Torture in retrospect (1992-2000)

This text is a compilation of Henrik Marcussen's editorials from Torture, Quarterly Journal 1992-2000 supplied with inserted quotations from his editorials.

Henrik Marcussen, MD, DMSc

The current TORTURE journal originally began in 1991 as Torture, Quarterly Journal. Launched anew in 2004, TORTURE sought to position itself as a core international scientific journal on torture. In the last two decades, from the launch of the original Torture, Quarterly to this edition you hold in your hand, the issues we address within these pages – the struggle against torture and the rehabilitation of torture victims – has also developed from its initiation. From the founding of the Rehabilitation and Research Centre for Torture Victims (RCT) and the 1985 launch of the International Rehabilitation Council for Torture Victims (IRCT) – which celebrated 25 years in December 2010 – our dialogue and discourse around torture has also grown and morphed.

This article will track the major themes emerging from several years of work on Torture, Quarterly Journal. Within this review is also the key events that changed the manner in which we discuss torture – increasing UN declarations, collaborations between the Indian Medical Association and the IRCT, and finally the arrest of Chilean dictator General Pinochet in England.

Justice and Prevention: Torture as a human rights violation

While torture has long been a global problem and crime, only within the last few decades has this come to be recognized by international legal bodies and human rights treaties. Beginning with the 1975 Tokyo Declaration and, most relevantly, the 1984 UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the growing body of treaties, declarations, and protocols over the last few decades have aided victims access to justice, rehabilitation, and the work of preventing torture globally.

As such, defining characteristics of torture emerged through these treaties and discussions. The IRCT and the RCT – the Danish rehabilitation member centre and founding organisation – typically address systematic torture performed by governments and state agents. However, rehabilitation needs are much more widespread. Related torture victims, such as families and friends who are also traumatised, require rehabilitation.

Most importantly, the fight against torture has also become a "continuous fight for democracy and for general respect for human rights,"[1] this author wrote in 1992.

"Those of us who live in democratic societies should never forget to induce the spirit of respect for the individual, wherever he lives. This, however, is a product of a Western perception. In many civilizations, the group, be it the family or a defined circle

of political friends, is more important than the individual – and respect for other different groups is rare."[1]

While many NGOs and international rights groups have taken up this fight, only the countries themselves can remove these dictatorships and oppressive governments; "Only the populations themselves of the countries concerned can do away with torture."[1]

In 1994, the UN added the post of High Commissioner for Human Rights as part of the continuous global efforts to eradicate violations and to increase pressure on governments involved in torture and other crimes.

"The new post is a strong reminder that states can no longer refer to non-interference in internal affairs. It is also a way of giving human rights a proper political tool. Human rights used to be something that politicians all over the world were good at pushing aside and putting at the bottom of the negotiating pile. In the person of the new High Commissioner, the UN Human Rights Commission has a minister who can approach governments at the highest level."[2]

At the time, the newly appointed commissioner Mr. José Ayala Lasso paid an official visit to Denmark to appeal for global funding for the UN Voluntary Fund for Victims of Torture (UNVFVT). His message was simple: Prevention of torture is of the highest importance and that requires the funding of the fund to provide treatment and rehabilitation for the victims of torture.

In that same year, 1994, Torture, Quarterly's editorial focused on the need for compensation for victims of torture based on three M's – moral, money, and medical. That year, the UN determined a ceiling limit for the amount of compensation a victim was afforded. In support of the IRCT's position, this author argued that compensation should include funds for rehabilitation, injury, trauma, loss of working capacity and property, and a lump sum "paid to victims by the country responsible for the torture in consideration of the special nature of the trauma."[3] Our 1995 edition provided us with the opportunity to review our methods and goals of torture rehabilitation and supporting a culture of human rights. That year was the 50th anniversary of the end of World War II.

The management and care of concentration camp victims, both their physical and psychological state, formulated the background work for later efforts in the 1970s, and thus, the foundation of the IRCT and RCT. And the anniversary of the war also provided this author with an opportunity to examine the social and political causes that result in state-sponsored torture.

"However, the anniversary was also an occasion for other reflections. The evil, the suffering, the destruction, the breaking down of what good forces had created – these were not weakened, not sufficiently toned down, in the clearing up after World War II. Some parts of the world may well have got more order and democracy. But state or government- sanctioned repression and evil, including torture as one of the worst weapons, continue to crop up in many countries; in 79 countries in 1994 according to Amnesty International."[4]

In 1997, the author reaffirmed that while the journal remained separate from the IRCT/RCT and welcomed dissenting views and articles from outside these specific spaces, the editorial position supports IRCT/RCT's continued commitment to rehabilitation of torture committed by state agents. While some have asked the IRCT and RCT to open their focus to torture and trauma from non-state agents – such as in the workplace, from individuals, or in the home – this

author supported the continued focus on state agents and a culture of human rights.

"The introduction and acceptance of human rights are prerequisites for the disappearance of torture. Therefore, the abolishment of torture should be a logical consequence of the introduction of a wide range of the elements that guarantee human rights. This ought to take place, it does take place, and is an ongoing process that takes place particularly through international relations within the diplomatic system and through various treatment initiatives."[5]

Rehabilitation, justice and prevention remain the cornerstones of work in the fight against torture as they cyclically reinforce one another. As stories and testimonies of torture come to light and crimes of tortures are revealed, it will "increase opposition to their continued presence."[5]

"As an important side-effect, this extension may help to further the understanding of the other components that are important for the establishment of human rights. In this connection we consider the abolishment of torture the main prerequisite."[5]

By 1997, on the 10 year anniversary of the UN Convention Against Torture, the UN General Assembly recommended that the 26th of June be International Day in Support of Victims of Torture. The day was designed to not only support the survivors and their families and the efforts of rehabilitation, but remind governments of their obligations under UNCAT to provide such services and engage in systematic efforts to prevent torture.

"The research done by the IRCT has revealed that torture, which is used in more than one third of the countries of the world today, is done because governments want to stay in power. Therefore we refer to torture as the most destructive instrument of power used against democracy.

The Commission recalls that freedom from torture is a non-derogable right and that the prohibition of torture is explicitly affirmed in article 5 of the Universal Declaration of Human Rights. The Commission is convinced that a society that tolerates torture can never claim to respect human rights."[6]

In the following year, after the U.N. Secretary General Kofi Annan declared the 26th of June as a day to support the victims, Torture, Quarterly celebrated this occasion in its editorial.

"Torture makes people silent. It destroys them both physically and psychologically. Torture entangles people in a web of silence which is as difficult to get out of as the prison, in which they obtained these wounds to their body and soul.

The United Nations International Day in Support of victims of torture on June 26 is a day which was given in memory of and support to the many torture victims in the world. This day is indeed important in altering the above situation. The strong support from the UN and the Secretary-General Kofi Annan, from many governments, human rights organizations, NGOs, and numerous initiatives will help break through the silence, the insecurity, the indifference and will make a stand to make torture visible, a stand for openness, for acceptance among the boards of various foundations, for the understanding of the necessity for moral rehabilitation of torture victims."[7]

On the first year, the first of many successful global campaigns against torture, the 26th of June was celebrated around the world in more than 40 countries and 62 centres and organizations. From candle-light vigils in Tibet to a rally in Bangladesh, an artistic exhibition in Denmark, and the opening of a rehabilitation centre in Estonia, victims, their families, and supporters around

the world joined in the global fight against torture and the silence that surrounds it.

Medical work and Torture

Beginning in 1994, the IRCT and the Indian Medical Association (IMA) teamed up to focus on the medical community's role in preventing and reporting on torture, and sadly at times, colluding with torture.

The first workshop was held in Dehli in 1994. The focus was to create a comprehensive programme to prevent medical practitioners from becoming involved or colluding with torture, and to ensure the proper medical treatment of torture victims.

Doctors from all areas of medicine may encounter victims of torture: emergency physicians for first-aid, hospital physicians for further treatment, forensic physicians when a medical certificate is required, and, of course, prison, police, and military doctors who work in close contact with torture victims. The goal of the cooperation between the IRCT and IMA was to ensure a systematic prohibition of forcing physicians to collude with torture and act against medical ethical traditions.

The IRCT 1995 annual report stated that, "For the first time a national medical association has decided to launch a comprehensive national program on medical aspects of torture, including prevention (professional and public information, education, prison visits), and clinical activities, with examinations, counselling, and rehabilitation of victims of torture."[8]

By 1998, an article in Torture, Quarterly provided further evidence for the need of more collaboration between medical associations and the IRCT.

"The role of health professionals in relation to torture falls into three categories — in relation to rehabilitation and treatment of torture victims, in relation to prevention of torture and finally in relation to their participation in the practicing of torture."[9]

At that time, studies had emerged that pointed to a systematic problem of doctors and medical practitioners colluding with torture. Ole Vedel Rasmussen found, in a 1990 study, that 20 percent of torture victims, within his study group of 200, reported that medical personnel were involved in torture through treatment, resuscitation, and attention for the purposes of continuing the torture. In the 1998 edition of the journal, Knud Smidt-Nielsen provided increasing support to the claim that doctors were often colluding in the practice of torture; he found that 34 percent of victims, within the 80 torture survivors he spoke with, reported doctor participation in their torture.

"This sad fact that doctors are heavily involved in different aspects of torture gives deep mistrust to a profession that is expected to relieve and help."[9]

The cooperation between the IMA, the Delhi Psychiatric Society, and the IRCT had been increasingly fruitful through the years. In 1998, the three groups coordinated to create a successful debate and essay competition on torture, where almost 300 prospective and younger doctors participated.

By 2000, this author was invited as a co-editor on the IMA's Medical Journal for a special issue entitled 'Focus on Torture'.

In the editorial, this author praised the IMA for their foresight and courageous stand in meeting the challenge of medical collusion, disregard, and/or negligence of torture. When the IMA created an essay competition for young doctors to provide the Indian perspective on medical collusion with torture, the IRCT ensured to have this published in their 1997 edition of Torture, Quarterly.

The partnership between the Indian

Medical Association and the IRCT was particularly fruitful in addressing the need for prevention of torture through their focus on the medical community.

"Certainly, it is by prevention … that we will find the strongest expectations for eradication of torture. Knowledge and enlightenment, as well as those means and tools necessary to obtain this, are the fundamental and ultimate principles as primary prevention in the struggle against torture. Secondary prevention that will incorporate specific education spread of knowledge and attitude to ethics towards special elected target groups as medical profession, the Bench, prison and military personnel and the police, however, shows a practical aim and represents a reality."[10]

In sum, the IRCT worked in hand with the Indian Medical Foundation to ensure an adherence to medical ethics so that no Indian doctors would willfully ignore, collude, or participate in torture. At the same time, the IRCT also turned to Southwest Asia, to Turkey, to support doctors there who had been arrested for refusing to turn over medical records of patients treated at torture rehabilitation centres. The trials, from 1996 to 1999, required the frequent assistance of the IRCT, in conjunction with other NGOs, to respect the medical ethics of privacy and confidentiality of medical records and treatment of patients.

In a 1997 edition of Torture, Quarterly, it stated, "Mr. Tufan Köse, Medical Doctor, and Mr. Mustafa Cinkilic, Lawyer, from the Rehabilitation Centre for Torture Victims in the Turkish town of Adana, were charged with disobeying the order of official authorities because they would not disclose information about the 167 clients who had had treatment at their centre. The authorities' demand to see the client reports is contrary to the universal Hippocratic oath on confidentiality. A sentence of the accused would be totally devastating for continued rehabilitation work with torture victims in Turkey."[11]

After 15 months and eight hearings – some of which only lasting five to 10 minutes – Cinkilic was found not guilty, but Dr. Köse was asked to pay a fine of 18 million Turkish Lira (approximately $110 US). However, the centres were able to continue as they had before, and it was doubtful that authorities would again try to discover the identities of their clients.

Despite the disappointment that Dr. Köse had to pay a fine, the outcome was generally perceived by the accused and their supporters as positive. However, for the IRCT and the partnering NGOs who provided assistance during this time, the incident proved revelatory. They found that, first and foremost, large-scale international solidarity can fuel assistance in such cases. The IRCT collaborated with member centres in Berlin, Copenhagen, and Minnesota to participate in every hearing. In addition, human rights organizations, the World Medical Association, and the Council of Europe joined to provide assistance to the Turkish doctors in this issue of medical ethics and patient privacy.

"All in all, a very encouraging sign directed at a serious violation of a basic human rights principle, and highly essential in the work for torture survivors.

The Turkish trial has also shown how assistance of the accused could be established, carried out, and presented to a wider public attention, and how it led to a conclusion which, under the circumstances, we could not have hoped would be any better. This assistance will be remembered and can be used again under different circumstances. This process has given experiences with presentation of awareness-raising activities

directed at important international institutions, and these experiences will form the basis of future discussions and hearings in e.g. the UN, OSCE, Council of Europe, and US Congress."[11]

As a result of the Turkish case and the collaboration between international institutions, NGOs, and professional organizations, the IRCT spearheaded an international campaign in Turkey to pressure the national authorities to cease harassment and censorship of doctors treating victims of torture. After the original case, the Turkish government had again impeded the work of medical practitioners by interfering with a meeting on prison health. As a result, the IRCT and international partners sought to send a clear message to both the Turkish officials and victims of torture that doctors shall not discriminate based on the political standing of their patients. Medical ethics are inviolable, wrote this author in 2000.

The Turkish campaign also began the same year as the Torture, Quarterly marked the 25 years of rehabilitation and medical work for torture survivors. In 1974, a group of 10 doctors met in Denmark under Amnesty International to aid in the access to justice and rehabilitation of torture victims.

"The systematic diagnostic work made it necessary to start treatment of the incurred traumas, which had been so excellently described. This led to the creation and development of the proper rehabilitation initiative, which has developed as described above.

The ideas and initiative that in 1974 led to this systematic analysis, and thus increased knowledge about torture, resulted in a change in the attitude towards the concept of torture and its place in relation to other pathological conditions due to external causes. Previously, torture had not been clearly identified as a society-created means of destruction. This initiative resulted in a development that, based on rationality, made it possible to start goal-oriented rehabilitation of torture's physical and mental sequels."[12]

In 1999, this connection between health, medical professionals, and human rights was again acknowledged when Medecins Sans Frontieres (MSF) won the Nobel Peace Prize. Like the IRCT, MSF is based in the medical profession but have increasingly recognized the political and humanitarian importance of their work in human rights interventions and violations. In the 1999 editorial congratulating MSF, we quoted their director Philippe Bibersen, who said, "This prize recognizes the necessity of a humanitarian rebellion, totally independent of political and military influence, against all persecution and injustice."[13]

Need for rehabilitation centres in post-Soviet states

In 1994, the Torture, Quarterly editorial focused on the reality of post-Soviet states and the deep marks of trauma left there by 50 years of Soviet rule, which included prolonged detention, torture, and murder of thousands of people in the Baltic states.

"The need for the establishment of the rehabilitation centres is obvious,"[14] this author stated.

Firstly, thousands of ex-Soviet soldiers were forcefully conscripted and traumatised during military service; approximately 80% were enlisted in the years up to 1989. In Lithuania, about 1,000 people died during their service and a further 1,000 were mutilated and injured. Furthermore, about 350,000 Lithuanians were deported, "usually to Siberia where they either died or were tortured in the gulags."[14] And their families back home suffered the loss of their absence.

