evidence exposes US use of torture." BMJ **336**(7659): 1458-1459.

Murray, J. S. (2010). "There is no evidence that military nurses participated in torture and abuse of detainees." Nurs Outlook **58**(1): 6-7.

Nordgren, L. F., et al. (2011). "What constitutes torture?: psychological impediments to an objective evaluation of enhanced interrogation tactics." Psychol Sci **22**(5): 689-694.

Torture is prohibited by statutes worldwide, yet the legal definition of torture is almost invariably based on an inherently subjective judgment involving pain severity. In four experiments, we demonstrate that judgments of whether specific interrogation tactics constitute torture are subject to an empathy gap: People who are experiencing even a mild version of the specific pain produced by an interrogation tactic are more likely to classify that tactic as torture or as unethical than are those who are not experiencing pain. This discrepancy could result from an overestimation of the pain of torture by people in pain, an underestimation of the pain of torture by those not in pain, or both. The fourth experiment shows that the discrepancy results from an underestimation of pain by people who are not

experiencing it. Given that legal standards guiding torture are typically established by people who are not in pain, this research suggests that practices that do constitute torture are likely to not be classified as such.

O'Connor, M. (2009). "Can we prevent doctors being complicit in torture? Breaking the serpent's egg." J Law Med **17**(3): 426-438.

A significant minority of the tortured prisoners who survive report that a doctor was present during their torture. Yet few medical practitioners are ever criminally prosecuted or even disciplined by their regulatory bodies. Can such gross violations of the Hippocratic Code be so easily ignored or are these doctors carefully shielded from detection and prosecution by a grateful state? Mostly doctors act to vet prisoners for their capacity to withstand the torture or resuscitate them to allow torture and interrogation to continue. However, on occasion, the "healers" may be the actual torturers as happened in Russian psychoprisons in the latter part of the 20th century. This article argues that the de facto immunity which complicit doctors currently appear to enjoy must be stripped away and replaced by effective processes to detect and then prosecute criminal behaviour. This will require widespread reporting of cases and action by international bodies, including non-government organisations. Prevention is clearly preferable and this will require improvements in undergraduate and graduate medical education about international humanitarian and human rights law. There is evidence that many medical faculties pay scant attention to this education and their students graduate with serious flaws in their understanding and attitudes towards human rights. Education should target "doctors at risk" in prisons, armed forces and the police. It should address professional behaviour which tolerates or even protects cultures of abuse. A code of professional conduct would assist "doctors at risk" to resist overtures for them to become complicit in torture, Medical Practice Acts should include statements on respecting human rights when defining good professional conduct. Doctors who become complicit in torture betray their profession. Swift action should be taken to stop such abuses and perpetrators should receive strong disciplinary action from regulatory bodies.

O'Neill, D. (2010). "Moral obligations. What about abuse other than torture?" BMJ **340**: c1610.

Olofsson, G. (2012). "[Israeli physicians have to stop participating in torture]." Lakartidningen **109**(41): 1837-1838.

Owens, P. (2010). "Torture, sex and military Orientalism." Third World Q **31**(7): 1041-1056.

This article revisits the debate about recent American torture practices, particularly the use of discredited anthropological texts to validate long-held Orientalist assumptions about the sexual vulnerability of Muslim males. Such practices are placed in an historical context of older imperial constructions of sexually deviant Muslims as well as of more general forms of gendered and sexual subordination required for war. American torturers intended to produce very particular objects of torture-ones willing and able to confess their 'true' orientation in terms of a binary hetero/homo sexual code established in 19th-century Europe. The torturers had the power to confirm through confession and re-enactment their crude assumptions, irrespective of the actual sexualities of those being tortured, with consequences for the transnational and reactionary politics of sexual identity.

Pabilonia, W., et al. (2010). "Knowledge and quality of life in female torture survivors." Torture **20**(1): 4-22.

BACKGROUND: Immigrant women represent disadvantaged and vulnerable members of the torture survivor population. They tend to be isolated and have negative coping strategies resulting in poor health and well-being. The purpose of this pilot study is to develop and evaluate an educational and interactive women's health-based programme using health promotion and empowerment strategies, with the intent of using the knowledge gained to contribute to an ongoing women's health programme. METHODS: A one-group pre-test to post-test design was used with weekly intervention sessions over six weeks, with final evaluation on week seven. Topics covered included nutrition, exercise, healthy cooking, medications, personal and dental hygiene, women's health, and birth control. Achievement tests for health-related knowledge were developed by the principal investigator to match the content of each session. Tests were given before and after the session on weeks one through six, and tests on all content modules were repeated one week after the conclusion of the programme. The short version of the World Health Organization quality of life scale (WHOQOL-BREF) was administered at the start of the first session and at the conclusion of the programme. FINDINGS: Participants' WHOQOL-BREF scores improved significantly from the beginning to the end of the programme. Improvements in achievement scores from pre to post test for each session and from pre-test to the follow-up test at the end of the programme were also statistically significant. Finally, the overall change from pre to post to follow-up achievement test scores was statistically significant. Observable changes in the women were also seen over the duration of the programme, adding confidence to the results and effectiveness of the intervention. IMPLICATIONS: Little is currently known about health-based interventions for the vulnerable population of female torture survivors. Public health nurses and other professionals who work with this population have a unique opportunity to influence behavior change and promote empowerment in this population. The techniques employed in this study can be used by public health nurses as a basis for designing women's health-based programmes at other torture treatment centres throughout the world.

Pant, S., et al. (2012). "Contributory torture." Torture **22**(1): 62.

Perera, C. and A. Verghese (2011). "Implementation of Istanbul Protocol for effective documentation of torture - review of Sri Lankan perspectives." J Forensic Leg Med **18**(1): 1-5.

Documentation of torture is a multidisciplinary, multistage scientific procedure evolved over the past decades through the experience of various strata in medical and related fields. It plays a key role in effective corroboration of facts, providing redress to victims and also has a long term regulatory impact on prevention of torture in a society. The UN endorsed Istanbul protocol serves as the model for effective documentation of torture in the present context and there were many attempts in the recent years to create a systematic and uniform approach among professional bodies to document torture by adopting it to the local medico-legal and legal systems in some less resourced countries. The post independent Sri Lanka is widely known in international human rights forums for the prevalence of torture and its endemicity since 1970s. The long term struggle to ensure justice to torture victims in Sri Lanka has been greatly enhanced by the submission of detailed medico-legal reports on them to relevant courts. As strengthening of medico-legal and legal reporting strategies were more focused towards the end of twentieth century the medico-legal and legal professionals in consensus attempted to use Istanbul Protocol for documentation of torture since 2004. However Sri Lankan experience on application of Istanbul protocol for documentation of torture signifies that unless and until a political commitment is shown by the government to

internalize Istanbul Protocol into legal and medico-legal systems locally the expected outcome of effective documentation would not be evident.

Perez-Sales, P., et al. (2010). "Transitory Ischemia as a form of white torture: a case description in Spain." Torture **20**(2): 104-107.

Transitory Ischemia is a form of torture that has been insufficiently described and studied in forensic and psychiatric studies of torture. It is usually left out of medical evaluation reports and not explored in detail under the Istanbul Protocol. Although ischemia, when experienced during brief periods of time, does not produce any detectable sequelae, prolonged periods of ischemia can be detected by either clinical examination or electromyography. The authors describe the use of brief periods of ischemia as a torture technique against a non-violent activist in Seville (Spain).

Pesic, P. (2008). "Proteus rebound: reconsidering the "torture of nature"." Isis **99**(2): 304-317.