In Latvia, waves of arrests began as the Second World War began. By 1941, 7,000 Latvians were arrested – about 900 were tortured, shot, and secretly buried while the remaining were sent to Soviet prisons and gulags. In June 1941, another 15,000 – predominantly intellectuals and democracy advocates – were deported to the far regions of the Soviet Union. The pattern horrifically continued. After the end of the war, 70,000 Latvians were shot or deported. And again, in 1949, a further 50,000 were shot or deported.

These horrific crimes of murder, torture, deportation, and imprisonment have left a deep mark of trauma on the Baltic states of Estonia, Latvia, and Lithuania.

"As a result of these outrages the following groups in Latvia as well as in the two other Baltic countries are in need of rehabilitation efforts: a) Those who have survived the physical and psychological torture perpetrated by the Soviet regime and in the gulag camps; b) Those who have survived being starved out, gulags and German concentration camps; c) Lithuanian soldiers who have been subjected to torture during their military service."[14]

The Pinochet case
– The end of impunity for dictators?

During a stay in London, Augusto Pinochet, the former dictator of Chile was arrested following a Spanish indictment. The arrest was a watershed moment for international law and impunity for dictators. Not only had a foreign government arrested a brutal dictator, but for the first time the principle of international jurisdiction was invoked to bring a former head of state to justice for crimes committed in that nation, despite amnesty laws.

Pinochet had been charged by Spain – and later Switzerland, Norway, France and Sweden – for murder, kidnapping, forced disappearance, and violations of human rights. These were in addition to the crimes of leading the torture of perhaps several tens of thousand Chileans during his rule.

"The process that was started by Spanish lawyers thus gives hope to the many people, not least Chileans, who have lived in the shadow of the misdeeds for which Pinochet as head of state is responsible during his dictatorship. For those who survived the dark years, this gives a hope for justice and for healing of the wounds they sustained."[15]

At the time, many debated whether it was valid, appropriate, and legal to arrest a former head of state and whether diplomatic immunity protected him. At the time, this author pointed to Article 5 in the UN Convention Against Torture:

"Each State Party shall take such measures as may be necessary to establish its jurisdiction over the offences [...] when the offences are committed in any territory under its jurisdiction [...] shall likewise take such measure as may be necessary to establish its jurisdiction over such offences in cases where the alleged offender is present in any territory under its jurisdiction ...".[15]

And to Article 7:
"The State Party in the territory under whose jurisdiction a person alleged to have committed any offence [...] shall [...] submit the case to its competent authorities for the purpose of prosecution."[15]

Furthermore, opinion polls taken around 1998 showed that 74% of Chileans wanted a court case against Pinochet.

Despite the fact that later the dictator was allowed to return to Chile without a trial in the UK, "the Pinochet case has strengthened awareness of a further step forward towards the justice, already written into the UN Convention against Torture that

may lead to an efficient legal system in the form of a permanent Court of justice to sentence and punish war criminals, torturers, terrorists, and others who seriously violate human rights."[15]

The case showed that torture was a crime of universal jurisdiction and one that went beyond immunity for heads of state. For other brutal dictators, the Pinochet case was indeed a watershed moment.

"The Pinochet case was a milestone since former dictators can no longer automatically expect immunity outside their own jurisdiction, and potential dictators will have to think twice before they violate human rights. In this way, the case has broken down the myth of dictators being sacrosanct. The spell is broken."[16]

The results, were nearly immediate, as Torture, Quarterly wrote in 2000. Former regime leaders, dictators, and human rights violators suddenly feared the arms of justice for their crimes. At the time, Mengistu Haile Mariam of Ethiopia fled to North Korea; Suharto of Indonesia cancelled a medical visit to Europe; and former President Habré of Chad has been threatened with lawsuits while in Senegal. In addition, the International Criminal Tribunal has been working hard to charge the biggest criminals of the former Yugoslavia.

And while many still remain free despite their horrific crimes, a growing awareness of the crimes of torture and the need for justice has taken root.

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Comparison of two methods of inquiry for torture with East African refugees: Single query versus checklist

Joseph Westermeyer, MD, PhD*,, Michael Hollifield, MD***, Marline Spring, PhD*, David Johnson, MD, MPH****, James Jaranson, MD, MA, MPH*****

Abstract

Purpose was 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 single-query 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 non-torture trauma in Africa.

Conclusion. Inconsistent reporting of torture occurred when two methods of inquiry (one open-ended 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.

Keywords: refugee, torture, trauma, posttraumatic stress symptoms, Africa

Introduction

Clinicians have been advised to query refugee patients about their traumatic experiences, including torture.[1] This task seems simple enough, given the United Nations (U.N.) definition of torture from 1984[2,3]:

*) Minneapolis Veterans Administration Medical Center, USA. weste010@umn.edu

**) University of Minnesota, USA

***) Behavioral Health Research Center of the Southwest, Albuquerque, USA

****) Department of State, Washington D.C., USA

*****) Division of Epidemiology and Community Health, University of Minnesota, USA

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

However, application of this specific definition in clinical practice poses a number of problems. Clinical reports on torture do not utilize these detailed criteria.[4-6] In an effort to increase the validity of torture self-report, clinical investigators have tried to identify specific pathognomonic physical identifiers of torture, but without success.[6,7] In a systematic review of 161 published reports, drawn from 5,904 articles, an international panel observed, "The assessment of torture across the majority of surveys reviewed was reliant on self-reports, most commonly based on the endorsement of the Harvard Trauma Questionnaire, leaving open the possibility of variation in personal understandings of the term."[8] Despite this methodological limitation, they found that a single-query self-report of torture "emerged as the strongest substantive factor associated with PTSD…"

Refugee studies have revealed high rates of torture and other trauma.[9-12] Nonetheless, the reliability of self-reported torture has been questioned. For example, in our study of East African refugees, dozens of refugees reported having been tortured on a single query but then provided no instance of harm at the hands of authorities when specific examples were sought.[9]

The current study aimed at identifying the prevalence of torture using two different methods (the traditional single-query method and a checklist of torture experiences that occurred in that time and place) and improving our understanding regarding the self-report of torture by refugees.

Background

Somalia and Ethiopia underwent civil disruption during the early 1990s, a decade before the current study. In Ethiopia, the majority Oromo tried to establish a separate country of Oromia,[13] resulting in a pogrom against them. In Somalia, the independence movement involved organized assaults on clans that held sway over government and commerce.[14] Violence occurred in home invasions, traffic stops, and armed invasions into shops. Thus, two different scenarios regarding torture resulted.[9] In Ethiopia, the torture involved primarily men in prison. Among Somalis, women experienced more violence in numerous settings (homes, streets, police stations) as their men had been killed or had already fled.

At the time of the study, all participants lived in the Minneapolis-Saint Paul metropolitan area of Minnesota, U.S.A. They lived freely in society (i.e., not in a refugee camp). Many Somalis lived in a single Minneapolis neighbourhood, whereas the Ethiopians inhabited many neighbourhoods. Most participants had official status as legal refugee residents of the U.S. Small numbers had non-refugee immigrant status or other status (student, visitor). Virtually all of them planned to remain in the U.S. as permanent residents or as citizens. Most had first fled to a neighboring African country as asylum

seekers before coming to the U.S. for permanent resettlement.

Method

Definition of terms

Single-query self-report of torture. Terms for torture existed in the Somali and Oromo languages. Translation and back-translation using standard translation techniques[15-17] produced semantic equivalence. Self-report of the occurrence of torture was based on a single query for these reasons:

- Study participants had no difficulty answering this query.
- Translated terms for torture were semantic equivalents of torture in English.
- Common clinical practice depends on a single query rather than a multi-event screen or scale.
- The research literature on torture has relied upon single-query self-report to establish a history of torture. Compared to demographic, historical, diagnostic, and trauma scales, this single-query self-report method has been shown to be the strongest substantive correlation with Posttraumatic Stress Disorder (PTSD) in a review of published reports on torture.[8]

Torture items checklist. We identified 61 torture events based on ethnographic interviews and pilot interviews during the first year of the study. We identified an additional 11 events based on later queries, such as trauma perpetrated by authorities while the survivor was incarcerated. Finally, we added four "other" events in case we had not obtained all traumatic events to which study participants were exposed (i.e., "other stress to senses", "other deprivation", "other physical suffering", and "other psychological suffering"). The relative paucity of "other" endorsements (i.e., 41 endorsements) indicated that we identified most of the trauma events suffered by these groups. These total 75 traumatic events are listed in the first column of Table 1. Since one event could occur only among women (i.e., pregnancy as a result of rape) and one event could only occur among men (i.e., weights tied to testicles), a maximum of 74 events could occur to any one individual. A total of 829 study participants reported one or more of these torture events.

Of these 75 traumatic events, we judged 27 to be feasible only in a context of torture, rather than non-torture situations involving general abuse of detainees. These 27 events considered by us to be pathognomonic for torture are listed in Table 2.

The four categories of single-query for lifetime torture versus checklist for torture items are as follows:

- Group a: negative response to single query and no endorsed items on checklist items
- Group b: negative response to single query but one or more endorsed checklist items
- Group c: positive response to single query but no endorsed checklist items
- Group d: positive response to single query and one or more endorsed checklist items.

The categorization above differs from that in our earlier publication,[9] which was concerned with validity of torture group assignment, rather than with comparing torture self-report on two methods of data collection (the focus of this report). In our earlier study, participants were classified as torture survivors if they met one of these criteria:

1. Responded positively to any of the three queries:

Table 1. *Torture single-query versus torture checklist (all 75 items) in study participants endorsing any checklist item (n = 829)*

Torture checklist items	Single query regarding torture		Statistics	
	b. n = 551	d. n = 278		
			OR	X^2
Probability < 0.0007				
Thought control	4	56	27.14	101.51
Burned with boiling water	2	19	17.09	28.78
Electrical shock	2	14	12.59	18.92
Head injury w/torture	17	102	12.30	167.13
Immersion in water	10	51	10.19	71.66
Strangling	9	45	10.12	61.90
Blows to ears	12	50	8.18	64.46
Electricity to genitals	4	13	6.68	12.46
Suffocation	8	27	6.47	29.17
Rope bondage, w/tightening	8	27	6.47	29.17
Weights to testicles *	5	16	6.39	15.68
Total darkness > 2 days	20	59	5.90	64.31
Release w/immediate re-arrest	17	50	5.80	53.23
Severe overcrowding	21	61	5.77	66.13
Beaten on soles of feet	29	84	5.70	95.61
Immobilized, tied up	28	78	5.50	85.42
Blindfolding	18	47	5.12	45.70
Nakedness	6	15	4.91	12.19
Deprived of medical care	38	91	4.74	91.92
False accusation, self-incrimination, recanting	23	53	4.54	47.42
Lifted by hair	17	38	4.41	31.73
Maimed, bone fracture	12	27	4.41	21.75
Forced to do things that now are disturbing	12	27	4.41	21.75
Prevent urination, defecation	10	22	4.40	16.91
Deprived of sleep	25	54	4.32	45.79
Isolated > 3 days	20	43	4.30	35.21
Lost consciousness with abuse	9	19	4.27	13.76
Blows w/weapon	80	166	4.12	178.68
Deprived of food	65	130	3.96	123.64
Forced position for hours	25	49	3.92	37.34
Deprived of hygiene	21	41	3.88	30.38
Sexual touching w/assault	17	33	3.83	23.64
Family/friend made to observe your torture/ abuse	15	28	3.73	18.83
Deprived of water	70	123	3.68	101.16
Mock execution	34	61	3.54	43.76
Flogged	57	100	3.49	20.66
Forced watch/listen to torture, killing	21	36	3.41	22.69
Made to inform on others	43	65	3.00	38.21

Torture checklist items	Single query regarding torture		Statistics	
	b. n = 551	d. n = 278		
			OR	X^2
Death threats, self/other	101	115	2.26	49.71
Punched, slapped, kicked	163	190	2.37	111.97
Knife/sharp wounds	47	55	2.33	101.08
Demeaning comments, self/family	102	97	1.89	26.29
Forced hard labor	102	93	1.81	22.11
Threats, self/family/etc.	151	130	1.70	30.04
Probability 0.05 to 0.007 (borderline)				
Forced teeth extraction	1	5	8.99	Fisher
Forced degrading act	1	5	8.99	Fisher
Amputation	2	8	7.19	Fisher
Sex w/animal, object	1	4	7.19	Fisher
Finger-, toe-nails removed	2	7	6.29	Fisher
Hanging by extremities	4	9	4.62	Fisher
Torturer attitude changes	6	13	4.25	9.08
Forced watch sun, lights	7	15	4.15	10.63
Made to harm others	7	14	3.87	9.14
Immersion, dirty fluid	7	14	3.74	9.14
Limbs, body stretched	6	11	3.60	6.21
Abuse w/excrement	5	8	3.20	Fisher
Burned w/cigarette	13	20	3.00	10.07
Thrown from a height	11	15	2.70	5.95
Constant loud noise	38	34	1.77	5.97
Detonate explosive nearby	103	80	1.54	10.34
Non-significant (> 0.05)				
Forced choices	5	7	-----	Fisher
Other psychological suffering	1	6	-----	Fisher
Other stress to senses	4	5	-----	Fisher
Genital infection after rape	6	0	-----	Fisher
Burned w/fire, burning stick	3	4	-----	Fisher
Other deprivation	2	3	-----	Fisher
Forced, sexual acts	7	6	-----	Fisher
Rape, by opposite sex	12	9	-----	0.47
Forced to take harmful drugs	3	0	-----	Fisher
Burned w/chemicals	2	2	-----	Fisher
Rape, by same sex	7	2	-----	Fisher
Other physical suffering	9	3	-----	Fisher
Water dripped on head	16	9	-----	0.003
Pregnant after rape **	5	3	-----	Fisher
Needles under nails	3	2	-----	Fisher

Statistics: Chi Square w/correction for continuity and Fischer Exact test, 2-tailed.
*Man-only item (weights from testicles)
**Woman-only item (pregnancy)

Table 2. *Torture single query versus torture checklist in study participants endorsing any pathognomonic item (n = 405)*

Torture event on questionnaire	Single query regarding torture		Statistics:	
	b. n = 163	d. n = 242	OR	X^2
I. 27 events considered pathognomonic for torture				
Probability < 0.0007				
Burned with boiling water	3	32	7.33	14.57
Immersion in water	15	84	3.77	32.95
Electrical shock	5	28	3.74	18.92
Rope bondage, w/tightening	11	50	3.09	13.67
Beaten on soles of feet	36	122	2.28	31.67
Total darkness > 2 days	29	85	1.97	13.62
Probability 0.05 to 0.0007 (borderline)				
Weights to testicles (male)	6	30	3.35	8.09
Abuse w/excrement	5	25	3.32	6.47
Hanging by extremities	6	27	3.03	6.31
Limbs, body stretched	8	32	2.69	6.66
Immersion, dirty fluid	9	35	2.64	7.14
Torturer attitude changes	8	27	2.29	4.06
Head injury w/torture	33	86	1.76	10.25
Forced position for hours	29	74	1.72	7.74
Mock execution	42	92	1.47	6.06
Non-significant (> 0.05)				
Forced to watch/listen to torture/killing	25	57	-----	3.58
Forced teeth extraction	3	13	-----	2.34
Finger-, toe-nails removed	4	15	-----	2.27
Electricity to genitals	5	16	-----	1.82
Thought control	19	41	-----	1.76
Forced choices	7	19	-----	1.50
Burned w/cigarette	17	35	-----	1.08
Forced watch sun, bright lights	12	24	----	0.50
Sex w/animal, object	2	5	-----	Fisher
Needles under nails	4	7	-----	Fisher
Water dripped on head	18	22	-----	0.23
Forced to take harmful drugs	4	3	-----	Fisher
II. 48 events not considered pathognomonic for torture				
Probability < 0.0007				
Strangling	10	68	4.61	28.82
Suffocation	9	51	3.84	17.46
Blows to ears	15	79	3.54	28.73
Blows w/weapon	58	182	3.11	61.71
Blindfolding	17	72	2.87	20.10
Immobilized, tied up	25	100	2.70	29.61
Forced hard labor	28	112	2.69	35.20
Flogged	32	124	2.61	39.77
Severe overcrowding	21	80	2.57	20.13

Torture event on questionnaire	Single query regarding torture		Statistics:	
	b. n = 163	d. n = 242		
			OR	X^2
Made to inform on others	21	77	2.47	18.02
Release w/immediate re-arrest	20	73	2.46	16.64
Deprived of sleep	23	75	2.20	14.23
False accusation, self-incrimination, recanting	22	71	2.17	12.94
Deprived of food	54	163	2.04	44.51
Deprived of medical care	38	114	2.02	22.52
Deprived of water	65	154	1.59	21.19
Punched, slapped, kicked	90	200	1.50	34.71
Probability 0.05 to 0.0007 (borderline)				
Amputation	2	16	5.50	5.44
Made to harm others	6	31	3.46	8.71
Nakedness	7	35	3.37	9.77
Prevent urination, defecation	11	42	2.60	8.72
Sexual touching w/assault	14	52	2.50	10.95
Lifted by hair	16	56	2.36	10.94
Forced to do things that now are disturbing	13	42	2.18	6.52
Family/friend made to observe your torture/abuse	13	41	2.11	6.02
Maimed, bone fracture	14	43	2.07	6.05
Isolated > 3 days	23	67	1.96	9.62
Deprived of hygiene	24	60	1.69	5.41
Demeaning comments, self/family	45	100	1.50	7.39
Death threats, self/other	54	108	1.35	4.90
Reverse association				
Genital infection after rape	5	0	∞	Fisher
Non-significant (> 0.05)				
Forced degrading act	2	13	-----	3.60
Lost consciousness w/abuse	12	32	-----	2.87
Other psychological suffering	1	6	-----	Fisher
Knife/sharp wounds	36	66	-----	1.13
Thrown from a height	13	28	-----	1.02
Other deprivation	2	6	-----	Fisher
Forced sexual acts	5	12	-----	0.46
Burned w/chemicals	3	8	-----	Fisher
Other physical suffering	7	9	-----	0.00
Threats, self/family/etc.	77	115	-----	0.00
Burned w/fire, burning sticks	4	6	-----	Fisher
Other stress to senses	4	6	-----	Fisher
Pregnant after rape	3	4	-----	Fisher
Rape, by opposite sex	9	12	-----	0.00
Constant loud noise	31	39	-----	0.39
Rape, by same sex	7	6	-----	0.53
Detonate explosive nearby	59	76	-----	0.80

a. I was tortured.
b. Have you been tortured in prison?
c. Were you tortured in jail or prison?

2. Reported one of the 27 torture techniques that we considered could have occurred only during torture sessions (see Table 2 for these 27 torture techniques), even if the participant responded negatively to the three queries above. For convenience, we will refer to any of these 27 techniques as being "pathognomonic" of torture.

For the current study, we employed criterion 1a as a self-report of torture. Criterion 1b and 1c were excluded from the current study, since they are not the usual queries used to establish whether torture has occurred in survey studies similar to this one[8] or in clinical practice. Criterion 2 was utilized for our second checklist analysis. Due to differing goals and definitions in this report as compared to our earlier report,[9] the four categories in this study (as described above) contained different numbers than our earlier publication.

Among the 1,134 study participants, 344 (30%) reported torture on the single query noted in 1a above. This percentage was higher than the mean torture prevalence of 21% reported in a review of 84 surveys, falling into the extreme 5% of outliers (95% CI, 17%-26%).[8]

Some torture events occurred repeatedly (e.g., beatings, food deprivation), whereas other highly traumatic events occurred once. For example, one woman was forced to have sex with her husband's older brother, then the older brother was tortured in her presence to force the sex act, and finally he was killed in front of her – three traumatic events within one continuous episode.

Non-torture trauma. Torture usually occurs in a context of armed conflict and/or social disruption, including war, revolution, or ethnic-religious conflict. For this reason, most studies of torture have also assessed the prevalence of other forms of trauma besides torture.[8] We studied 30 other traumatic events not perpetrated by authorities. These occurred during civil unrest, armed conflict, flight out of the country, and criminal activities fostered by the general chaos and lack of civil security during the period.

On average, the 1,134 East Africans endorsed 6.5 non-torture trauma events. Using the convention employed by Steel et al to report non-torture trauma,[8] "0" refers to no trauma experienced by anyone and "1" refers to each participant experiencing all 30 traumatic events. In this study, the participants reported 22% of all potential non-torture traumatic events (i.e., 6.5/30 = 0.22). This rate of non-torture trauma was less than the mean of 29% reported in 120 surveys of torture, but well within the 95% confidence interval (16%-42%).[8]

Sample

The method of targeted sampling to obtain representative samples in each ethnic group has been published.[12]

Single-query self-report of torture. Among the 512 Ethiopians, 40% (206/512) reported having been tortured. Among the 622 Somalis, 22% (138/622) reported having been tortured on a single-query self-report question. The two groups showed a significant difference in their single-query self-report of torture (X^2=42.44, 1 d.f., $p < 0.001$).

More Ethiopian men than women reported torture on the single query (69%-vs-31%, X^2=50.32, 1 d.f., $p < 0.001$). Among Somalis, reports of torture on the single query were more common among women than men (69%-vs-31%, X^2=29.59, 1 d.f., $p < 0.001$).

Torture items checklist. Most Ethiopians (420/512, or 82%) endorsed one or more torture checklist items events (including all 75 pathognomonic and probable torture events). Most Somalis (428/622, or 69%) endorsed one or more torture events (including all 75 pathognomonic and probable torture items. This difference was significant (X^2=29.14, 1 d.f., $p < 0.001$).

More Ethiopian men endorsed one or more torture items on the checklist compared to women (92%-vs-73%, X^2=29.05, 1 d.f., $p < 0.001$). More Somali women than men endorsed one or more torture items on the checklist (78%-vs-60%, X^2=21.49, 1 d.f., $p < 0.001$).

Ethno-religious affiliations. Among the 512 Ethiopians, 99% were ethnic Oromo, with 1% either of mixed ethnic heritage or married to Oromos. Religious affiliations among Ethiopians were predominantly Islam (389/512 or 76%) and Christianity (105/512 or 21%). All 622 study participants from Somalia reported Somali was their identity and predominant language. Among the 622 Somalis, 601 (97%) reported practicing Islam.

Other data collection instruments

Demographic characteristics included age, gender, current marital status and nationality. The self-rated posttraumatic stress disorder checklist[18] assessed current posttraumatic symptoms. Translations and back-translations were undertaken as defined above, with the goal of semantic equivalence.

Statistical analyses

Table 1 includes all 551 who endorsed one or more of the 75 torture items on the checklist. Some of these 75 items might not have met World Health Organization criteria for torture, since the traumatic event may have been punishment, may have been perpetrated by other prisoners, or may have been perpetrated by rogue jailors without official approval. For each item on the checklist, the Odds Ratio (OR) compared those reporting torture versus no reporting torture on the single query. Chi Square test (with correction for continuity) and Fisher Exact test (if any expected cell number was less than 5) were employed. Cut off for significance was set at $p < 0.0007$ for these 75 bivariate comparisons using the Bonferoni correction (i.e., .05/75). Borderline significance was set at 0.05 to 0.0007. ORs were not determined if the significance was $p > 0.05$.

In Table 2, only those participants who reported one or more pathognomonic torture events were included in the analysis (n = 405). The method of analysis for this table replicated that used in Table 1.

In Table 3, the four groups a, b, c, and d were compared using three torture-trauma scales, three demographic characteristics, and the PCL posttraumatic symptom scale. Those study participants who reported one of the 27 pathognomonic torture items were categorized as "checklist positive" as this was judged to be a more conservative means of comparing the four groups. Comparisons across all four categories involved two Chi Square tests for categorical data, four ANOVA's with post hoc comparisons for normally distributed data (i.e., skew < 1.0), and, for non-normally distributed data (skew of 1.0 or more), one Kruskal-Wallis test (see the right-hand column of the table). For the 27 pathognomonic checklist items, only groups b and d were compared (since all of those in groups a and c had no checklist reports by definition). Only the 27 pathognomonic torture events showed a skew greater than one (skew = 1.73), so the Kruskal-Wallis test was used for this comparison. Cut-off was set at 0.007 for the seven comparisons using the Bonferoni correction (i.e., .05/7). At the

Table 3. *Comparison of four groups a, b, c, and d. Using the 27 pathognomonic torture items for "checklist positive" categories: 1,134 East African refugees*

Variables	Single query negative		Single query positive		
	Checklist negative	Checklist positive	Checklist negative	Checklist positive	
Category (n)	a. (627)	b. (163)	c. (102)	d. (242)	Statistics P<0.0003
Pathognomonic torture events (n = 27)					b vs. d:
Range	0	1-16	0	1-20	K-W Z=7.70
Mean (sd)	0	2.2 (2.5)	0	4.5 (4.1)	
Probable torture events (n = 48)					F=277.5; 3 d.f.
Range	0-22	1-53	0-2	1-60	
Mean (sd)	2.9 (3.1)	7.6 (9.8)	8.2 (5.8)	17.6 (13.6)	
Trauma, other					F=98.18; 3 d.f.
Range	0-18	0-16	0-18	0-22	
Mean (sd)	4.8 (3.6)	7.1 (4.2)	7.9 (4.2)	9.8 (4.6)	
Age*					F=18.6; 3 d.f.
Mean (sd)	33.4 (14.7)	33.5 (13.4)	37.9 (14.7)	39.5 (14.1)	
Gender					X^2 = 19.3; 3 d.f.
Men	340	80	37	148	
women	287	83	65	94	
Marital status					
Single	227	50	27	38	X^2 = 60.5; 6 d.f.
Married	202	42	22	68	
div-sep-wid	198	71	53	136	
PCL score					F=19,712.3; 3 d.f.
Range (total)	17-77	17-83	17-85	21-85	
Mean (sd)	27.3 (9.7)	34.7 (12.9)	40.2 (17.1)	46.6 (14.1)	

* Current age is about 10 years after torture/trauma occurred.

bottom of Table 3, four comparisons were made for each variable as follows: a versus b, a versus c, b versus d, and c versus d.

In Table 4, a logistic regression analysis was conducted with self-report of torture (presence versus absence) as the dependent outcome. Variables with an alpha ≤ 0.1 in Table 2 (far right column) were entered into the regression. Since the 27 pathognomonic checklist items and the 48 non-pathognomonic checklist items were highly correlated with each other, only a single value (based on all 75 checklist items) was entered into the regression. A regression alpha < 0.05 was considered significant.

Results

Description

Of the 1,134 participants, 829 (73%) reported one or more of the total 75 items on

Table 4. *Binary logistic regression analysis: Self-report of torture (presence-vs-absence) as the dependent outcome.*

Variable	B (SE)	Wald	Signif	Exp (B)	95% C.I.
Constant	- 2.564 (0.605)	17.97	0.001	0.08	---
All 75 torture events	0.056 (0.014)	16.01	0.001	1.06	1.03-1.09
Male-female	- 0.842 (0.310)	7.39	0.007	1.35	1.09-1.67
Age (deciles)	0.298 (0.110)	7.28	0.007	1.03	1.01-1.06
Non-torture trauma	0.080 (0.038)	4.53	0.03	1.08	1.01-1.17
Single-married-other	0.257 (0.196)	1.71	0.19	1.29	0.88-1.90
PCL score	0.008 (0.009)	0.90	0.34	1.01	0.99-1.03

the torture checklist. A total of 405 participants (36% of 1,134) reported one or more of the 27 "pathognomonic torture" events listed in Table 1. Those reporting any torture item numbered twice those reporting only the pathognomonic torture events.

As shown in Table 3, the largest group was denying torture on the single query and no endorsement of any of the 27 pathognomic torture items, with 627 out of 1,134 or 55%. The next largest group was d (i.e., reporting torture on the single query and endorsing a pathognomonic torture event on the checklist), with 242 of 1,134 or 21%. Group b (i.e., denying torture on the single query but endorsing one of the pathognomonic torture items on the checklist) was third largest, with 163 out of 1,134 or 14%. The least number of people fell into group c (i.e., reporting torture on the single query, but not endorsing any pathognomonic torture items on the checklist), with 102 out of 1,134 or 9%.

Comparison of group b and group d

Table 1. The item analysis shown in Table 1 was conducted to assess whether certain torture items were more apt to be associated with a positive single-query response (i.e., having been tortured). These 75 items could comprise torture, but 48 of them might also involve licit punishment (e.g., a period of solitary confinement), conflict with other prisoners (interpersonal trauma), or individual harsh treatment by some jailers not acting with official support (e.g., threatening, insulting). Thus, these data likely include some number of people who were not tortured by the U.N. criteria, and some whose torture did not include any of the 27 torture checklist items that we have designated as pathognomonic of torture. Among the 829 people in this group, 551 (or 66%) responded negatively to the single query regarding torture; and 278 (or 34%) responded positively. A high OR in column 4 suggested that those experiencing the item were more apt to report on a single query that they had been tortured. Column 5 shows the statistical difference between columns 2 and 3. ORs were computed only on those torture items showing a significant difference of 0.05 or less.

Of the 75 items, 44 (or 59%) showed a highly significant difference between those reporting torture on the single query. These items tended to be more common; up to 68% of the positive-query group reported them. For many items, the cooperation or coordination of several people would be needed to impose the violent event, so a system-driven effort would be required. Of

the 75 items, 16 (or 21%) were in the borderline category. These items were less common overall; up to 29% of the positive-query group reported them. Of the 75 items, 15 (or 20%) were in the non-significant group. These items were the least common, with a maximum of 3% in the positive-query group reporting them.

Table 2. Column 1 of Table 2 includes only those 405 participants who reported one or more of the 27 trauma events that we judged were pathognomonic of torture. Of these 405 people, 163 (40%) in column 2 reported that they had not been tortured, and 242 (or 60%) in column 3 reported that they had been tortured. This analysis was conducted as a supplement to Table 1, which probably over-counted those who had been tortured. Table 2 was probably an undercount of those who had been tortured, and thus a more conservative estimate. As compared to Table 1, the analysis in Table 2 shows fewer items that are significantly different (44 versus 23 items), somewhat more borderline items (16 versus 23 items), and more non-significant items (15 versus 29 items). As shown in Table 2, only six out of the 27 pathognomonic events (or 22%) showed a significant difference (at $p < 0.0007$) between the two groups. Four items involved pain or physical damage, one involved oxygen deprivation (immersion in water), and one involved decreased sensory input (total darkness for more than two days). ORs ranged up to 7.3.