Though Carolyn Merchant has agreed that Francis Bacon did not advocate the "torture of nature," she still maintains that "the very essence of the experimental method arose out of human torture transferred onto nature." Her arguments do not address serious problems of logic, context, and contrary evidence. Her particular insistence on the influence of the torture of witches ignores Bacon's skepticism about witchcraft as superstitious or imaginary. Nor do the writings of his successors sustain her claim that they carried forward his supposed program to abuse nature. We should be wary of metaphorical generalizations that ignore the context of the metaphor, the larger intent of the writers, and the fundamental limitations of such metaphors as descriptions of science. There are no scientific methods which alone lead to knowledge! We have to tackle things experimentally, now angry with them and now kind, and be successively just, passionate, and cold with them. One person addresses things as a policeman, a second as a father confessor, a third as an inquisitive wanderer. Something can be wrung from them now with sympathy, now with force; reverence for their secrets will take one person forwards, indiscretion and roguishness in revealing their secrets will do the same for another. We investigators are, like all conquerors, discoverers, seafarers, adventurers, of an audacious morality and must reconcile ourselves to being considered on the whole evil.

Piggott, F. (2008). "Justification doctrine in the prohibition on torture, cruel, inhuman or degrading treatment." Torture **18**(2): 116-129.

This paper looks at the legacy of a justification doctrine evident in early international jurisprudence that set the threshold for treatment prohibited under international law as torture, cruel, inhuman or degrading treatment or punishment [hereafter the prohibition], excusing from its reach deliberately inflicted, potentially severe, suffering proportionately inflicted for a legitimate purpose. Debates over a 'threshold' at which point the prohibition engages, or at which point 'inhumane' treatment reaches a level sufficient to be deemed 'torture', typically invoke an implicit 'severity' threshold. This paper is not primarily concerned with severity or the instrumentality of any 'severity threshold' either in engaging the prohibition or in distinguishing categories of prohibited treatment. Neither is the article concerned directly with the legal distinction between categories of prohibited treatment (i.e. the distinction between 'torture', other 'inhuman', or even any subcategory 'degrading' treatment). Rather the article focuses on the distinction between (i) treatment prohibited, as either torture or other cruel, inhuman or degrading, and (ii) treatment prima facie 'justified'. What the article looks at is the operation of a 'justification' threshold in triggering the

prohibition, one that understands 'justified' treatment as never reaching the level of, or never amounting to inhuman, cruel or degrading treatment under the prohibition. The article interprets the current prohibition on torture, cruel, inhuman or degrading treatment as one on 'unjustified' inflicted suffering, suggesting that the notion of 'justifiability' active in this definition is problematic in encouraging arguments seeking to circumvent the protection afforded under the prohibition. In the absence of a clearly defined notion of the 'victim', or circumscribed class afforded protection, this paper both identifies and addresses a correlation between (i) a broadly inclusive contextual scope for the prohibition's applicability - one that contemplates a broad notion of the potential victim - and (ii) an enhanced role for a justification doctrine in excusing the infliction of [potentially severe] suffering where necessary and proportionate. In light of identified dangers associated with a role for justification doctrine in the definition of prohibited treatment, an alternative is put forward that would redefine the prohibition as one, not on 'unjustified' but one on 'all' suffering deliberately inflicted restricted to contexts of detention, custody, control or other deprivation of liberty. A brief disclaimer and clarification should also be made at the outset: The article addresses balancing exercises, active in determining the justifiability of treatment, that draw on the nature of its purpose and the degree of its severity. However the author wishes to make clear that the article in no way means to suggest that proportionality is, or should ever be, active in excusing treatment deemed cruel, inhuman, degrading or even torture; the article does not, in referring to 'balancing exercises', 'justification' or 'proportionality', mean to invoke, and much less to argue for, any justification doctrine or proportionality that would balance the prohibition against, for example, national security concerns. What the article is concerned with is a degree of balancing between the severity of suffering inflicted and a potentially legitimate purpose, operating in certain circumstances either to determine treatment as prohibited as torture, cruel, inhuman or degrading or alternatively to excuse it as 'justified'. It is not, then, balancing exercises which might mitigate (notwithstanding the absolute nature of the prohibition) the infliction of treatment deemed 'cruel, inhuman or degrading', or even that amounting to 'torture', but those balancing exercises which 'precondition' the triggering of the prohibition that are the subject of the article and of which will be attempted as lucid an analysis as possible. It is in this context that any reference to 'proportionality' in the article is made. Lastly the author wishes to clarify that anything presented or put forward by the article is done so solely in the interest of securing the maximum protection for the most vulnerable.

Polat, J., et al. (2010). "Ocular manifestations of torture: solar retinopathy as a result of forced solar gazing." Br J Ophthalmol **94**(10): 1406-1407.

Polatin, P. B., et al. (2010). "Helping to stop doctors becoming complicit in torture." BMJ **340**: c973.

Poole, G. E. and G. Galpin (2011). "Prevalence of victims of torture in the health screening of quota refugees in New Zealand during 2007-2008 and implications for follow-up care." N Z Med J **124**(1338): 18-24.

New Zealand annually accepts approximately 750 quota refugees from around the world for resettlement in New Zealand. The humanitarian nature of the quota composition consists of those who are determined by the United Nations refugee agency to be in high need of immediate protection, a large proportion of medical and disability cases, and women and children at risk. Quota refugees arrive in group intakes and participate in assessment and orientation for the first 6 weeks at the national Mangere Refugee Resettlement Centre in South Auckland. This paper describes the findings of screening for refugees with a history of torture during 2007-2008. There were 144 refugees or 19.2% of the new arrivals found to

have histories of torture during this period. The implications for future research, and follow-up care of people who have survived torture are discussed.

Pope, K. S. (2012). "Psychological assessment of torture survivors: Essential steps, avoidable errors, and helpful resources." Int J Law Psychiatry **35**(5-6): 418-426.

This article provides ideas, information, and resources that may be helpful in conducting psychological evaluations of people who have been tortured. The first section discusses essential steps, including achieving competence; clarifying the purpose; selecting methods appropriate to the individual, the purpose, and the situation; addressing issues of culture and language; maintaining awareness of ways in which the presence of third parties and recording can affect the assessment; attending carefully to similarities, echoes, and triggers; and actively searching for ways to transcend our own limited experiences and misleading expectations. The second section discusses avoiding five common errors that undermine these evaluations: mismatched validity; confirmation bias; confusing retrospective and prospective accuracy (switching conditional probabilities); ignoring the effects of low base rates; and misinterpreting dual high base rates. The third section identifies resources on the web (e.g., major centers, legal services, online courses, information about asylum and refuge, networks of torture survivors, human rights organizations providing information and services, guides to assessment) that people working with torture survivors, refugees, and asylum-seekers may find helpful.

Pounder, D. J. (2011). "The medical contribution to assessing allegations of torture in international fact-finding missions." Forensic Sci Int **208**(1-3): 143-148.