Nine of the 27 items (or 33%) showed a borderline significance between 0.05 and 0.0007. Five items involved pain or physical damage, three involved psychological torture (abuse with excrement, torturer changes attitudes toward victim during torture, mock execution), and one involved oxygen deprivation (immersion in dirty fluid). ORs were lower overall than in the first group (1.5 to 3.4).

Twelve of the 27 items (or 44%) showed no difference between true positive and false negative groups. The non-significant trauma events tended to occur less often. Six events involved pain or physical damage, three were psychological (forced to watch/listen to torture or killing, thought control, forced aversive choices), two were sensory (forced to stare at sun or bright light, water dripping on head), and one was sexual.

As shown in the second section of Table 2, 17 of the 48 non-pathognomonic items (or 35%) showed a significant difference at $p < 0.0007$. They tended to occur frequently in the group responding positively to the single query on torture. Six items involved pain or physical damage, eight items involved deprivations (oxygen, food, water, sleep, medical care, adequate space, and insufficient rest due to excessive labor), and three entailed psychological torture.

Of the 48 items, 14 (or 29%) showed a borderline significance. They were a mix of physical, sexual, deprivation, and psychological torture. Only one event was more frequent in the group not reporting torture on the single query than in the positive response group (genital infection after rape).

Seventeen non-pathognomonic items (35%) showed no difference between the two groups. Several of them were commonly experienced (loud noises, threats, cutting wounds, explosions detonated nearby), but most were infrequent.

Comparison of four groups (see Table 3)

For this analysis we used those responding to one or more of the 27 pathognomonic torture items as "checklist positive" in order to conduct a conservative analysis. All seven variables showed a significant difference with the four groups a, b, c, and d. Since the 27 pathognomonic torture events did not occur in groups a and c by definition, comparisons

involving these variables and these groups were not conducted.

Group a versus group b. Group b reported more "probable torture events" as well as more "non-torture trauma" as compared to group a. Posttraumatic stress symptoms were significantly greater in group b, lending internal validity to the two categories. Age, gender, and marital status did not differ between the two groups.

Group a versus group c. Group c reported a higher mean "probable torture events" and "non-torture trauma events" than group a. Demographically, group c was 4.5 years older on average, included more women, and had more separated-divorced-widowed marital status (all at a significant level).

Group b versus group d. Group b reported half as many "pathognomonic torture items" and half as many "probable torture items" as group d (both significant). The difference in mean number of "non-torture trauma items" events was less great, but still significant, with a lower mean number in group b. Group b was 6 years younger on average and had more single members (both significant). On the self-rated PCL symptoms, group b had a mean of 6.4 points less than group d (also significant). Gender distribution did not differ in the two groups.

Group c versus group d. Group c had about one-half as many "probable torture items" and almost two fewer "non-torture trauma events" as compared to group d (both significant). Group c members included more women and had lower mean PCL scores (both significant). Marital status did not differ.

The same analysis as that described above was conducted using the 829 people endorsing one of more of the 75 torture items as "checklist positive". This analysis revealed the same categorical similarities and differences as those described above, albeit

Bivariate statistical associations between groups

27 pathognomonic torture events, Mann-Whitney Z

b vs. d: $Z = 7.70$, $p < 0.0001$

NB: The True-negative and false-positive groups (In which pathognomonic torture events = 0) were not compared since the count of pathognomonic torture events is confounded with the definition.

48 Probable torture events, Tukey's b Post Hoc test, $p < 0.05$

Subset	1	2	3
a	2.9		
b		7.6	
c		8.2	
d			17.6

Non-torture trauma (e.g., civil unrest, combat, flight, crime), Tukey's b Post Hoc test, $p < 0.05$

Subset	1	2	3
a	4.8		
b		7.1	
c		7.9	
d			9.8

Age, Tukey's b Post Hoc test, $p < 0.05$

Subset	1	2
a	33.4	
b	33.5	
c		37.9
d		39.5

Gender: a vs .c: $X^2 = 10.62$, 1 d.f., $p = 0.001$
c vs. d: $X^2 = 16.89$, 1 d.f., $p < 0.0001$

Marital status: a vs. c: $X^2 = 16.31$, 2 d.f., $p < 0.0001$
b vs. d: $X^2 = 13.29$, 2 d.f., $p = 0.001$

PCL total score, Tukey's b Post Hoc test, $p < 0.05$

Subset	1	2	3	4
a	27.3			
b		34.7		
c			40.2	
d				46.6

with some differences in levels of significance. The primary author will provide this material to interested readers upon request.

Regression analysis: factors predicting a self-report of torture (see Table 4)

A logistic regression analysis was conducted with the single-query self-report of torture (presence vs. absence) as the dependent variable. Variables were entered together. The "pathognomonic" and "probable" torture events were combined into a single 75-item variable, since the data in Table 2 did not indicate major differences in the two separate variables vis-à-vis a single-query self-report of torture.

The factor with the highest Wald score was the number of events from the 75 torture items, indicating that endorsing more torture items was a strong predictor in the model for single-query self-reported torture. Each additional torture item increased the chance of reporting having been tortured on the single query by 6% (95% C.I. 3% to 9%). Next, female gender independently increased the likelihood of reporting torture on the single query by 35% (95% CI 9% to 67%). Third, each decade of age increased the rate of single query reporting by 3% (95% CI 1% to 6%). Non-torture trauma events also independently predicted single query torture reporting, showing an 8% increase with each trauma event (95% CI 1% to 17%). Marital status and posttraumatic stress disorder symptoms (on the PCL) did not affect the rate of single-query torture self-report.

The same regression analysis as that described above was conducted using the 829 people endorsing one of more of the 75 torture items as "checklist positive". This analysis replicated this finding, with the number of torture items endorsed on the checklist most strongly predicting a single-query self-report to torture, and PCL symptoms not predicting the single-query response. The primary author will provide this material to interested readers upon request.

Discussion

Single-query self-report of torture

These data confirmed the work of Steel et al.[8] in demonstrating that a single-query self-report of torture can show strong association with other findings. In their review, Steel et al. showed a strong association of PTSD symptoms and torture self-report. We confirmed this association in our bivariate analysis of torture self-report versus the PTSD Checklist (PCL) score.

Our data did not support the association of PTSD symptoms and a single-query self-report of torture once the number of torture events was entered into a logistic regression analysis. Steel et al. did not have the same or similar variable available in their panoply of review data. The elimination of the PTSD symptoms from a self-report of torture suggests that symptoms alone do not drive the self-report of torture. Rather, a larger number of torture items are apt to lead to a self-report of torture. This is an important clarification, for it indicates that numerous torture experiences and not simply clinical distress predicts single-query self-reported torture.

That said, the number of torture items was not the only predictor of torture self-report. In this study, older age was a predictor. This was probably due to older people being at great risk, both because of their role and status in society, but also because many study participants were still children at the time of greatest civic chaos in East Africa.

Female gender also increased the self-report of torture, as compared with men. Likewise, non-torture trauma increased the self-reporting of torture. These latter findings are elaborated in the discussion below.

Reliability of torture prevalence rates

The prevalence rate of single-query self-reported torture in this sample was 36%. This rate would be reduced to 27% if the cases in group c (i.e., no endorsements of torture items on the checklist) were removed. However, the rate would be increased to 39% if the cases in group b (with one or more endorsements on the torture checklist) were added to the 27%. Thus, this analysis of single-query self-reports of torture does not minimize the extent of torture in societies exposed to widespread war or other violence. On the contrary, the findings indicate that torture is probably under-reported in surveys using a single-query self-report of torture. If other violence that is "probable torture" is considered, the under-reporting of torture is perhaps even greater. In this study, addition of "probable torture" cases to "pathognomonic torture" cases would double the number of people exposed to torture in this East African sample (and greatly increase the number of cases in group b).

This study includes only two African ethnic groups coming from two countries and differing violent contexts. Thus, our apparent under-count of torture may not extrapolate to other countries, ethnic groups, and contexts. However, collection of additional data besides the single-query on torture is apt to provide a truer and more useful assessment of violent experience and posttraumatic maladies.

Posttraumatic symptoms did not bear a relationship to a self-report of torture, once other factors were considered in the logistic regression. Thus, personal misery did not produce the self-perception of having been tortured in this sample. Basoglu et al[20] also noted that posttraumatic symptoms alone, in the absence of torture events, did not lead to a self-report of torture.

Reluctance to identify a person as tortured

We did not anticipate that such a large number of people (12% of the study participants) would deny having been tortured on a single query while reporting experiences that we considered pathognomonic for torture on a checklist. Factors associated with this reticence were fewer torture items endorsed on the checklist and fewer non-torture trauma events. Group b participants were also younger on average and more apt to be single than those reporting torture. Rationales for minimizing torture reports, drawn from anecdotal cases in our clinical work, may include:

- For those steeped in a traumatic environment (with cascades of omnipresent torture, abuse, deprivation, armed conflict, trauma during flight), one's own trauma may be discounted in comparison with greater trauma observed in others.
- Some study participants knew that they were undertaking rebellious acts against a ruling class (especially the Ethiopian males), expected to be punished if detained, and may have prepared for harm – factors associated with improved mental health following torture.[20] They may have seen the torture and other trauma as punishment rather than as unwarranted victimization.
- Some refugees may view severely tortured people as stigmatized, with brain injury, posttraumatic symptoms, and disabilities leaving them unfit for employment, marriage, and leadership. Thus, denial of torture may be salutogenic, as the traumatized person engages in self-directed recovery, and/or an attempt to avoid stigmatization, especially among younger, single men.

Group b versus group c

Group c experienced a high level of trauma, albeit without any pathognomonic torture items endorsed on the checklist. They reported a mean of 8.2 "probable torture" events and a mean of 7.9 "non-torture trauma" events (associated with flight, armed conflict, crime, and general chaos) – a total of 16.1 traumatic events. This compared with a mean 16.9 torture and non-torture events reported by group b – a comparable level of trauma events. In addition, group c reported a mean of 5.5 more PTSD symptoms on the PCL, as compared to group b. In summary, group c comprised a highly traumatized group, comparable to group b, and with more current posttraumatic stress compared to group b.

The demographic characteristics of group c distinguished them from the other groups. Compared to group a, they were 4.5 years older on average and included many separated-divorced-widowed people. Group c included significantly more women than groups a and d. These demographic factors may have contributed to their perception of having been tortured. Older age, female gender, and loss of a marital partner may also have fostered a perception of having been tortured when traumatic events of diverse kinds were experienced.

Non-torture traumatic experiences are common in circumstances that spawn crescendos of violence, such as war, revolution, genocide, tyranny, anarchy, and similar chaotic situations.[8,11,21] A perception of having been tortured may have extended to any trauma in the personal lexicon of group c. Or they may have viewed the inability or unwillingness of reigning authorities to protect them from trauma as evidence of official sanctioned violence, essentially a form of torture. More information is needed about this group, their experiences, and their points of view.

Pathognomonic versus probable torture events

The "pathognomonic torture" category was developed to solve a validity problem in our earlier analysis. This convention met the goal of our earlier analysis, which was to identify a group of people who had undergone torture. However, this process led to the discovery that many study participants denied having been tortured in a single-query self-report, but nonetheless reported pathognomonic torture events.

Despite its utility for the validity study, the concept of "pathognomonic torture" has certain limitations. For example, both pathognomonic and probable torture can produce the same damaging effects. Using "cutting off oxygen to the brain" as common modality, two events were judged to be pathognomonic of torture (immersion in water, immersion in dirty fluid), and two events were judged not to be pathognomonic of torture (strangling, suffocation). One might argue that the suffocation or strangling might have occurred in another context, such as resisting arrest or fighting with police, jailers, or other prisoners. However, the ORs for these four methods fell into the same range, suggesting that participants who experienced strangling or suffocation were as apt to say they had been tortured as those who had suffered immersion.

The concept of "trauma pathognomonic of torture" needs further examination. Despite its limited utility in this study, some experiences appear highly apt to be labeled torture. For example, water boarding to cut off oxygen might rank along with immersion in fluids, strangulation, and suffocation from the perspective of the victim. "Blindfolding", which may seem fairly benign outside of a context involving trauma-by-authorities, appears to be highly associated with reports of torture (OR in Table 2 is 2.87). Using the more highly selective pathognomonic items

as an inclusion criterion did not increase the number of significant items associated with single query responses. Possible explanations for the lack of enhanced selectivity might include the following:

1. the smaller number of cases in Table 2 (n = 405) as compared to Table 1 (n = 829);
2. the infrequent occurrence of some pathognomonic items; and
3. lack of empirical support for our notion of pathognomonic torture items.

Caveats

In the absence of collateral data regarding torture, we relied upon the participants themselves for data in this study. Participants were reporting their experiences in confidence, using a checklist that had been developed by interviews with their peers. We did not inquire for each harmful event whether participants considered the event to be torture or more general abuse; future work might employ such an approach.

The findings apply to two East African nations in which widespread torture and trauma occurred in the 1990s; they may not apply to other peoples, times, or places.

Terms such as torture and the items on the Posttraumatic Checklist were translated from English into Somali and Oromo, and then back translated into English for semantic equivalence. Although we used standard procedures to establish semantic equivalence, small differences in psychometric equivalence can survive these methods.[22]

In devising the torture single-query self-report and trauma checklists, we adhered to the participants' subjective description of the events (e.g., immersion in water, strangling) even though certain physiological consequences (lack of oxygen to the brain) might have comprised a final common pathway in the traumatic experience.

Conclusions

Our torture checklist originated from people who had undergone harm at the hands of authorities in Somalia and Ethiopia. As shown in Tables 1 and 2, the ORs provided a measure of the likelihood that any one event, if experienced, would be associated with a self-report of torture. A survey of those ORs suggests the following:

- Some traumatic experiences were more strongly associated with a self-report of torture than others (e.g., burned with boiling water, immersion in water, strangling, suffocation, electrical shock).
- No one traumatic event, whether in the pathognomonic torture category or the probable torture category, was inevitably associated with a self-report of torture.
- Number of torture events and number of non-torture trauma events influenced the self-report of torture, whereas current posttraumatic symptoms did not independently predict a self-report of torture.
- Older age and female gender were associated with an increase of self-reported single-query torture.

Acknowledgements

National Institutes of Mental Health grant numbers R01-MH59579 and 1R01-MH59570 supported this study. The authors acknowledge the valuable contributions in advising, translating, recruiting, and interviewing by the following: Abdullahi Gas, M.D., Osman Ahmed, M.D., Israel Gobena, J.D., Johara Mohammed, Elizabeth Namara, Abulqadir Omar, M.D., and Nadifa Osman, M.S.

We dedicate this work to Senators Paul Wellstone (Minnesota – deceased) and Pete

Domenici (New Mexico), whose efforts produced the legislation that funded these projects.

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How to combat torture if perpetrators are supported by a religious "justification"

Siroos Mirzaei, MD*,, Lilla Hardi, MD***,****, Thomas Wenzel, MD**,***

Abstract

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.

Keywords: Torture, medical examination, prevention, sexual torture, religion, perpetrator psychology.

We know that close collaboration between the health and legal professionals is crucial in the effective investigation of alleged cases of torture and in establishing procedures on how to recognise and document symptoms of torture in order that this documentation can later serve as valid evidence in court and also be used in international monitoring. The importance of this development is reflected in the dedication of a special standard to this challenge endorsed by the United Nations General Assembly, the "Istanbul protocol" (IP).[1] While there are some few examples of legal cases which have resulted in the prosecution of perpetrators and successful reparation for survivors,[2] in countries such as Iran such due procedure is close to impossible since torture is practiced by state officials and could be described as forming part of the legal system. One of the worst cases of torture is the stoning of humans, that also is "cruel and inhuman punishment" as in the in Article Five of the Universal Declaration of Human Rights and Article 16 of the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.[3] There have been documented cases of stoning in the last years in this country,[4] and public hangings are well documented.[5] Lashes on the body are also decreed by law and practiced often in public,[6,7] while recent studies have documented further forms of torture.[8-10]

Physical traces as documentary evidence of such incidences can vanish after days, but psychological and some often less easily detectable sequelae can be still identified after longer time intervals. The IP asks for the use of state-of-the-art examination technologies (Annex II) in documentation that so far have

*) Institute of Nuclear Medicine with PET-center, Wilhelminen Hospital, Austria

**) Hemayat, Therapy Centre for Survivors of Torture and War, Austria

***) Medical University of Vienna, Austria

****) Cordelia Foundation, Hungary

not been sufficiently used, most probably due to limited availability or due to political barriers such as the danger in providing documentation for both medical professionals and victims. The World Medical Association underlines the importance of support of and by health care professionals in difficult circumstances and in case of apparent "double obligations" (in the case of Iran, see for example a recent WMA statement[11]).

This indicates that at least in case of exile, or if a patient can travel, host countries should take the task of providing such advanced documentation. This constitutes an important protection of evidence procedure as due to the transitory nature of many sequelae even when no immediate court case can be filed; all traces must be recognised and documented for later use in a way following the best available standards.

A man who was examined by our team reported that he was imprisoned and tortured in one of the notorious prisons for political inmates[12] in Iran. Two years later there was still focal tracer enhancement in the bone scintigraphy of the skull (Figure 1) and left foot as signs of traumatic skeletal lesions,[13,14] that were in accordance with the pattern of beatings described by the patient, supporting his report. He further explained that during torture sessions which took one week, he was blindfolded and had no access to a restroom and had been forced to urinate during interrogations. After that he reported having been placed on a chair which was open in the middle and being exposed to sexual torture with a truncheon. His hands were handcuffed, his feet were fixed to the chair and he was threatened "to be inseminated" if he did not cooperate. Before some further violating acts the perpetrators reportedly used religious phrases such as "... my Imam Zahra, accept it for me..." or "... my Imam Mehdi accept it for me...". Scars were visible on the head and scrotal area corroborating the alleged blows to the head and injuries inflicted by a pincer to the genital area. An external psychological testing based on ICD 10 criteria by a certified psychologist/psychotherapist yielded diagnosis of panic disorder, severe depressive episode without psychotic symptoms and posttraumatic stress disorder. The overall objective medical findings therefore supported the patient's description of torture, using the approach outlined in the IP.

The findings reflect a characteristic challenge posed by situations where immediate examination that could confirm or contradict allegations of torture through existence or absence of transient symptoms such as haematoma or local fissures in soft tissue in case of sexual torture[15] is not provided, limited or not possible. Still, a complete examination using IP recommended procedures can be used to evaluate and possibly give credibility to claims of torture, especially if technologically advanced medical procedures can be used.

The case also illustrates a further issue. The patient's report as well as further diagnostic interviews with exiled survivors from Iran by our group (using information triangulation models) and reports by non-governmental organisations[9] indicate that the perpetrators in the Iranian political prisons might frequently claim or belief that they are following a "superior aim", an interpretation also supported by the presentation of the issue in public media promoting the present government's opinions,[16] even if concrete practices might contradict religious and other laws. Homosexual acts for example would be prohibited by law and young individuals have been executed because of such orientation.[17] In the last years we had reports of insulting sexual offence to male inmates in an outwardly "rigorously religious"

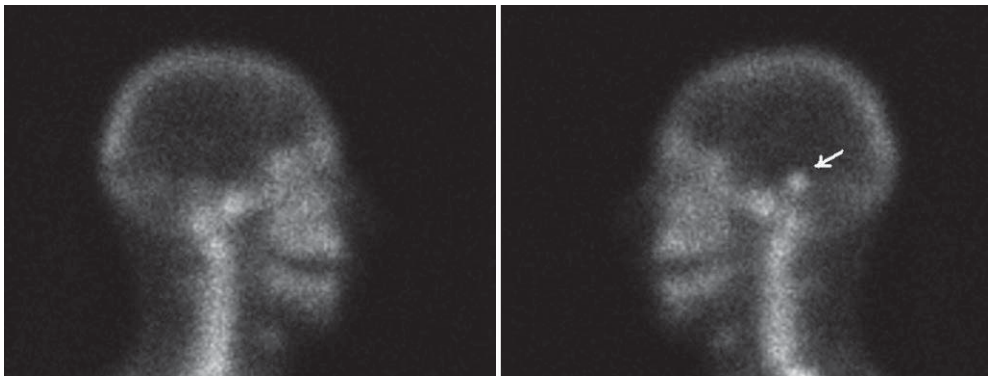

Figure 1. ^{99m}Tc-MDP Bone Scintigraphy: Focal pathologic tracer enhancement (elevated bone turnover) in the left temporal region (arrow).

country as described above in the case of a young man.[18] The question which arises is how to combat torture with religious background where the perpetrators are of the opinion that they are doing the "right thing" and the justice system still appears to support these claims. The stoning of women because of adultery, especially, or the hanging of men on reason of homosexual relations in the recent Iran as mentioned above are based on religious codes, which is not the case in a secular state. This matter has been precisely addressed by the UN Special Rapporteur on Torture. Accordingly, the "lawful sanctions" exclusion must necessarily refer to those sanctions that constitute practices widely accepted as legitimate by the international community, such as deprivation of liberty through imprisonment, which is common to almost all penal systems.[19]

Contrary to what might be expected, recent research has demonstrated that torture perpetrators – who most commonly are not "mad psychopaths" as in popular perception, but rather "the neighbour next door" - can build a cognitive system that permits a "double standard" of contradictory values,[20] or create a "doubling" by separate selves as in Lifton's conceptualisation.[21] Impact is especially severe if no future social support, safety and access to justice, are given. Clarifying the confusion caused by contradictory standards through restorative justice[22] is a further important aspect of possible answers to the problem. Ethical guidance provided by religion could be an important protector of human rights (e.g. Ayatollah Taleghani),[23] if respected in this way.

As recommended by the UN standards including the IP, a country's legal or prison system should permit independent experts to examine prisoners at risk before, during and after imprisonment. It could be seen as being in the interest of such countries to follow the procedure to either discredit possible unjustified claims, or alternatively to stop torture and inhuman treatment if they are confirmed through independent expertise. This could also be supported by an invitation to the UN Special Rapporteur on Torture to visit the country, as recommended in earlier discussions.

The psychological and medical evidence of torture may help in the individual case not only in an "immediate" court case but also in specific situations such as the asylum

process or in monitoring the work of UN institutions such as the UN Special Rapporteur on Torture[24] or human rights organisations. It cannot be expected to have an immediate effect on the suspect practice of torture in a country with a strong religious background of legislation.

Shirin Ebadi,[25] Manour Osanloo[26,27] or Jafar Panahi[28] have been celebrated with international awards and they have still been confronted with major repression and imprisonment. In other words – international interest and high level awards do not have any protective impact against governmental based political imprisonment and torture.

The western countries focus their criticism regarding Iran on the nuclear threat using economic embargos against Iran.[29] The system is now, after 30 years, described as a well established, however national democratic movements seem to be immediately oppressed. Thus, international attention seems insufficient and ineffective. There are many examples in history of totalitarian countries, but the image painted by present findings[30] exceeds such examples in regard to human tragedy and it should be in the interest of the country's government to disprove such a perspective. An international effort has been recently been undertaken by the UN Human Rights Council to nominate a special rapporteur on Iran,[31] but whether he will have the possibility of visiting Iranian prisons will remain to be seen, since, until now, no invitation was offered to the UN Special Rapporteur on Torture.

In conclusion, we would hope for the development of an effectual international instrument to bring torture perpetrators to justice independent from any "justification", especially where the system might not offer balanced justice in an enmeshed juridical-religious background protecting systematic violence.

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Near-death experience and out of body phenomenon during torture – a case report

Maxwell J.F. Cooper, MD*

Abstract

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.

Keywords: Altered consciousness, torture, crisis, NDE

Near death experience (NDE) is a powerful state of altered consciousness reported following a life-threatening crisis. Commonly reported features include a sense of euphoria, a bright light, "out of body" phenomena, and paranormal or mystical qualities.[1] During an "out of body" experience individuals typically feel as though they are floating on the ceiling and report being able to observe activity below around their physical body.[2] NDE is distinct from the persistent state of de-personalisation reported by many torture survivors in their daily lives. NDE has been described in a wide range of causes, including cardiac arrest, septicaemia, accidents, attempted suicide and electrocution.[3] Notable other causes include head injury and syncope during peril.[1] NDEs have been reported across a wide range of cultures[2,4] and age, including children.[5-9] The phenomenon is ancient[10] and its incidence surprisingly high: in one prospective study, NDE was reported to occur in ten percent of cardiac arrest survivors.[11,12] Three overarching explanations for NDEs have been advanced[12]: A neuro-physiological process associated with the dying brain;[4,10,12] a psychological response to the perceived threat of death;[4,12] and a transcendental or divine experience.[4,12]

An evidence search using Pubmed, Psychlit and Web of Knowledge databases with the terms "out-of-body" or "near-death experience" and "torture" failed to identify existing accounts of NDE reported during the medical examination of torture victims. A professional librarian participated in the

*) University of Glasgow, Great Britain.
mjfcooper@clinmed.gla.ac.uk

evidence search. The patient read this article and gave consent for publication.

Case study

In 2009 a Black African man in his mid twenties attended for assessment to document alleged torture. He spoke fluent English and his only past medical history of note were symptoms of sleep paralysis. During the interview he described being detained and tortured eight years earlier in Africa to elicit information. He reported being repeatedly taken from a cell into a dedicated torture chamber where he was kicked, punched and beaten with batons and whips. His limbs were bound and he was suspended from the ceiling. During one interrogation a gun was pointed at him at close range. His aggressors were formidable torturers and the patient witnessed the death of another detainee. Scars on the patient's back, arms and legs were consistent with the injuries described. There was no electrocution reported during his torture. As a result of detention and torture, the patient was left with persistent symptoms consistent with Posttraumatic Stress Disorder (PTSD), including nightmares and flashbacks. Whilst recounting one of these interrogations he spontaneously reported a distinct "out of body" phenomenon.

During this NDE he felt himself rising toward the ceiling of the torture chamber and looking down to observe his body being beaten below. There was a "pure white" light and a sound like "an open ocean". He felt as though he had "left suffering behind". At one point he heard familiar, "gentle voices". Images flashed before his eyes, for example of himself as a baby. He also reported visions of future events, for example the birth of his yet unborn first child. In between these "flashes" he continued to see his physical body lying on the floor below being beaten. The bright light then formed a tunnel and he saw his body starting to fade away. The experience ended in his losing consciousness. Although the patient described himself as a Christian there was no overtly religious component to the experience.

Further enquiry was undertaken using the Greyson scale[13,14] (see Table 1). This tool is a recognised measure of NDE depth and categorises the overall quality of an NDE as cognitive, affective or transcendental. Using

Table 1: *Greyson Criteria for assessing depth of NDE and qualitative category (in brackets). The Patient Score (x/y) gives the score for this patient (x) and the maximum points potentially achievable (y) for each criterion according to the Greyson scale. A total of more than 7/32 is a "true positive" NDE.*

Greyson NDE Scale Element[13,14]	Patient Score
Altered sense of time (c)	2/2
Accelerated thought processes (c)	1/2
Life review (c)	2/2
Sense of sudden understanding (c)	0/2
Affective feeling of peace (a)	1/2
Feeling of joy (a)	0/2
Feeling of cosmic unity (a)	1/2
Seeing/feeling surrounded by light (a)	1/2
Purportedly paranormal vivid senses (p)	0/2
Purported extrasensory perception (p)	0/2
Purported precognitive vision (p)	1/2
Sense of being out of physical body (p)	2/2
Apparent transcendental sense of an "otherworldly" environment (t)	0/2
Sense of a mystical entity (t)	1/2
Sense of deceased/religious spirits (t)	1/2
Sense of a border/"point of no return" (t)	0/2
Total Score	13/32

Qualitative category of elements: c = cognitive; a = affective; p = purportedly paranormal; t = apparent transcendental

the scale, this patient's experience was confirmed to be a "true positive" NDE and its dominant quality to be cognitive.

Discussion

Although NDE has been reported as a result of a range of traumatic injuries, case reports emerging from the medical examination of torture victims are lacking. The torture experienced by the patient in this report was not distinct in technique or severity from that commonly presenting to the author and his colleagues. Whilst in detention, the patient reported only receiving water to drink and denied consuming any food or medication. This effectively eliminates a psychogenic agent as a cause; nevertheless, a causative role for starvation cannot be excluded. A history of symptoms of sleep paralysis was only elicited upon specific enquiry: this common condition has been found elsewhere to be associated with NDE.[1] This patient's NDE occurred eight years prior to the medical examination. Nevertheless, there exists good evidence for the reliability of NDE reports over a period of almost two decades.[15]

Discussion with colleagues experienced in the medical examination of victims of torture failed to identify further cases of NDE. The combined experience of these examiners shows that NDE associated with torture is very rarely reported. This suggests that the incidence of NDE during torture may be considerably less than for other medical crises. A number of reasons could underlie this. First, language, cultural and time barriers may reduce reporting. Second, fear of disbelief is known to prevent disclosure of NDEs, even to close family members.[2] Finally, NDEs may not be specifically sought by examiners. The precise incidence of NDE during torture clearly requires further investigation. The author would welcome being informed of other cases reported to medical examiners of torture victims.

If the postulated low incidence of NDE in torture victims is correct, two explanations may be responsible. First, it is possible that many torture techniques do not lead to a window of critical ischemia of the brain required to trigger an NDE. This may be due to torturers' ingenuity in inflicting pain, usually in increments of severity and often not resulting in death. Second, there may be psychological or physical characteristics of torture that render NDE harder to recall after the event. This might be due to the protracted infliction and diverse nature of injuries sustained in torture. Finally, a genuinely low incidence of NDE in torture would discount one psychological explanation of NDE: as profound fear is always part of torture, a low incidence of NDE in victims would refute the theory that it is a psychological response to perceived threat of death.

One interesting aspect of this case report is ongoing dreams that include powerful visions from the patient's NDE and seemingly revealing future events. This finding may be related to the distressing nightmares and flashbacks experienced in PTSD and supports evidence elsewhere that NDE is associated with increased activity of the arousal system.[1]

It is well known that the experience of an NDE may lead to transformative shifts in patients' personal values and their understanding of the world.[2,16] In the present case the patient reported no longer fearing death and being certain of consciousness reaching beyond bodily death. These are common beliefs following NDE.[2] Positive sequelae such as these suggest that physicians should consider exploring the possibility of NDE amongst torture victims under their care.

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Intercultural encounters in counselling and psychotherapy – communication with the help of interpreters

Mechthild Wenk-Ansohn, MD* & Norbert Gurris

Abstract

Treatment and rehabilitation of torture victims and persons traumatized by war or persecution can require working in an intercultural setting, as is the case when working with refugees and migrants. The following article offers practical advice for diagnostics, counselling and treatment of patients from other cultures who are not speaking the language of the therapist.