International fact-finding missions directed towards the exposure of possible ill-treatment of persons deprived of their liberty have become increasingly common within the framework of international treaties. Such country visits occur with the consent and co-operation of government, provide unfettered access to all places of detention and allow private interviews with detainees. The Committee for the Prevention of Torture of the Council of Europe, the United Nations Special Rapporteur on Torture, and the United Nations Subcommittee on Prevention of Torture all engage in such missions, and make use of a medical professional as part of the investigative team. The medical contribution to fact finding missions assessing ill-treatment of detainees includes an assessment of the conditions of detention, the regime and the medical services. Custody doctors and their records can be a rich source of information about physical ill-treatment. The interview and examination of detainees often occurs in circumstances which are far from ideal. The safety and wellbeing of the detainees, including protection from reprisals, is always paramount. A medical examination may disclose injuries corroborative of specific allegations. More often, a medical history of the effects of ill treatment and the description of resolved transient injuries provides corroboration, and also forms part of assessing the overall credibility of the detainee. Equally important is the consistency of the allegation with other evidence obtained from a wide variety of sources including the inspection of the place of alleged ill-treatment. The evolved working methods draw on the basic principles underlying police criminal investigations and crime scene examinations as well as forensic medicine. A forensic medical expert can be a useful part of the team in such international fact finding missions.

Prip, K. and A. L. Persson (2008). "Clinical findings in men with chronic pain after falanga torture." Clin J Pain **24**(2): 135-141.

OBJECTIVES: To explore clinical findings in men with chronic pain after falanga torture as compared with controls, and to try to understand the nature of the pain mechanisms responsible. METHODS: Eleven male torture victims from the Middle East with chronic pain after falanga, and 11 age, sex, and ethnically matched controls with no history of torture were recruited. All participants were interviewed regarding pain characteristics in the feet and lower legs at rest and when walking. Structural changes and motor and sensory function were clinically assessed according to a standardized protocol. The walking pattern was observed for compensatory gait patterns. RESULTS: The torture victims had pain in their feet and lower legs and a compensated gait pattern, usually with severe pain during walking. Reduced light touch and thermal sensation, tactile dysesthesia, allodynia, and tenderness on palpation were common findings. Structural changes in the feet were found in more than half of the victims, but did not correlate with pain reports. These clinical findings were nonexistent or seen only rarely in controls. DISCUSSION: We found clear clinical signs of nerve injury in the feet. The sensory findings indicated 2 neuropathic pain mechanisms, one dominated by a peripheral pain generator and other by irritative phenomena (dysesthesia, allodynia), indicating central sensitization. It is reasonable to assume that these changes are due to the falanga exposure. A nociceptive contribution cannot be excluded. It is important to perform an individual diagnostic analysis to facilitate adequate treatment.

Prip, K., et al. (2012). "Pain when walking: individual sensory profiles in the foot soles of torture victims - a controlled study using quantitative sensory testing." BMC Int Health Hum Rights **12**: 40.

ABSTRACT: BACKGROUND: With quantitative sensory testing (QST) we recently found no differences in sensory function of the foot soles between groups of torture victims with or without exposure to falanga (beatings under the feet). Compared to matched controls the torture victims had hyperalgesia to deep mechano-nociceptive stimuli and hypoesthesia to non-noxious cutaneous stimuli. The purpose of the present paper was to extend the group analysis into individual sensory profiles of victims' feet to explore possible relations between external violence (torture), reported pain, sensory symptoms and QST data to help clarify the underlying mechanisms. METHODS: We employed interviews and assessments of the pain and sensory symptoms and QST by investigators blinded to whether the patients, 32 male torture victims from the Middle East, had (n=15), or had not (n=17) been exposed to falanga. Pain intensity, area and stimulus dependence were used to characterize the pain. QST included thresholds for touch, cold, warmth, cold-pain, heat-pain, deep pressure pain and wind-up to cutaneous noxious stimuli. An ethnically matched control group was available.The normality criterion, from our control group data, was set as the mean +/- 1.28SD, thus including 80% of all values.QST data were transformed into three categories in relation to our normality range; hypoesthesia, normoesthesia or hyperesthesia/hyperalgesia. RESULTS: Most patients, irrespective of having been exposed to falanga or not, reported severe pain when walking. This was often associated with hyperalgesia to deep mechanical pressure. Hypoesthesia to mechanical stimuli co-occurred with numbness, burning and with deep mechanical hyperalgesia more often than not, but otherwise, a hypoesthesia to cutaneous sensory modalities did not co-occur systematically to falanga, pain or sensory symptoms. CONCLUSION: In torture victims, there seem to be overriding mechanisms, manifested by hyperalgesia to pressure pain, which is usually considered a sign of centralization. In addition there was cutaneous hypoesthesia, but since there was no obvious correlation to the localization of trauma, these findings may indicate centrally evoked disturbances in sensory transmission, that is, central inhibition. We interpret these findings as a sign of changes in central sensory processing as the unifying pathological mechanism of chronic pain in these persons.

Prip, K., et al. (2012). "Sensory functions in the foot soles in victims of generalized torture, in victims also beaten under the feet (falanga) and in healthy controls -- A blinded study using quantitative sensory testing." BMC Int Health Hum Rights **12**(1): 39.

ABSTRACT: BACKGROUND: Falanga torture (beatings on the foot soles) produces local chronic pain and severe walking difficulties. We have previously reported signs of neuropathic pain in the feet of falanga victims. The objective here was to clarify underlying pain mechanisms by quantifying sensory impairments in the feet of torture victims who had experienced both generalized torture and those who had been exposed to falanga in addition. An ethnically matched control group was available. METHODS: We employed quantitative sensory testing (QST) by investigators blinded to whether the patients, 32 male torture victims from the Middle East, had (n=15), or had not (n=17) been exposed to falanga. Pain intensity, area and stimulus dependence were used to characterize the pain as were interview data on sensory symptoms. QST included thresholds for touch, cold, warmth, cold-pain, heat-pain, deep pressure pain and wind-up to cutaneous noxious stimuli in the foot soles. Clinical data on anxiety and depression were retrieved. RESULTS: Almost all falanga victims had moderate or strong pain in their feet and in twice as large an area of their foot soles as other torture victims. One-third of the latter had no pain in their feet and many reported slight pain; in spite of this, there were no differences in foot sole QST data between the tortured groups. A comparison with normal data indicated that both tortured groups had hypoesthesia for all cutaneous sensory fibre groups except those transmitting cold and heat pain, in addition to deep mechano-nociceptive hyperalgesia. CONCLUSION: A comparison of the QST data between victims having been exposed to generalized torture and victims who in addition had been exposed to falanga, showed no differences on the group level. The sensory disturbances in relation to our control group are compatible with central sensitization and de-sensitization, pointing to a core role of central mechanisms. A further analysis to create individual sensory profiles from our measurements is in progress.

Punamaki, R. L., et al. (2010). "Nature of torture, PTSD, and somatic symptoms among political ex-prisoners." J Trauma Stress **23**(4): 532-536.

The authors examined how different types of torture methods are associated with posttraumatic stress disorder (PTSD) and somatic symptoms among political ex-prisoners. Participants were 275 Palestinian men who reported their experiences in detention and imprisonment, PTSD (the Harvard Trauma Questionnaire), and somatic symptoms. A principal component analysis revealed physical torture, psychological torture, sensory discomfort and deprivation, and beatings as dimensions of exposure to torture. Both physical and psychological torture methods were associated with increased PTSD symptoms, especially when combined. Psychological torture was also associated with increased somatic symptoms. The results are discussed in relation to their contribution to the current debate on the nature and definition of torture.

Quiroga, J. (2009). "Torture in children." Torture **19**(2): 66-87.

This is a review article that studies the problem of torture in children. Torture in children is a significant worldwide problem, but there are no official or reliable independent statistics to measure the magnitude of the problem. The definition of torture in the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment applies to adults and children. The Convention on the Rights of the Child defines children as "every human being below the age of eighteen years". Torture in children happens during peace times and during political violence and war conflicts. The majority of torture victims happen during peace times. The high-risk groups are impoverished children living in the street, children

deprived of parental care, children in conflict with the law, and children in detention. During political violence and war the high risk children are the children detained during political violence, child soldiers, children internally displaced in refugee camps, detained children during the war against terrorism and children tortured by peacekeeping forces. The perpetrators of torture in children are the members of the same forces that torture adults, generally the police, civil police, security guards trained by police, prison guards, and military forces. The paper identifies some preventive measure and develops recommendations for action at the local, national and international level.

Rakatansky, H. (2009). "Doctors and torture." Med Health R I **92**(8): 286-287.

Rasmussen, A., et al. (2011). "Screening for Torture: A Narrative Checklist Comparing Legal Definitions in a Torture Treatment Clinic." Z Psychol **219**(3): 143-149.

Torture has been defined most precisely in legal contexts. Practitioners who work with torture survivors and researchers who study torture have frequently cited legal definitions, particularly those in the United States' Torture Victims Relief Act, the United Nations Convention against Torture, or the World Medical Association's Declaration of Tokyo. Few practitioners have operationalized these definitions and applied them in their practice. We describe how a New York City torture treatment clinic used a coding checklist that operationalizes the definitions, and present results. We found that in practice these definitions were nested; that using guidelines for applying the definitions in practice altered the number of cases meeting criteria for these definitions; and that the severity of psychological symptoms did not differ between those who were tortured and those who were not under any definition. We propose theoretical and practical implications of these findings.

Reeler, T., et al. (2009). "The Tree of Life: a community approach to empowering and healing the survivors of torture in Zimbabwe." Torture **19**(3): 180-193.

The article explores the effectiveness of the use of an empowerment workshop, called the Tree of Life, in the treatment of torture survivors. The approach is based on a survivor-to-survivor model of assistance. Research into the effectiveness of the method is carried out using a pre- and post measures using a psychiatric screening instrument, measuring depression and anxiety. Participants were also asked for feedback in a structured self-report upon completion of the workshop. In addition, an exit interview was conducted after follow-up, three months after the first workshop session. A total of 73 persons attended the workshops, and detailed follow up data was only available for 33. 36% showed significant clinical improvement, and the sample as a whole showed significant changes in their psychological state. More complete information was available for a smaller sample [19], which showed 39% having significant improvement. On follow-up, 44% were still experiencing difficulties, with most (72%) experiencing economic difficulties. On the positive side, 56% reported coping better, only 9% reported health problems, and most were still connected to the group with which they participated in the process. All felt that that the process had helped them, had helped them new things, and had changed in the way that they felt about their torture. The Tree of Life appears to be a useful, cost-effective, non-professional method of assisting torture survivors.

Reeve, A. M. (2011). "Medically assessing refugees who may have been victims of torture." N Z Med J **124**(1338): 15-17.

Reyes, H. (2008). "Doctors in prison: documenting torture in detention." Torture **18**(3): 179-182.

Riska, O. (2008). "[Medical proof of torture use in the USA]." Tidsskr Nor Laegeforen **128**(16): 1860.

Rubenstein, L. S. and S. N. Xenakis (2010). "Roles of CIA physicians in enhanced interrogation and torture of detainees." JAMA **304**(5): 569-570.

Sanders, J., et al. (2009). "The epidemiology of torture: a case series of 58 survivors of torture." Forensic Sci Int **189**(1-3): e1-7.

INTRODUCTION/CONTEXT: Torture is widely practiced throughout the world and, yet, the ways by which torture is perpetrated, its regional similarities and differences, is not well understood. Our goal for this cases series was to elucidate the methods of torture practiced within different countries to both add to and expand upon previous research. This knowledge is important since it can buttress efforts to assist with torture survivors' recovery--medically, psychologically, and legally. METHODS: Fifty-eight survivors of torture who presented to a single interviewer over a 15-year period (1990-2005) for purposes of assisting with their claim for political asylum in the U.S. were enrolled into the study. The survivors' legal affidavits were examined and both quantitative and qualitative data were extracted for analysis. This data included the following: (1) duration, condition, and frequency of imprisonment, (2) abductors' affiliation and dress, (3) torture type, method, and frequency (both physical and mental), and (4) qualitative description of above items. RESULTS: Twenty-three countries were represented in the sample covering six major world regions. Women appear to be at greater risk for sexual torture than men. Sub-Saharan Africans tend to have more abuse compared to other world regions. Furthermore, the length of confinement also appears to trend towards longer duration in those survivors from Sub-Saharan African countries. Certain types of torture were almost universal in their application such as threats of death and beatings, but the manner by which survivors were beaten varied considerably, with hitting/kicking and beating with a stick/baton being the most common. There was no correlation between types of torturous acts and religion. CONCLUSION: This case series confirms some earlier findings about regional similarities and differences in torture methodology. Study results built upon previous studies as well as uncovered new findings suggesting that more work needs to be done. Further, our results will help survivors of torture with their recovery both through improved patient care outcomes and by impacting upon the way asylum cases are adjudicated.

Schubert, C. C. and R. L. Punamaki (2011). "Mental health among torture survivors: cultural background, refugee status and gender." Nord J Psychiatry **65**(3): 175-182.

BACKGROUND: The experience of torture places the survivors at a heightened risk for somatic and mental health problems. AIMS: This study examined the role of culture, refugee status and gender in the mental and somatic health among help-seekers in a centre for torture survivors in Finland. METHOD: The 78 participants (29 women and 49 men) were interviewed and assessed with the Impact of Event Scale-Revised (IES-R) and the Hopkins Symptom Checklist-25 (HSCL-25) scales and their somatic complaints were registered. Groups with Middle Eastern, Central African, Southern Asian and South Eastern European cultural backgrounds were compared. RESULTS: Group differences were found in post-traumatic stress disorder (PTSD) and depressive symptoms and somatic complaints. As hypothesized, Southern European torture survivors showed a higher level of PTSD than

cultural groups from more traditional collective societies in Middle East, Asia and Africa, and more depressive symptoms than survivors from a Southern Asian background. Against the hypothesis, South Eastern European subjects reported also more somatic complaints than Central African survivors. Women suffered more from PTSD and depressive symptoms than men in all cultural groups. Asylum-seeking status was marginally associated with anxiety symptoms only in the South Eastern European group. CONCLUSION: Health services should consider the influence of culture in the expression of psychological and somatic symptoms and avoid a simplistic distinction between somatic and psychological expressions of pain.

Seltzer, A. (2010). "Medical complicity, torture, and the war on terror." Lancet **375**(9718): 872-873.

Siddiqui, N. A., et al. (2012). "Physician Involvement in Torture: An Ethical Perspective." J Med Humanit.

Evidence proves that physician involvement in torture is widely practiced in society. Despite its status as an illegal act as established by multiple international organizations, mandates are routinely unheeded and feebly enforced. Philosophies condemning and condoning torture are examined as well as physicians' professional responsibilities and the manner in which such varying allegiances can be persuasive. Physician involvement in torture has proven detrimental to the core values of medicine and has tainted the field's commitment to individuals' health and well-being. Only when this complex issue is addressed using a multilevel approach will the moral rehabilitation of medicine begin.

Silove, D. M. and S. J. Rees (2010). "Interrogating the role of mental health professionals in assessing torture." BMJ **340**: c124.

Sinamati, A., et al. (2011). "Osteological proofs of torture and cruelty: forensic findings form a secret cemetery in Tirana, Albania." Torture **21**(3): 197-207.