Key words: Torture victims, intercultural communication, interpreting, practical advice

Perception, feeling, thinking and modes of expression are influenced by culture and context. Values, social norms, the individual's attitude towards members of the group, meanings, patterns of thought and action are established in the interaction of the group, evolve with the historical and social context across generations and create internalised "maps of meaning".[1] These constitute sometimes conscious, though predominantly subconscious, references for the individual, his or her identity formation and development. Thus influenced, concepts of the self, the world and modes of interaction form a wealth of opportunity but also restrictions.[2] Breaches of norms are connected with feelings of guilt and shame. In a traumatic situation, the culture specific frames of reference influence the evaluation of the event of the trauma itself, its interpretation and its consequences. The culturally shaped actual and anticipated reaction of the social environment significantly affects the course of trauma reaction and coping mechanisms.[3]

If women from traditional societies – where honour and shame are of paramount importance in the regulation of social standing and relations – have experienced rape or other forms of sexual violence, they frequently suffer from complex PTSD[4] with chronic processes sustained by collective-dysfunctional cognition.[5] Somatic pain develops as a consequence of a chain reaction of dissociation, intrusion, avoidance, anxiety/stress in connection with chronic muscular tension. At the same time the somatic pain is a non-verbal expression for the trauma, anxiety and depression, to communicate the suffering without revealing its source and to seek primary care from physicians.[6] The women know that having been dishonoured by sexual violence they might be ostracized or even killed. The tendency to keep these experiences secret in order to protect oneself and the extended family from loss of honour and marginalization, makes therapeutic access difficult and supports impunity of the perpetrators.

For diagnostics and therapeutic interventions the frames of reference as well as modes of thinking and behaviour underlying

*) Center for the Treatment of Torture Victims Berlin, Turmstr 21, 10559 Berlin, Germany, m.wenk-ansohn@bzfo.de

culturally bound interpretations need to be taken into account and researched individually. Symptoms and accompanying behavioural patterns may also be pronounced differently. Remarkably, for example, women from the former Yugoslavia and Kurdish women from rural areas in Turkey often exhibit psychogenic seizures.[4] These are particular manifestations of dissociative states (so-called dissociative seizures, ICD-10: F44.5)[7] or changes of consciousness resulting from agitation and hyperventilation.

Even though clusters of symptoms of PTSD occur across cultures, the interpretation of complaints, their classification and the understanding of illness are culturally differentiated.

Psychotherapy for migrants means coming in touch with people whose frames of reference can be different in some areas from one's own. This coming together requires openness to reflect on one's own frames of reference, the consciousness of one's own cultural and contextual constraints as well as the perception of and respect for culturally and socially determined differences and flexibility of perspectives. Psychological models based on western societies cannot be transferred without examination and adaptation for people whose socialisation happened in collectively oriented societies. Working with peri- and posttraumatic schemata requires an adaptation of the interventions under consideration of rooted, culturally determined attitudes as well as an adaptation to the level of education. Therefore, the societal, historic-political and the current social context of the traumatisation are also to be included in systemic consideration.

Since, as a therapist one is unlikely to have a thorough understanding of all cultures, one risks falling back on stereotypes that can distort perception of the individual patient. That is why it has proven useful to approach the world of the patient with an attitude of respectful curiosity and engaged neutrality through circular questioning.[8,9] This approach also enables the therapists to reduce their position of power that is attributed to them by their professional and social standing.

Helpful elements for intercultural communication

- Openness and genuine interest toward the patient's cultural background
- Respect, observation of codes of courtesy
- Using great care when dealing with topics involving shame and taboos
- Learning about culturally divergent styles of communication/cultures of language, paying attention to indirect communication
- Inquiring about the meaning of words, figures of speech and metaphors
- Circular questioning, approaching the topic from different angles
- Clarification of misunderstandings, encouraging follow up questions
- Reflection on and transparency of one's own culture/culturally determined behaviour
- Dialogs about differences between the country of origin and the country of exile or different cultures within one country (this can lead to humorous discussions about observations of the patient in the current context)
- Transparency of the professional role and the therapeutic process
- Repeated stressing of the doctor-patient confidentiality (including also the interpreter). This also means to assure no communication to close relatives and friends of the patient
- Imagination and the courage to improvise (e.g. asking the patient to draw, visualisation using items of symbolic reference)
- Attentiveness to non-verbal communication

Verbal communication with interpreters

In most cases interpreters are part of the therapeutic or counselling setting when working with patients from other countries or cultural backgrounds.

Apart from enabling patient and therapist to communicate verbally, the interpreter also plays a major role in clarifying culture and communication specific questions; a resource that should be made use of in the form of a brief exchange after every session.

The interpreter has to be fluent in both languages, respectful and of a controlled empathetic posture. The role of the interpreter has to be clear to all involved. She or he has to be trained specifically.

The training of interpreters working in therapeutic contexts includes the instruction of the basics of:

- his or her role in the setting and the form of translation
- psychopathological symptoms in traumatized patients
- basics in therapy, therapeutic relationships and the methods that may be used
- meaning of specific medical/psychological terminology
- knowledge about the everyday reality of asylum seekers or displaced persons

The training should also include methods for the prevention of burnout and secondary traumatisation. Even if the interpreter makes an effort to translate with utmost neutrality and with maximum accuracy, it can be assumed that his or her presence and personality will have an impact on the interaction.

Transfer and counter-transfer reactions occur in a triad: patient – interpreter – therapist.[10] The therapist needs to be constantly aware of this process and has to reflect on this together with the interpreter after the treatment session.

Psychotherapy with the assistance of interpreters always requires a clearly structured cooperation based on a distinct definition of function and role.[11-13] The therapist is responsible for the structuring of communication, the course of the conversation and the therapeutic process. He or she also needs to protect the interpreter from extreme emotional stress, which might cause the interpreter to suffer the risk of secondary traumatisation or burnout. To be able to monitor the dynamics of the triad a triangular seating arrangement is recommended. This type of seating illustrates the importance of partnership for successful communication.

Certain principles and rules have proven useful in the work with interpreters in psychotherapy. See the box alongside for more details.

After getting used to working with interpreters, most therapists do not experience this setting as being difficult or hindering the process of counselling or therapy. Working with patients coming from different cultural backgrounds is a challenge, but also a very enriching experience.

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Rules for working with interpreters

- Working with professional, well trained interpreters (wherever possible with specific training for therapy settings and counselling situations).
- Relatives or friends should not be used. Much information would not be communicated and personal relationships could be affected.
- The interpreter signs a written statement concerning the doctor/patient confidentiality.
- Keeping impartiality.
- There should be no private contact between interpreter and patient, which also includes not giving the patient the interpreter's phone number.
- Before the first therapy session, there should be a preliminary talk where the therapist briefs the interpreter.
- At the first session introduction of the interpreter and explanation of the rules and how the communication will be conducted with therapist/interpreter/patient.
- The interpreter translates everything that is being said by the patient and therapist in the first person ("I cannot sleep, I have nightmares", "I understood that you are waking up out of horrible dreams", etc).
- The translation should be as literal as possible (this is very important, also when doing diagnostics with patients who need psychiatric care, especially when dealing with psychotic patients).
- Generally consecutive translation is preferred (an exception is simultaneous translation when working with specific techniques, e.g. EMDR or screening-technique when simultaneous translation is often perceived as stressful).
- The interpreter should not add or leave out anything.
- Everything said in the room is translated.
- If terms used in a translation lead to misunderstandings they should be clarified through retranslation.
- The patient has to be made aware that if there is relevant communication outside the therapy room between him or her and the interpreter, the therapist will be informed about the content of the conversation.
- The therapist should use short sentences and phrases and avoid abstract concepts as well as technical terminology.
- The therapist should take care to communicate appropriately to the patient's level of education and ability to abstract and not leave it up to the interpreter to adapt and explain.
- The therapist pays attention to the flow of the conversation and interrupts politely if the patient speaks for too long. He or she also allows for the interpreter to interrupt to ask a clarifying question.
- The therapist makes an effort to speak to the patient directly and to establish eye contact.
- The therapist is aware of non-verbal communication.
- Exchange after the therapy session between therapist and interpreter. Clarification of misunderstandings, cultural characteristics, methodological approach, triadic relationships and debriefing with the goal to relieve the interpreter.
- The interpreter attends supervision and uses opportunities for further training.

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Statement on Hooding

International Forensic Expert Group*

Keywords: Torture, hooding, cruel inhuman and degrading treatment

Background

Hooding is the practice of fully covering the head of a person. Hooding has been used in a number of countries with increasing frequency during the past 50 years.

The practice of hooding has been recognized as a form of torture and/or cruel, inhuman and degrading treatment or punishment (CIDT) by a number of international and regional human rights bodies.

The U.N. Committee Against Torture has determined that "hooding under special conditions" constitutes both torture and cruel, inhuman or degrading treatment or punishment.[1] It noted that this finding would be "particularly evident" when hooding is used in combination with other coercive interrogation methods.[1] The Committee Against Torture has subsequently reaffirmed that blindfolding constitutes torture.[2] The U.N. Special Rapporteur on Torture has determined that "blindfolding and hooding should be forbidden".[3]

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment has noted that blindfolding "will frequently amount to psychological ill-treatment", and that the practice should be abolished.[4]

The European Court of Human Rights has determined that blindfolding a prisoner constitutes cruel or inhuman treatment when it is used in combination with other interrogation or detention methods[5] and can constitute torture when used with other techniques.[6]

The Inter-American Court of Human Rights found that playing the radio at full volume while hooding a detainee or otherwise subjecting her to light manipulation constitutes "mental torture", as these techniques formed part of an overall effort to "obliterate the victim's personality and demoralize her".[7]

The U.N. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol) also recognizes the deprivation of

*) International Forensic Expert Group:
D. Alempijevic; R. Beriashvili; J. Beynon; M. Duque; A. van Es; R. Fernando; S. Fincanci; S. Hansen; L. Hardi; H. Hougen; V. Iacopino; P. Leth; S. Louahlia; J. Modvig; M. Mendez; Ö. Özkalipci; J. Payne-James; M. Peel; J. Quiroga; O. Rasmussen; H. Reyes; B. Rich; S. Rogde; A. Sajantila; D. Somasundaram; J. Thomsen; F. Treue; P. Vanezis; D. Vieira.

Correspondence to irct@irct.org

For full details about the International Forensic Expert Group please visit www.irct.org/our-support/medical-and-psychological-case-support/forensic-expert-group.aspx

normal sensory stimulation, such as sound, light, sense of time, isolation, manipulation of brightness of the cell, abuse of physiological needs, restriction of sleep, food, water, toilet facilities, etc. as methods of torture.[8]

In addition, the U.S. Department of State has described blindfolding as a form of torture[9] and the new U.S. Army field manual on human intelligence collection also prohibits the use of sensory deprivation and techniques such as placing of hoods or sacks over the heads of detainees or using duct tape over the eyes.[10]

Despite international recognition of hooding as a form of torture and/or ill treatment, there have been a number of recent legal cases in which the use of hooding has been examined. The purpose of this statement is to provide legal experts and adjudicators with an understanding of the physical and psychological effects of hooding and other equivalent forms of sensory deprivation and whether hooding and other equivalent practices may constitute torture and/or CIDT.

The International Forensic Expert Group consists of 33 medical experts from 18 countries with more than 500 years of collective experience in the evaluation and documentation of physical and psychological evidence of torture and ill treatment. The opinions expressed in this statement on hooding are based on the collective experience of documenting the physical and psychological effects of hooding and other similar forms of sensory deprivation among thousands of detainees that they have examined.

Hooding Practices

The practice of hooding typically involves covering the head of a detainee in some manner. Hooding practices may vary and the effects of hooding may depend on a number of factors related to the application and context of its use including: the material composition of the hood (i.e. the effectiveness of sensory deprivation and interference with air exchange), duration and frequency of its use, tightness of the hood around the head, the presence of contaminants (i.e. urine, feces and blood) in the hood, and the use of additional methods of torture and/or CIDT. Mock executions, beatings and other methods of torture are often practiced in conjunction with hooding to maximize the infliction of physical and psychological pain.

Hooding in this statement also refers to other equivalent forms of sensory deprivation such as the use of goggles or blindfolds and earmuffs. In contrast, covering a detainee's head with plastic bags or other impermeable barriers to respiration (effective exchange of oxygen & carbon dioxide) and the use of hoods with noxious substances such as petrol, chilli pepper, talc and other respiratory irritants represent primary methods of asphyxiation and are not considered as forms of hooding in this statement. It is important to recognize, however, that hooding may impede normal respiratory function and that this may have serious consequences in some individuals. Hoods with eye slits also have been used to coerce the identification of "suspected terrorists". In the absence of detainee's consent, such practices would be considered "hooding" as defined in this statement.

While policy makers and legal experts may consider the effects of hooding independently from other methods of torture and/or CIDT, the practice of hooding is virtually always used in combination with other methods of torture and/or CIDT. Among the thousands of detainees we have examined during the past 36 years from virtually every country in the world, we are unaware of any case in which the only method of alleged abuse was hooding.

Physical and Psychological Effects of Hooding

Hooding is a form of sensory deprivation that is associated with a number of physical and psychological effects, and also may have significant adverse legal consequences.

Hooding deprives individuals of normal vision and also may impair hearing, respiration, and the sense of smell. Deprivation of normal vision also may impair balance and coordination. Impaired respiration (oxygen & carbon dioxide exchange) may be exacerbated by pre-existing medical conditions (cardiovascular, respiratory, hematologic, neurologic, and others) and psychological disorders such as anxiety and claustrophobia. Interrogation personnel are rarely aware of such conditions and cannot reasonably be expected to be able to make an assessment of whether the use of a hood would pose a risk to health. Other factors that may promote hooding-related respiratory distress include: inadequate ventilation of ambient air, heat and humidity, and the detainee's physical and psychological responses to hooding (e.g. struggling against restraints, pain, and fear). Hooding may prevent the observation of the detainee's physical condition and further contribute to respiratory distress and ultimately result in loss of consciousness, anoxic brain injury, and even death.

Hooding increases the likelihood of severe physical pain, injury and subsequent disability as it increases an individual's vulnerability to other methods torture by preventing the anticipation of harm such as kicks and punches and subsequent defensive response.

Although hooding is virtually never practiced in isolation of other physical and/or psychological methods of torture, we have observed significant psychological effects that are directly related to hooding practices. Hooding and other equivalent forms of sensory deprivation typically cause fear, anxiety, high levels of stress, disorientation, especially with respect to time and location, and a sense of loss of control and powerlessness. The adverse cognitive and emotional effects of hooding may impair individual psychological coping mechanisms. Hooding may serve as a means of moral disengagement for perpetrators of torture. Hooding may have a dehumanizing effect on the detainee in the eyes of the perpetrators which may subsequently facilitate and intensify additional acts of torture.

In addition to its physical and psychological effects, hooding may have adverse legal consequences for individuals who allege torture and/or CIDT. Hooding frequently prevents detainees from being able to identify their alleged perpetrators. Hooding also may affect an individual's ability to accurately recount the details of the alleged torture and/or CIDT and, consequently, adversely affect judicial credibility determinations.

Conclusion

Hooding and other equivalent practices are intentional forms of sensory deprivation which constitute cruel, inhuman and degrading treatment or punishment and should be prohibited in interrogations and detention. When hooding is practiced in conjunction with other acts that may be considered cruel, inhuman and degrading treatment or punishment, it may constitute torture. In our experience, hooding is very often practiced in combination with other methods of abuse and typically, under such circumstances, constitutes torture.