Two decades after the fall of the communism in Albania, documenting the human rights violations and proving torture and cruelties suffered from ex-politically persecuted and dissidents of the regime, is still a societal priority. Due to several reasons, the judicial way toward redressing the historical injustices has been slowed down. This is mainly because of the lack of proper documentation of torture, mass executions and extrajudicial ill-treatment. Several governmental and civil society organizations have tried to define the issue, but perpetrators have rarely, if ever, been brought to court. Secret cemeteries and mass graves have recently been found in different zones of Albania, and victims exhumed; thus proofs of torture and ill-treatments are being made widely known, potentially creating the necessary legal conditions for punishing the perpetrators and for identifying victims. In the present paper, authors describe osteological forensic findings from Linza secret cemetery in Tirana, where several ante mortem fractures prove the severe and cruel ill-treatment the victims suffered before the execution that was usually by bullet shot in the posterior region of the skull.

Singh, H. K., et al. (2008). "Oral health status of refugee torture survivors seeking care in the United States." Am J Public Health **98**(12): 2181-2182.

We assessed the oral health status of 216 refugee torture survivors seeking care at an urban torture treatment center in the United States. Results showed that patients' dental health ranged from poor to fair; 76% had untreated cavities, and approximately 90% required

immediate or near-immediate dental care. Torture treatment centers, in addition to offering safe environments for educating and examining patients, are ideal settings to provide basic oral health services without the risk of retraumatization.

Sjolund, B. H., et al. (2009). "Rehabilitating torture survivors." J Rehabil Med **41**(9): 689-696.

Refugees have often been exposed to torture in their countries of origin. A core issue is the resulting multifaceted presentation of somatic, psychological and social problems in the same individual, leading to severe activity limitations and participation restrictions. An international conference, "Rehabilitating Torture Survivors", was organized by the Rehabilitation and Research Centre for Torture Victims (a rehabilitation clinic and global knowledge and research centre with government support) in collaboration with the Centre for Transcultural Psychiatry at Rigshospitalet in Copenhagen, Denmark, in December 2008. The main topics were: the context of torture; mental problems including psychotherapy; internet-based therapy and pharmaco-therapy; chronic pain; social integration and family; and functioning and rehabilitation. Available evidence highlights the importance of an interdisciplinary approach to rehabilitation, but scientifically rigorous studies of comprehensive rehabilitation programmes for torture survivors are lacking. Therefore, effect studies are urgently warranted. Nevertheless, by combining expertise from different scientific and professional areas, important elements in the problems of torture survivors can be addressed from an evidence base generated both from traumatized and non-traumatized patient populations. Thus, trauma-focused cognitive behavioural therapy and/or eye movement desensitization and reprocessing, as well as interdisciplinary pain rehabilitation, should be components of a successful rehabilitation process, and great attention should be paid to contextual components.

Speers, R. D., et al. (2008). "Preventing dentists' involvement in torture: the developmental history of a new international declaration." J Am Dent Assoc **139**(12): 1667-1673.

BACKGROUND: For more than half a century, the risk of physicians participating in torture has received thoughtful attention in the field of medicine, and a number of international organizations have issued declarations decrying such involvement. Despite publications that provide evidence of dentists' having participated in torture as well, until recently the dental profession was quiescent on the subject. METHODS: The authors describe the historical background for a new declaration against dentists' participation in torture developed by the International Dental Ethics and Law Society and the Federation Dentaire Internationale (FDI) World Dental Federation. They review various levels of involvement by dentists in torture and related activities in reference to existing World Medical Association declarations. Finally, they outline the process of drafting the new dental declaration, which was adopted by the FDI in October 2007. CLINICAL IMPLICATIONS: The authors provide insight and guidance to clinicians who diligently serve their patients, unaware that they may face military or other pressures to participate in torture.

Spiric, Z., et al. (2010). "[Gender differences in victims of war torture: types of torture and psychological consequences]." Vojnosanit Pregl **67**(5): 411-418.

BACKGROUND/AIM: Torture for political reasons is an extreme violence in interpersonal relations resulting in not only acute psychiatric disorders but also very often in very severe and far reaching negative consequences for the overall psychosocial functioning of a victim. The aim of this study was to investigate gender differences in types of torture and psychological consequences in subjects who experienced war torture. METHODS: A sample

(410 men and 76 women) included clients of "Centre for rehabilitation of torture victims--IAN, Belgrade" who experienced torture in prisons and concentration camps during civil wars in ex-Yugoslavia 1991-1995 and 1999. Types of Torture Questionnaire with 81 items was used for collecting data about forms of torture. Symptom Checklist 90-Revised (SCL-90-R) was used for assessing type and intensity of psychological symptoms, and Impact of Event Scale (IES) was used to estimate posttraumatic complaints. RESULTS: A gender difference was found for 33 types of torture: 28 more frequent in men, and 5 in women. Factor analysis of torture types revealed three factors explaining 29% of variance: "common torture", "sadistic torture", and "sexual torture". Discriminant analysis revealed significant gender difference concerning the factors. "Common torture" and "sadistic torture" were more prominent in men, and "sexual torture" was more present in women. Higher scores on depression, anxiety, somatization, interpersonal sensitivity and obsessive-compulsive dimensions on SCL-90-R were found in women. General score and scores of subscales (intrusion and avoidance) on IES were significantly higher in women. CONCLUSION: Women exposed to war torture experienced less torture techniques and shorter inprisonment than men, but had more frequent and severe symptoms of posttraumatic stress disorder and other psychological symptoms. Gender differences in posttraumatic symptomatology can not be explained exclusively by gender differences in types of torture found in this study.

Stam, A. C., et al. (2012). "Fear and attitudes towards torture and preventive war." Twin Res Hum Genet **15**(1): 60-70.

This paper examines the association between individuals' beliefs that the world is a dangerous place and their support for a variety of national security policies. We find that the source of the covariance between perceived danger and support for aggressive national security policies is primarily due to a common genetic factor. Latent genetic factors that influence individuals' perception of danger also appear to influence their positions on policies purported to alleviate such danger. Covariation between individuals' experiences and genes suggests that priming messages alone do not drive the covariation between feelings of danger and acceptance of policy changes.

Steel, Z., et al. (2009). "Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis." JAMA **302**(5): 537-549.

CONTEXT: Uncertainties continue about the roles that methodological factors and key risk factors, particularly torture and other potentially traumatic events (PTEs), play in the variation of reported prevalence rates of posttraumatic stress disorder (PTSD) and depression across epidemiologic surveys among postconflict populations worldwide. OBJECTIVE: To undertake a systematic review and meta-regression of the prevalence rates of PTSD and depression in the refugee and postconflict mental health field. DATA SOURCES: An initial pool of 5904 articles, identified through MEDLINE, PsycINFO and PILOTS, of surveys involving refugee, conflict-affected populations, or both, published in English-language journals between 1980 and May 2009. STUDY SELECTION: Surveys were limited to those of adult populations (n > or = 50) reporting PTSD prevalence, depression prevalence, or both. Excluded surveys comprised patients, war veterans, and civilian populations (nonrefugees/asylum seekers) from high-income countries exposed to terrorist attacks or involved in distal conflicts (> or = 25 years). DATA EXTRACTION: Methodological factors (response rate, sample size and design, diagnostic method) and substantive factors (sociodemographics, place of survey, torture and other PTEs, Political Terror Scale score, residency status, time since conflict). DATA SYNTHESIS: A total of 161 articles reporting results of 181 surveys comprising 81,866 refugees and other conflict-affected persons from

40 countries were identified. Rates of reported PTSD and depression showed large intersurvey variability (0%-99% and 3%-85.5%, respectively). The unadjusted weighted prevalence rate reported across all surveys for PTSD was 30.6% (95% CI, 26.3%-35.2%) and for depression was 30.8% (95% CI, 26.3%-35.6%). Methodological factors accounted for 12.9% and 27.7% PTSD and depression, respectively. Nonrandom sampling, small sample sizes, and self-report questionnaires were associated with higher rates of mental disorder. Adjusting for methodological factors, reported torture (Delta total R(2) between base methodological model and base model + substantive factor [DeltaR(2)] = 23.6%; OR, 2.01; 95% CI, 1.52-2.65) emerged as the strongest factor associated with PTSD, followed by cumulative exposure to PTEs (DeltaR(2) = 10.8%; OR, 1.52; 95% CI, 1.21-1.91), time since conflict (DeltaR(2) = 10%; OR, 0.77; 95% CI, 0.66-0.91), and assessed level of political terror (DeltaR(2) = 3.5%; OR, 1.60; 95% CI, 1.03-2.50). For depression, significant factors were number of PTEs (DeltaR(2) = 22.0%; OR, 1.64; 95% CI, 1.39-1.93), time since conflict (DeltaR(2) = 21.9%; OR, 0.80; 95% CI, 0.69-0.93), reported torture (DeltaR(2) = 11.4%; OR, 1.48; 95% CI, 1.07-2.04), and residency status (DeltaR(2) = 5.0%; OR, 1.30; 95% CI, 1.07-1.57). CONCLUSION: Methodological factors and substantive population risk factors, such as exposure to torture and other PTEs, after adjusting for methodological factors account for higher rates of reported prevalence of PTSD and depression.

Strozier, C. B. (2011). "Torture, war, and the culture of fear after 9/11." Int J Group Psychother **61**(1): 67-72.

Sydhoff, B. (2010). "Combating torture with medical evidence--the use of medical evidence and expert opinions in international and regional judicial mechanisms and in selected domestic jurisdictions. Foreword." Torture **20**(3): 117-118.

Tamblyn, J. M., et al. (2011). "Patients from abroad becoming patients in everyday practice: torture survivors in primary care." J Immigr Minor Health **13**(4): 798-801.

Since 1975, over 3.5 million refugees have resettled in the United States, many of whom have experienced some form of torture, and little data exists on their primary care needs. This is retrospective chart-review of sixty-one torture survivors in Denver, Colorado. The patients were predominantly from Africa, 88% experienced physical torture, 21% sexual torture. Medical conditions included: major depression (45%), PTSD (48%), anxiety (31%), insomnia (50%), hypertension (29%), dyslipidemia (6%), HIV (6%) and tuberculosis class 2-4 (32%). Physical torture increased rates of PTSD (OR 7.29; CI 1.81, 29.45) and insomnia (OR 5.08; CI 1.41, 18.34). Sexual torture increased rates of major depression (OR 5.44; CI 1.29, 22.99), PTSD (OR 8.24; CI 1.61, 42.18), and insomnia (OR 6.84; CI 1.34, 34.90). Somatic complaints were more frequent in those who had experienced sexual torture (P = 0.041). Torture survivors have complex primary care needs, requiring multidisciplinary treatment.

Tanne, J. H. (2010). "Bush administration should be investigated for torture of prisoners, says human rights group." BMJ **340**: c3182.

Thomas, N. K. (2011). "On turning a blind eye and a deaf ear: society's response to the use of torture." Int J Group Psychother **61**(1): 6-25.

The present paper undertakes an individual and group psychoanalytic examination of what happens to the citizens of a society that not only condones but authorizes torture. Drawing

on the experiences of countries like those in Latin America during the period of the military dictatorships of the 1970s and 1980s, South Africa during the apartheid years, the Nazi era in Germany in the 1930s and 1940s, and Eastern Europe in the Communist era, the author focuses on the denial that was necessary to maintain daily life. At the same time, such denial and its accompanying "compartmentalization" produced a citizenry that was both blind and deaf to the practices and ultimately supported the dangerous hypocrisy of the respective political regimes. The impact of such "blindness" and "deafness" to the use of torture and abrogation of basic civil rights on the psychological life of individuals and society is examined for its parallels to our current times within the United States.

Thomas, S. P. (2010). "American Academy of Nursing policy on torture." Nurs Outlook **58**(1): 5.

Thompson, H. (2010). "Savage poetry: torture and cruelty in Mirbeau and Barbey d'Aurevilly." Fr Stud **64**(4): 410-422.

Octave Mirbeau's Le Jardin des supplices and Barbey d'Aurevilly's L'Ensorcelee and Les Diaboliques depict a range of cruel attacks on the human body. These examples of violence, hitherto neglected by critical readers of the texts, have much to tell us not only about the authors' approach to violence, but also about the relationships between author, reader, and text that such representations of violence foreground. The notion of readerly pleasure theorized by Roland Barthes and linked to identity formation by Emma Wilson is associated with the witnessing or experiencing of pain in these texts. The reader is problematically positioned as both sadist, vicariously enjoying the suffering he or she is forced to witness, and masochist, taking pleasure in the authors' manipulations of them. These depictions of violated bodies ask whether and by what means violence can be represented in language, and this discussion leads to an analysis of the impact that such representations of violence have on the reader's experience of a text.

Tinta, M. F. (2009). "Legal consequences for torture in children cases: the Gomez Paquiyauri Brothers vs Peru case." Torture **19**(2): 118-131.

The Gomez Paquiyauri Brothers case, before the Inter-American Court of Human Rights, was the first international case concerning the protection of children in the context of armed conflict where an international court stated the law concerning the duties of States towards children even in the context of war, and provided for reparations. As such it represents a landmark decision. The case arose from the illegal detention, torture and extrajudicial execution of two minors, Emilio and Rafael Gomez Paquiyauri, at the hands of Peruvian Police in 1991, under the Fujimori Administration at a time when the internal war in Peru was at its peak. Unlike most cases coming to the jurisdiction of the Inter-American Court, the case had been subject to domestic criminal investigations that had led to the convictions of two low ranking policemen. Yet a more subtle pattern of impunity lied at the root of the case. Torture had been denied by the State, and the prosecutions of low ranking policemen had intended to cover up the responsibility of those who ordered a policy of torture and executions (including the existence of secret codes for the torture and elimination of suspects of "terrorism") during the years of the internal armed conflict in Peru. The joint work of legal and medical expertise in the litigation of the case permitted the establishment of the facts and the law, obtaining an award of 740,500 dollars for the victims and a number of measures of reparation including guarantees of non-repetition and satisfaction, such as the naming of a school after the victims.

Tol, W. A., et al. (2009). "Brief multi-disciplinary treatment for torture survivors in Nepal: a naturalistic comparative study." Int J Soc Psychiatry **55**(1): 39-56.

BACKGROUND: Little is known about the effectiveness of treatment for torture survivors in low-income settings. Multi-disciplinary treatment is an often used approach for this target group. AIMS: This study was aimed at examining the effectiveness of brief multi-disciplinary treatment for torture survivors in Nepal. METHODS: A naturalistic comparative design with help-seeking torture survivors and internally displaced persons assigned to a treatment and a comparison group respectively (n = 192; treatment group n = 111, comparison group n = 81), with baseline measurements on psychiatric symptomatology, disability, and functioning and a five-month follow-up (n = 107; treatment group n = 62; comparison group n = 45), was employed. Intervention consisted of brief psychosocial services, minimal medical services and/or legal assistance. RESULTS: Study groups were generally comparable and non-completers did not significantly differ from completers. The treatment group improved more than the comparison group on somatic symptoms, subjective well-being, disability and functioning, with mostly moderate effect sizes. CONCLUSION: Treatment was moderately effective, with regards to reducing the nonspecific mental health consequences of torture, but disability scores remained high. For clients presenting with more severe mental health problems, other treatments that are realistic in the resource-poor Nepali context need to be sought.