It is important to bear in mind that in each assessment of alleged torture and/or CIDT, forensic experts base their opinions on the extent to which the sum total of physical and/or psychological evidence corroborates an individual's allegations of abuse

and on evidence of physical and mental pain and disabilities associated with the alleged abuse. In our opinion, consideration of hooding as torture and/or CIDT should be based on a clear understanding of actual and torture practices and on individual forensic medical evidence.

About the International Forensic Expert Group

The International Forensic Experts on Torture was established in 2009 by the International Rehabilitation Council for Torture Victims (IRCT) in partnership with Copenhagen University Department of Forensic Medicine. It consists of prominent international forensic experts with extensive experience in the evaluation and documentation of torture and ill treatment. These independent experts participate in investigations of alleged torture and ill treatment and provide impartial forensic reports and legal testimony on their findings. They also provide consultative and technical advice on medical legal issues related to torture and ill treatment.

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A Mental Healthcare Model for Mass Trauma Survivors: Control-Focused Behavioral Treatment of Earthquake, War and Torture Trauma

Cambridge University Press Cambridge UK 2011, ISBN: 9780521880008, by Basoglu Metin and Salcioglu Ebru

Michael A. Grodin, MD*

There are literally thousands of published books in the field of psychological trauma. Many of these books focus on mass trauma including natural disasters, political violence, armed conflict and survivors of torture. The publication of a new book which promises a single integrated treatment model to care for all of these forms of mass violence is an ambitious and exciting project. A Mental Healthcare Model for Mass Trauma Survivors: Control-Focused Behavioral Treatment of Earthquake, War and Torture Trauma is a follow-up to a 1992 volume by Basoglu entitled Torture and Its Consequences: Current Treatment Approaches (Cambridge University Press) and is based on over 20 years of study involving animal and human responses to unpredictable and uncontrollable stressors.

The authors of this text are well known in the trauma field. Metin Basoglu and Ebru Salcioglu are both visiting scholars of trauma studies in the Department of Psychological Medicine at the Institute of Psychiatry at Kings College London, as well as Directors at the Istanbul Center for Behavior Research and Therapy. The author's have completed extensive research in Turkey and the former Yugoslavia since the early 1990s. The present text reviews over 20 studies covering some 15,000 survivors of mass trauma. Their key finding is that traumatic stress can be reversed by interventions that enhance a sense of control over and resilience against traumatic stressors.

The authors have developed what they claim is a theoretically sound, evidence-based, brief and cost-effective behavioral intervention, one which is easy to train therapists to deliver and suitable for dissemination to both professionals and lay people. The core of this treatment is what the authors call Control-Focused Behavioral Treatment. It shifts the focus from the standard habituation to exposure model to a focus on enhancing a sense of control over and resilience against the anxiety of traumatic stressors. The authors' learning theory model of traumatic stress focuses on the response of helplessness and hopelessness involved in unpredictable and uncontrollable events. Their treatment aims to develop anxiety tolerance and control rather than a pure anxiety reduction.

Much of the text focuses on the authors' work with earthquake victims. There is a chapter on assessment tools which includes client self administered screening instruments as well as instruments designed for research purposes. A detailed account of Control-Focused Behavioral Treatment outlines the steps of identifying

*) Boston University School of Public Health and the Boston Center for Refugee Health and Human Rights, Boston, Massachusetts, U.S.A., grodin@bu.edu

traumatic cues and avoidance behaviors followed by focusing on self exposure exercises which lead to mastery and control over anxiety. There is an excellent chapter on the assessment and treatment of prolonged grief reactions as well as sections on war and torture survivors. The appendix includes the complete 78 page manual with a set of assessment tools and the specific materials used for treatment of earthquake survivors.

While this is an important contribution to the literature, it contains several bold assertions which will be controversial. The authors argue that their treatment is equally successful for both acute, single traumatic events (earthquakes) and chronic trauma exposure (torture). They argue that "The fact that war, torture, and earthquake trauma share the same mechanism of traumatic stress implies that they are likely to respond similarly to effective interventions that can reverse the traumatic process." (page 181). They continue "The results of between sample comparisons do not support the view that war, torture, and earthquake traumas differ substantially in their subjective impact, cognitive effects, mechanisms of traumatic stress, and the nature, prevalence, and severity of their mental health outcomes." (page 187) Less controversial they claim that "All these findings imply that a resilient person subjected to extremely severe torture in objective terms (i.e. the nature and number of torture events endured) might present with relatively mild mental health problems, whereas a less resilient natural disaster survivor exposed to relatively milder trauma might present with severe psychiatric problems." (page 179)

The book does not address several key points that experienced clinicians would expect. For example, the authors do not discuss the evidence for Complex Posttraumatic Stress Disorder and the psychological consequence of prolonged inescapable exposure causing deeper personality changes in survivors. The authors also do not discuss the important use of bodywork to locate emotional stress in the body and empower and reconnect the mind with the body. Especially important there is little discussion of the effects of using a single protocol to treat patients from highly diverse societies in Africa, Latin America, Asia and the Middle East. It should also be noted that most of the assessment instruments presented were not culturally validated. The manifestation of trauma may be culturally bound and may manifest distress in a cultural context. Culture may also affect the acceptability of treatments and the assessment of outcomes. Attention to language and communication difficulties as well as the role of community and religious traditions may seriously impact the implementation of treatment strategies.

In the final chapter the authors are most critical of the torture treatment and rehabilitation center movement stating that funders of these organizations provide "unquestioning support for essentially ineffective rehabilitation services" (page 193) and "essentially ineffective rehabilitation services stand a better chance of obtaining funding than those that propose research to develop effective treatments". (page 193) These are provocative statements and as a practicing physician with over 30 years of caring for victims of trauma this is not my or my colleagues experience. While it is true that more research needs to be done, especially on stratified populations and conditions, I do not believe that the funding organizations unquestioningly support essentially ineffective rehabilitation programs.

The authors conclude, "On a final note in ending this book we are well aware of the fact that the implications of the material covered in this book go against mainstream thinking in the field of psychological trauma. There will most probably be challenges to the evidence presented or disagreements with our conclusions of recommendations and all this is natural in the field of science." (page 195). Here I wholeheartedly agree.

Contributory torture

Dr. Munawwar Husain, MBBS, MD, DNB, MNAMS*

Sir,

Contributory torture is a novel concept surviving in the domain of unshakeable reality. Its reference is not found in the literature despite extensive search.

The word 'contributory' denotes: "of the nature of or forming a contribution: entering, giving, occurring or acting as a contribution, share, or aid toward effecting an end or result".[1]

Taking a cue from the established "contributory negligence" which is defined as:

1. "Contributory negligence applies solely to the conduct of the claimant alone. If the claimant is guilty of an act or omission, which has materially contributed the matter comes within the concept of contributory negligence and courts are enjoined to apportion the loss between the parties as the facts and circumstances justify".[2]
2. Lord Denning points out that "a person is guilty of contributory negligence if he ought reasonably to have foreseen that, if he did not act as a reasonably prudent man, he might hurt himself; and in his reckonings he must take into account the possibility of others being careless".[3]

Hence, contributory torture may be defined thus: "the interrogee's outward display of defiant behavior/attitude that instigate provocation in the interrogator's mind-set at that point of time rendering at risk the interrogee to enhanced physical or mental torture thereby apportioning his share in the entire process and making him responsible for the outcome of the event".

A short survey was conducted with a fixed agenda to find out certain aspects about torture. Six police officers of the rank of inspectors and in charge of police stations in the district were questioned separately and on different occasions about the controversial role of the suspect during interrogation. Almost all the police officers agreed unanimously that the suspect's behavior motivates their desire to inflict or not to inflict pain. All interrogations begin with a primer; a desire to obtain confession – a true confession. The course of investigation is determined by probable factors, most importantly the suspect's cooperation during the interrogation sessions. No doubt the environment itself is coercive for the suspect. However, it is up to the suspect to mitigate the threateningly pervasive environment within the room. These police officers are entrusted the unpleasant task of investigation with

*) Department of Forensic Medicine
J N Medical College
Aligarh Muslim University
India.
husain_uia@yahoo.co.in

practically no leverage because they are obsessed to produce confession within a very restricted time frame. Some people may condone the investigation officers' behavior by demarcating emergency-induced "good torture" from that of leisurely practiced "bad torture",[4] the former being the offspring of unpopular "situational ethics".

However, all investigating officers linked excess torture to provocation. They analogized it to incidences like mob destruction, arson and unruliness. The more out-of-control the mob gets the more it incites equal provocation among the police controlling it. Citing the above situation they opined that initially there is modest reaction from the police – chasing, use of baton, high pressure water treatment, tear gas, rubber bullets and ultimately firing of bullets. According to them if there is resistance from the interrogee – whether ephemeral or persistent – much would depend on his personality and training. The level of resistance put forth by the interrogee cannot be predicted neither it can be quantified. Some break down under intense pressure, others do not – the so-called hardened type. The police are under pressure to elicit information – fast, reliable, and collaborative. This single factor itself coupled with steadfast stubbornness by the suspect provokes the police to resort to out-of-the-book methods. The investigation officers further elaborated that conventionally the police try to remain within humane limits because initially they try to separate chaff from the grain – the innocent from the guilty. The police patience runs thin very fast. They have the time-tested method under which the police conduct raids at the residence of the suspect in the wee hours and thrash the person indiscriminately but in a controlled way. Reason behind this treatment is to break the resistance and the spirit at the very beginning not only of the suspect but also of the people cordoning him so that later process becomes unhindered. A similar but modified treatment is meted out to the suspect in confinement. In certain cases the courts have carefully examined the use of treachery and deceit in the interrogation of suspects, and drew a very clear distinction between verbally misrepresenting evidence and creating a fictitious piece of evidence.[5] Nevertheless electronic recording of police interrogation would be a welcome move.[6] It thus transpires that provocation is an entity that cannot be wished away by the fanciful magic wand no matter how much we talk of protecting human rights. There is need to devise ways and means to reduce anger and retaliation against naked provocation. The interrogators must realize that they are the law and that the suspect represents the Wild West Outlaw – demeaning and disrespectful towards the law.

The same knowledgeable investigation officers opined that the provocation can be minimized if not altogether eliminated.

They suggested that:

1. The police must be trained for anger control by regular in-service training programmes.
2. Simulation exercises must be done to bring out the unruly from the police force itself.
3. Counseling by psychologists must be the regular feature, especially to those who are involved in the interrogation process.
4. Psychiatric/sadistic cases must be identified from within the police force itself and they must be sidelined from the interrogators task group.
5. Laws against torture must be specific, stringent and practical without too many legal frills attached. The torture cases must be tried as per the torture laws (to be framed if not already in place) and not against general criminal provisions.

This short communication is presented as a sounding board to the community of researchers from diverse disciplines to realize that if torture cannot be eliminated it can be brought to a minimal level. Despite international treatises, conventions, and covenants, and so-called "watch bodies", torture has come to stay and indications are that it is spreading rampantly. No civilization whether advanced or emerging from the cocoon of 'primitiveness' can boast of doing away with torture totally. Therefore, instead of fictionalizing the rock-solid reality it would be better if it is met with head-on resistance. Single counter-activity would not be able to control torture because too many improbabilities are involved.

At the end it is postulated that the genie of contributory torture exist. Our collective denial wouldn't change the position. Further studies in different perspectives on this aspect would be profitable to the entire world. This short communication is an attempt on my part to kindle the flagging effort against torture from sinking into an unroused dormancy. Correspondence on this aspect is welcome.

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Torture documentation inside detention centers

Max Cooper, BM*, Phil Cotton, MD*

Sir,

Concern has been raised about the quality of health care for asylum seekers in detention,[1] particularly in respect of mental health problems.[2] Here we write to highlight difficulties faced by clinicians preparing medico-legal reports as part of the process to document torture among detainees.

In the United Kingdom there are eleven detention establishments, known as 'removal centres'.[3] Some detainees are held at centres a considerable distance from their previous residence and may have passed through more than one such establishment. Transfer can occur at short notice and overnight, a distressing phenomenon known as "ghosting".[4] These realities pose logistical problems to accessing clients. Removal centres are often located a considerable distance from organizations specializing in torture documentation, thus necessitating additional travelling time for doctors and interpreters. Appointments must be arranged in advance and interview rooms may only be available for certain periods of the day. Limited time with clients may therefore compromise the quality of the medico-legal report. Entering the centre itself and clearing security is also a time-consuming process. On occasions, both of us have been fingerprinted prior to entry. The fate of these personal data is unclear: one of us was informed that records are erased 'after a few months'.

It is routine for useful equipment to be confiscated for the duration of the visit. Even plastic rulers can be disallowed: a paper tape-measure will prove invaluable under these circumstances. The absence of a laptop or voice recorder compels the clinician to take handwritten, rather than electronic notes. This prevents the clinician from composing a report during the information collection and clarification phases and means that time is required later to enter data. We have been informed that a camera to document torture scarring is only permitted following a written request by the client's lawyer and this must be made for each interview where photography may be necessary. The confiscation of mobile phones can make it difficult to contact a client's solicitor in order to discuss the case confidentially. For clinicians, it is equally inconvenient not to be contactable themselves during those hours spent in the centre.

Examination facilities may not be ideal, for example on account of poor lighting or low temperature. Clinical rooms are sometimes small and their physical layout unchangeable, forcing the client to face the

*) University of Glasgow, U.K.
mjfcooper@gmail.com

doctor across a desk. There is often insufficient space to seat the interpreter in an optimal position for effective communication. When clinical examination rooms are unavailable, the 'interview rooms' provided by the authorities may lack privacy. Unlockable doors, sometimes containing windows for inspection from public spaces, can render examination impossible in such rooms. In addition, these rooms are used for other official interviews with clients and may be reminiscent of earlier stressful meetings about their asylum claim or even of interrogations in their own country. As such this may hinder the dynamic required for the disclosure of traumatic experiences. Under these circumstances accessing an appropriate chaperone for intimate examinations may also be difficult.

Detention centres are not large institutions. For example Dungavel, Scotland's only removal centre, has room for 190 people including children.[5] Maintaining patient confidentiality remains an important issue as we have noticed that some detainees discuss their consultations with peers inside the centre and with outsiders via mobile phone.

During the course of an examination for evidence of torture, clients may request a medical opinion. The visiting examiner is normally without appropriate clinical equipment or the means to prescribe and general medical problems should be passed to the responsible physician at the centre. However, not being able to respond to clients may leave them feeling unimportant, helpless and dismissed. Occasionally, dissatisfaction with the general medical care provided has been expressed to us, despite direct access to primary care doctors and nurses and other services, such as dentistry.

There are additional difficulties. One common problem is the psychological pressure on the visiting clinician of being considered the client's 'last hope'. Referral onto other services routinely available for torture survivors outside removal centres is not straightforward. This situation can be particularly challenging in circumstances where the client threatens hunger strike or suicide if their case is unsuccessful.

It will be clear from this brief note that medico-legal examination in detention centres presents a number of challenges to clinicians. Suitable rooms with appropriate equipment and access to a computer and mobile phone would make the collection of information and compilation of reports much more efficient. Optimal conditions would allow the clinician to bring a little bit of humanity to an otherwise tense situation. A greater appreciation of the role of the medical examiner by the authorities would be beneficial. Nevertheless, clinicians should not be discouraged from undertaking this important and rewarding work.