Torp-Pedersen, S., et al. (2009). "Vascular response to ischemia in the feet of falanga torture victims and normal controls--color and spectral Doppler findings." Torture **19**(1): 12-18.

OBJECTIVE: To investigate whether signs of chronic compartment syndrome could be found in plantar muscles of falanga torture victims with painful feet and impaired gait. The hypothesis was that the muscular vascular response to two minutes ischemia would be decreased in torture victims compared to controls. On color Doppler this would be seen as less color after ischemia and on spectral Doppler as elevated resistive index (RI). METHODS: Ten male torture victims from the Middle East and nine age, sex and ethnically matched controls underwent Doppler examination of the abductor hallucis and flexor digitorum brevis muscles before and after two minutes ischemia induced with a pressure cuff over the malleoli. The color Doppler findings were quantified with the color fraction (CF) before and after ischemia. On spectral Doppler the resistive index was measured once before and three consecutive times after ischemia. RESULTS: Both torture victims and controls responded to ischemia with an increased CF. There was no difference between torture victims and controls. With spectral Doppler all subjects had an RI of 1.0 before ischemia. After ischemia, in nearly all subjects and all muscles the first RI was lowest, the second was higher and the third was highest indicating that the response to ischemia was disappearing as measurements were made. There was a trend that the first RI was higher in torture victims than in controls. DISCUSSION: The study was not able to confirm the presence of chronic compartment syndrome. However, the trend in RI still supports the hypothesis. The negative findings may be due to inadequate design where the CF and RI were measured in one setting, perhaps resulting in both methods being applied imperfectly. The response to ischemia seems short-lived and we suggest that the Doppler methods may be re-evaluated with separate ischemic phases for CF and RI.

Tufan, A. E., et al. (2012). "Post-traumatic stress disorder among asylum seekers and refugees in Istanbul may be predicted by torture and loss due to violence." Nord J Psychiatry.

Background: Turkey is both a source and target for asylum seekers seeking refugee status in countries of European Union. There is a scarcity of research on the mental health issues of

asylum seekers and refugees residing in Turkey. Aims: This study aimed: 1) to provide clinical and demographic information on asylum seekers and refugees receiving mental health services from a non-governmental refugee support program in Istanbul between 2005 and 2007, and 2) to evaluate the differences between patients diagnosed with post-traumatic stress disorder (PTSD) with those who did not meet criteria. Methods: The study was conducted at the Mental Health Division of the Refugee Advocacy Support Group. Between July 2005 and February 2007, 1209 asylum seekers applied to the support group; 75 of these individuals (6.2%) were referred for psychiatric evaluation while 57 were diagnosed as having a psychopathology. The number of analyzed subjects was 57. Results: PTSD and major depressive disorder were the most common diagnoses (55.2% for both). The most common criteria of PTSD reported were problems in concentration and social isolation (97.3% for both). Suffering torture and losing a significant other due to violence were found to be associated with a diagnosis of PTSD. Conclusions: This study is the first of its kind to be conducted on a mixed refugee population residing in Turkey and focusing on their mental health problems. Our results should be tested within larger samples of refugees residing in different cities of Turkey.

Vieira, D. N. (2012). "Forensic evidence against torture. Editorial." Torture **22 Suppl 1**: 1-4.

Volpellier, M. (2009). "Physical forensic signs of sexual torture in children. A guideline for non specialized medical examiners." Torture **19**(2): 157-166.

Proper forensic documentation of sexual torture in children is crucial. Informed consent for examination and documentation must be sought from the child/accompanying person and the examination conducted in a sensitive and respectful manner. Time should be given to the child to relate the history of torture and the examiner should start with open ended questions. The history of torture should be recorded verbatim as much as possible. The words used to describe the anatomy and the forensic findings have to be precisely defined. The child should be examined from head to toe and should be left partially clothed. Penile, digital or object penetration of the vagina does not always lead to injuries even if the child is seen very soon after the abuse. Genital injuries heal rapidly and can leave no scars. Penile, digital or object penetration of the anus does not always lead to injuries even if the child is seen very soon after the abuse. Sexual torture cannot be disproved by the absence of injuries or scars.

von Gunten, C. F. (2011). "Hospice care, medical torture, and Blockbuster video." J Palliat Med **14**(2): 122-123.

Wang, S. J., et al. (2009). "Household exposure to violence and human rights violations in western Bangladesh (II): history of torture and other traumatic experience of violence and functional assessment of victims." BMC Int Health Hum Rights **9**: 31.

BACKGROUND: Organised crime and political violence (OPV) and human rights violations have marred Bangladesh history since 1971. Little is known about the consequences for the oppressed population. This study describes the patterns of OPV and human rights violations in a disturbed area of Bangladesh and assesses the physical, emotional and social functioning of victims. METHODS: A total of 236 of selected participants in a household survey in Meherpur district were recruited for a detailed study. Interviews and physical examinations were used to obtain information about history of torture and other cruel, inhuman or degrading treatment or punishment (TCIDTP), and about injuries, pain frequency and

intensity. Handgrip strength and standing balance performance were measured. The "WHO-5 Well-being" scale was used to assess the subjective emotional well-being of study participants. RESULTS: The majority of the reported cases of TCIDTP occurred in 2000-2008, 51% of incidents occurred during winter; 32.0% between 20:00 and midnight. Police involvement was reported in 75% of cases. Incidents took place at victims' homes (46.7%), or at the police station, military camp, in custody or in prison (21.9%). Participants experienced 1-10 TCIDTP methods and reported 0-6 injury locations on their bodies; 77.5% reported having at least two injuries. Less than half of the participants were able to stand on one leg for 30 seconds. Only 7.5% of males aged 25-44 had handgrip strength in both hands exceeding average values for healthy people at the same age. Over 85% of participants scored low (<13) on the 25-point "WHO-5 Well-being" scale. The number of years since the TCIDTP event, pain frequency, the need to quit a job to take care of an injured family member, political involvement, personal conflicts and the fear of neighbourhood violence strongly affected emotional well-being. Good emotional well-being correlated with increased political and social participation. CONCLUSION: A detailed picture of characteristics of the victimisation is presented. The participants showed poor emotional well-being and reduced physical capacity. The results indicated that the simple and rapid method of assessment used here is a promising tool that could be used to monitor the quality and outcome of rehabilitation.

Wannag, S. A. (2010). "[Attitude of medical associations towards torture]." Tidsskr Nor Laegeforen **130**(13): 1333.

Westermeyer, J., et al. (2011). "Comparison of two methods of inquiry for torture with East African refugees: single query versus checklist." Torture **21**(3): 155-172.

PURPOSE: First to compare two methods of inquiry regarding torture: i.e., the traditional means of inquiry versus a checklist of torture experiences previously identified for these African refugees. Second, we hoped to identify factors that might influence refugees to not report torture on a single query when checklist data indicated torture events had occurred or to report torture when checklist data indicated that torture had not occurred. METHOD: Consisted of queries to 1,134 community-dwelling East African refugees (Somalia and Ethiopia) regarding the presence-versus-absence of torture in Africa (single query), a checklist of torture experiences in Africa that we had previously identified as occurring in these groups, demography, non-torture traumatic experiences in Africa, and current posttraumatic symptoms. RESULTS: Showed that 14% of the study participants reported a torture experience on a checklist, but not on a single query. Nine percent responded positively to the single query on torture, but then failed to check any torture experience. Those reporting trauma on an open-ended query, but not on a checklist, had been highly traumatized in other ways (warfare, civil chaos, robbery, assault, rape, trauma during flight out of the country). Those who reported torture on the checklist but not on the single query reported fewer instances of torture, suggesting that perhaps a "threshold" of torture experience influenced the single-query report. In addition, certain types of torture appeared more apt to be associated with a singlequery endorsement of torture. On regression analysis, a single-query self-report of torture was associated with traumatic experiences consistent with torture, older age, female gender, and nontorture trauma in Africa. CONCLUSION: Inconsistent reporting of torture occurred when two methods of inquiry (one openended and one a checklist) were employed in this sample. We believe that specific contexts of torture and non-torture trauma, together with individual demographic characteristics and severity of the trauma, affect the self-perception of having been tortured. Specific

information regarding these contexts, demographic characteristics, and trauma severity are presented in the report.

Williams, A. C., et al. (2010). "Persistent pain in survivors of torture: a cohort study." J Pain Symptom Manage **40**(5): 715-722.

CONTEXT: Refugee survivors of torture in the United Kingdom have multiple problems, of which pain may be underrecognized, given the high prevalence recorded in similar populations in Denmark. OBJECTIVES: To establish in a UK sample the prevalence of persistent pain and to investigate associations between specific pains and torture methods. METHODS: A cohort of a random 20% sample attending a specialist UK center for survivors of torture in 2005 was taken. All complaints of pain recorded at initial interview were categorized for body site and putative pain mechanism. These were compared with the database of personal variables and data on torture using odds ratios (ORs) and exact probability. RESULTS: Of 115 men and 63 women, with mean age of 30 years, 78% reported persistent multiple pains, mainly in the head and low back. They had experienced a median of six torture methods. There was a clear association between female abdominal/pelvic/genital pain and rape/sexual assault (17 of 34 vs. zero of 17: exact P<0.001) and between male anal pain and rape (two of nine vs. two of 77: OR=6.00; 95% confidence interval=1.79-20). Tests of foot/leg pain with falaka and shoulder pain with suspension did not show expected associations. CONCLUSION: A significant relationship emerged between torture and report of persistent pain at a high prevalence. Findings do not support the widespread clinical assumption that complaint of persistent pain after torture is predominantly a manifestation of psychological distress. Rather, complaints of pain in torture survivors should be assessed and treated in relation to physical trauma.

Winter, A. M. (2011). "Social services: effective practices in serving survivors of torture." Torture **21**(1): 48-55.

Wynia, M. K. (2008). "Laying the groundwork for a defense against participation in torture?" Hastings Cent Rep **38**(1): 11-13.

Yen, P. M. (2008). "Waterboarding is not torture: a physician's response." Lancet **371**(9627): 1838.

Yudkin, J. S. (2009). "The Israeli Medical Association and doctors' complicity in torture." BMJ **339**: b4078.

Yudkin, J. S., et al. (2010). "Medical complicity in torture. Time for WMA to take action." BMJ **341**: c4105.

Zarocostas, J. (2009). "Medical professionals' role in torture in secret prisons was "gross breach" of ethics, says Red Cross." BMJ **338**: b1546.

Zarocostas, J. (2011). "Torture of adults and children detained in Afghan conflict is widespread, finds UN." BMJ **343**: d6773.

(Source: PUBMED)

Books (selection)

The following list includes a selected, and by no means complete list of books on key aspects of legal, medical and psychological aspects of torture. Books that are available as free internet based downloads, have been listed in the "recommended links" manual.

1. *T. Elbert , R. Weierstall , A. Maercker:* Torture. Hogrefe Pub.; 2011.
2. Alayarian A. Trauma, torture and dissociation : a psychoanalytic view. London: Karnac Books; 2011. xxvii, 315 p. p.
3. Başoğlu M. Torture and its consequences : current treatment approaches. Cambridge ; New York, NY, USA: Cambridge University Press; 1992. xxiii, 527 p. p.
4. Başoğlu M, Şalcioglu E. A mental healthcare model for mass trauma survivors : control-focused behavioral treatment of earthquake, war, and torture trauma. Cambridge: Cambridge University Press; 2011. x, 284 pages p.
5. Biswas S, Zalloua ZA. Torture : power, democracy, and the human body. Seattle, WA: University of Washington Press; 2011. viii, 283 p. p.
6. Buchinger K. The Optional Protocol to the United Nations Convention against Torture. Wien: NWV, Neuer Wissenschaftlicher Verlag; 2009. 173 p. p.
7. Cassese A. Inhuman states : imprisonment, detention and torture in Europe today. Cambridge, UK, Cambridge, MA, USA: Polity Press ; Blackwell Publishers; 1996. ix, 141 p. p.
8. Forrest D, Amnesty International. A glimpse of hell : reports on torture worldwide. New York

England: New York University Press ; Amnesty International; 1996. x, 214 p. p.

9. Fujio C. Examining asylum seekers : a clinician's guide to physical and psychological evaluations of torture and ill treatment. Rev. and updated 2012 ed. Cambridge, MA: Physicians for Human Rights; 2012.
10. Hajjar L. Torture : a sociology of violence and human rights. New York: Routledge; 2013.
11. Haritos-Fatouros M. The psychological origins of institutionalized torture. London ; New York: Routledge; 2003. xxi, 270 p. p.
12. Kimmerle EH, Baraybar JP. Skeletal trauma : identification of injuries resulting from human rights abuse and armed conflict. Boca Raton: CRC Press; 2008. xxvi, 493 p. p.
13. Miles SH. Oath betrayed : torture, medical complicity, and the war on terror. 1st ed. New York: Random House; 2006. xv, 220 p. p.
14. Murray R, Steinerte E, Evans MD, Hallo de Wolf A. The Optional Protocol to the UN Convention Against Torture. New York: Oxford ; Oxford University Press; 2011. xx, 241 pages p.
15. Nowak M, McArthur E, Buchinger K. The United Nations Convention against torture : a commentary. Oxford ; New York: Oxford University Press; 2008. xxvi, 1649 p. p.
16. Nowak M, Schmidt R, Ludwig Boltzmann Institut für Menschenrechte. Extraordinary renditions and the protection of human rights. Wien Austria: NWV, Neuer Wissenschaftlicher Verlag; 2010. 188 p. p.
17. Peel M, Iacopino V. The medical documentation of torture. London ; San Francisco: Greenwich Medical Media; 2002. x, 227 p. p.

18. Schauer M, Elbert T, Neuner F. Narrative exposure therapy : a short-term intervention for traumatic stress disorders after war, terror, or torture. Toronto: Hogrefe & Huber; 2005. viii, 68 p. p.
19. United Nations. Committee against Torture., United Nations. Office of the High Commissioner for Human Rights. Selected decisions of the Committee against Torture. Volume 1. New York ; Geneva: United Nations; 2008. iii, 244 p. p.
20. United Nations. Office of the High Commissioner for Human Rights. Istanbul Protocol : manual on the effective investigation and documentation of torture and other cruel, inhuman, or degrading treatment or punishment. Rev. 1. ed. New York: United Nations; 2004. x, 76 p. p.
21. Wilson JP, Drožđek B. Broken spirits : the treatment of traumatized asylum seekers, refugees, war, and torture victims. New York: Brunner-Routledge; 2004. xxx, 706 p. p.