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Osteological proofs of torture and cruelty: forensic findings form a secret cemetery in Tirana, Albania

Admir Sinamati, MD*, Anila Tahiri, MD, Besim Ymaj, MD***, Zija Ismaili***, Gentian Vyshka, MD****, Bardhyl Çipi, MD****

Abstract

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.

Keywords: Secret cemetery, mass graves, identification, human rights violations, torture, communism.

Introduction

Identification of human remains in mass graves is a very important step toward documenting human rights violations and giving back to families the human remains of victims, that are considered, until exhumed, as lost or disappeared, mainly due to extrajudicial executions. The importance of redressing the injustices and bringing to justice perpetrators, who will therefore lose their impunity, cannot be underemphasized even for very remote crimes. For example, the identification process of human skeletal remains exhumed from mass graves has taken place in Spain, more than 50 years after the Spanish Civil War.[1]

In addition, mass grave excavations have gradually become an integral and very important part in the preparation of judicial files, and in accomplishing the hard task of defending them before the courts. Thus, general opinion regarding the uncontestable crimes perpetrated during the Nazi regime, or during numerous communist dictatorships, would have been judicially insufficient for condemning responsible executioners, unless pictures, photos and documentation

*) Institute of Forensic Medicine, Tirana, Albania. Member of the Task Force for the identification of disappeared persons of the communist regime.

**) Forensic Anthropology, School of History, Classics and Archaeology, University of Edinburgh, Scotland, UK.

***) Institute of Forensic Medicine, Tirana, Albania.

****) Faculty of Medicine, University of Tirana.

of suffering had been available. Availability of proof of torture and cruelty several years or decades after their perpetration can be scarce, and memories of survivors, in written or in verbal forms, rarely will suffice for a court to pronounce unappealable verdicts. Although excavating mass graves serves primarily for the identification process and for helping relatives to find remnants of lost persons, ensuring evidence from mass grave excavations is becoming a successful way to get war criminals convicted, like in Guatemala (Dos Erres Case) and in Bosnia (Krstić case, Srebrenica massacre).[2,3]

Even though, politically the communist regime in Albania has been widely and almost unanimously condemned, perpetrators of crimes, such as of torture in its different forms, mainly enacted from officials of secret services of the totalitarian state, never served any sentence that explicitly redressed the wrongdoings of the past. Inability to uncover the smoking gun in alleged crimes and political assassinations was not because of the lack of political will, but rather because of the lack of professionalism in gathering evidence and in conducting judicial maneuvers. Even official data of missing persons and of imprisoned or executed victims (both judicially and extrajudicially) are full of gaps, and non-governmental organizations generally offer different figures while engaged in advocacy for the politically persecuted families. There is discrepancy in the data in recent publications; thus the total figure of executed persons during the communist regime is considered to be 4,548 individuals from one source[4] and 6,007 individuals according to another source.[5] The figures of imprisoned and internally displaced persons differ even more.[4,5] A thorough description of methods of torture and periods of political persecution in Albania is available in English as well.[6]

Apart from discrepancies in the published figures, communism in Albania has perpetrated panoply of human rights violations, partially documented and partially not, among which mass murder and politicide are the most important and severe. In defining the term *politicide*, Rummel included the premeditated killing or murder of any person or people by a government for political purposes.[7] Mass murders were common in Albania in the period immediately after WWII, especially during punishing expeditions in Northern areas of the country and neighboring ex-Yugoslavia where the anticommunist resistance was fierce and prolonged. Mass graves and secret cemeteries are not intended only for the idea of punishing expeditions, but also because for the Albanian secret police and law enforcement agencies of the communist period, the option of not returning corpses of executed persons to the respective families was widely practiced.

Description of the secret cemetery at Linza, Tirana

Linza is a small place several kilometers from Tirana, east of the capital and at the foot of the mountain Dajti, which forms the natural eastern boundary of the city. The finding of a secret cemetery was not merely coincidental, since inhabitants of the zone were aware for years that certain hidden areas of a bushy and hilly zone were used for burying individuals executed from communist secret police. Relatives of the executed persons were digging the ground trying to find remains of their lost beloved ones, and in February, 2010, human skeletons were located; the fact received wide media coverage and public interest.[8] Experts from the Tirana Prosecution Office and from the Institute of Legal Medicine were called to the premises only after the diggings of the relatives gave

the first results, thus the process of exhumation was not professionally organized, as described in the Minnesota Protocol.[9] The crime scene examination took place thereafter, while the exhumed remains were already transferred to Tirana. The identifying team acknowledged the presence of a secret cemetery, since 13 skeletons had been found, buried in several pits, distancing five meters from each other. The area could be reached only by foot; four-wheel machines were able to stand by in a distance of 150 meters. The pathway was blocked to common people until 1990, since it was considered through appropriate signs a "military area".

The exhumed skeletons were examined only after they were sent to the Institute of Forensic Medicine in Tirana. In the latter a thorough osteological study was performed. The main feature, common to all skeletons, was the fact that all victims (100%) had perimortal lesions in the skull; bullet-shoot wounds in the skull or fractures caused by the blunt force trauma. i.e. characteristics of mass killings which are also reported in other mass grave exhumations, such as the Tuskulënai case in Lithuania.[10] All skeleton remains, during the exhumation and during forensic-anthropological evaluation in the laboratory, were photographed and stored into a WORM medium, as has been suggested.[11]

The definition of mass grave and secret cemetery varies depending on the point of view taken by different authors. There is a quantitative consideration from Mark Skinner, according to which a mass grave must contain at least half a dozen individuals, to deserve the appellation.[12] Other authors, apart from the mere figure of corpses found in a mass grave, converge upon the disrespectful, indiscriminate and tightly-packed method of burying victims, especially the fact that human remains are in close contact.[13]

Results

The totals of thirteen plastic bags containing human remains were examined by the forensic experts in Tirana. Bones and clothes were found together with the plants and soil from the area. Clothes were preserved for the forthcoming identification process.

In general, the skeletal remains, both cranial and non-cranial elements, were in a poor to moderate preservation condition. There was no soft tissue present. Some bones were characterized by surface erosion and postmortem fractures. Some of the bones were missing and some of them were completely fragmented to such a degree that examination was impossible. Some parts of the pelvis were missing, making it difficult to determine sex. General condition of the bones indicates the taphonomic changes that the skeleton underwent during burial. From thirteen skulls, most of them were fragmented with a few bones available for reconstruction and further analysis.

From all thirteen skeletons, one was considered to be female; the study of pelvis and cranium indicated that the other skeletons were males apart from one where sex determination was inconclusive. Stature was estimated through formulas based on the maximum length of femur, according to a method which has been suggested by several authors. The method has been validated recently in a Portuguese sample.[14-16] When a femur was totally fragmented or missing, fragments of the latter bone were used in accordance with other recommendations;[17] otherwise humerus was used for this purpose. The state of bone maturation and the scoring of epiphyseal activity were used to determine the skeletons' age, according to well-known methods.[18] All the standard method of aging, sexing, measurements, stature and dental recording were applied here, according to methods suggested from

several authors.[19,20] A multivariate approach was used to calibrate the results. Some findings from the thirteen skeletons (estimated age; estimated stature length and gender) are summarized in Table 1.

The vertebrae were in moderate condition in some skeletons, while some of them were missing. Most of the ribs were fragmentary. Some of the long bones were well preserved, making it possible to take some of the measurements. Most of the teeth and hand and foot phalanges were missing. A detailed inventory of the bones was done and archived for further study.

Signs of trauma could be found in most of the skull bones. The common pattern of the bullet wound in the skull was found in most skeletons. The recollected remains of one of the skeletons is presented in Photo 1 (page 204); other reconstructions were made in seven cases, when the bone preservation permitted it. In other cases the study was made upon partially reconstructed skeletons.

Table 1. *Characteristics of thirteen skeletons.*

Case	Age (yrs)	Gender	Stature (m)	Bone(s) used
1	25-35	M	1.65	Left femur
2	40	M	1.7	Femurs
3	NI*	NI*	NI*	Femurs diaphysis degraded
4	20-30	F	1.55	Right femur
5	35-45	M	1.7	Right femur
6	25-35	M	1.78	Right humerus
7	40	M	1.65	Right femur
8	40	M	NI*	Skull
9	30-40	M	NI*	Skull
10	20	M	1.75	Femurs
11	40-50	M	1.65	Right femur
12	30-40	M	1.6	Right femur
13	30-35	M	1.6	Left femur

*NI= non identifiable

All victims unequivocally had bullet hole mortal wounds with the entrance hole in the posterior skull zones (occipital bone); different ante mortem signs of cruel torture were evident. Signs of trauma could be found in most of the bones. The common pattern of the bullet wound in the skull was found in the skeletons, but the incompleteness of the cranial bones in some cases made it difficult to determine the trajectory of the bullet. Moreover, bone weathering and other post-mortem changes gave an unusual pattern of the bullet holes.

When possible, cranial vaults were reconstructed and CT-scan images were obtained. Photo 2 (page 204) represents a reconstruction of an exit bullet wound, from one of the craniums.

Illustrative photos from three skeletons

Hereafter we describe three cases, which were considered most illustrative by the forensic team, more in depth (i.e. numbers 1, 2 and 11 from table 1).

First case details

Photo 3 (page 205) shows the entrance hole of the bullet on the occipital bone. The photo on the left shows the pseudo outward beveling on the external surface of the occipital bone while the picture on the right shows the beveling of the bone on the internal surface of the occipital bone. The manner of death is homicide.

Second case details

Photo 4 (page 205) shows a bullet wound in the skull. Right image, down, shows the entrance hole of the bullet on the occipital bone followed by the corresponding fractures of the skull. The lesion on the frontal bone (left picture, up), shows the unusual bullet hole,

with the pseudo beveling of the bone on the internal surface created by the weathering of the bone. Right image, up, shows the possible bullet trajectory on the skull.

However, we believe that the lesion on the frontal bone can be an entrance hole for a second bullet. According to an eye witness, some victims were executed with one bullet on the back of the head followed by the other shot on the frontal part of the head, after the victim would be lying on the ground. The manner of death is homicide. The cause of death is the intracranial hemorrhage due to the severe injuries on the head, related to firearms.

Eleventh case details

Photo 5 (page 206) shows the perimortal fractures on the skull. The upper images show the fracture on the occipital bone and the images below show fractures on the left temporal and parietal bone. The lesions indicate the fractures caused by the blunt force trauma. The pathway of the fracture shows that the lesion on the back of the head was prior to the lesion on the temporal and parietal bone.

Photo 6 (page 206) is showing a CT reconstruction of the same skull, with the comminute fracture (exit wound) in the upper part of the image, and the entrance bullet wound (right linea nuchae) in the lower part of image.

According to the witness' data, some of the victims were executed by young and inexperienced soldiers. In these cases the soldier could miss the target by not shooting on the head but somewhere else in the body. In cases where this happened the experienced executer would interfere with the back of the firearm. We believe this case is one of those. The manner of death is homicide.

The same case shows more perimortal trauma lesions, such as the fracture of the right radius and ulna (Photo 7, 8, page 207).

Discussion

Identifying victims of secret cemeteries and mass graves is directly related to several factors, whose nature is not merely technical. Thus, in the Linza secret cemetery near Tirana, the experts concluded that the executions and burials should have taken place at least 20 years before the uncovering of the skeletons. However, connecting precisely the executions with a certain date and period, and with the official data of the events, proves to be an extremely difficult duty, especially when archives are incomplete, or even when executions are extrajudicial and therefore not registered at all. The identification process was mired in serious difficulties, mainly because of the fact that victims buried in Linza were obviously coming from different pre-detention facilities, and registers are full of omissions. In cases of extrajudicial executions, the entire process often went completely unregistered on purpose.

In fact, secret cemeteries and mass graves, according to several Albanian sources, are numerous and scattered over the country, dating back since the first months after WWII, i.e. immediately after the communists took power in Albania. Punishing campaigns in the northern areas started to be perpetrated. Obviously, the majority of the authors reporting the existence of such secret cemeteries and mass graves are ex-politically persecuted individuals. However, their memoires need to be officially validated before being used for judicial purposes aiming at bringing perpetrators to justice. The declared figures of the killings rarely coincide because archival data suffer from wide omissions and inconsistencies. For example, it can be easily realized from photo 9 how difficult it might be to connect events with memoires and findings, such as to correspond names with the skeletons uncovered in mass graves, when the technical quality of the registration process from the police or

law enforcement agencies of the period was the poorest one can imagine. This illustrative example is a mere written-paper of a pocket agenda, where the prosecuting official of the communist regime registered the executed persons, their provenance and, in other cases, the nature of their condemnation when it was not a capital one. Apart from such deliberately poor methods of registration, archives might also have been widely manipulated and important data have been omitted. This is a phenomenon also encountered in other ex-communist Eastern European countries, where the secret police has perpetrated crimes similar to those described in Albania.[21]

When working with secret cemeteries and mass graves, certain guidelines and standardized working procedures are an indispensable condition. The Minnesota protocol aimed to treat the issue exhaustively, thus creating a supportive tool for all forensic teams working in the field.[9] However, difficulties encountered are enormous when working in similar settings, not only from the political points of view, but also related to technical and logistic issues and support. The limitations of the present work are intrinsic to its pioneer nature and pilot form, but gaps in documentation process have also been emphasized elsewhere as a problem.[22] Documentation per se is an initial form of starting a long and difficult process of redressing injustices of the past, and of course will help to abolish or at least to restrict impunity.

All skeletons found in Linza, Tirana, are still under process of identification and for these purposes the bone samples were taken to perform a DNA analysis. The importance of such an analysis in the process of identification is widely accepted and actually is uncontestable not only in technical forums, but from other organizations that are dealing with the delicate process of victim identifications.[23] As said, the lack of archival data, and the absence of a DNA bank from relatives of victims executed during the communist regime in Albania, are both important hindering factors toward a prompt identification of the victims. Even recently, authors have tried to find a way out for identifying people in the absence of DNA data.[24] Nevertheless, the fractured bones and the ante mortem

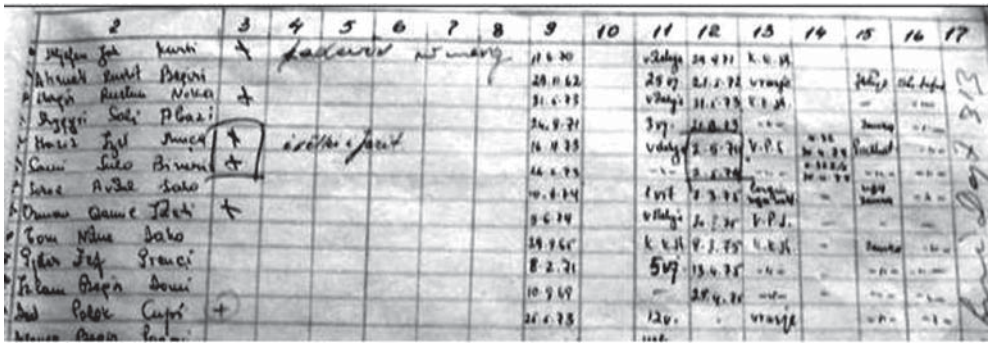

Photo 9: *The horrific fate of the condemned was expressed not only through physical ill-treatment and unlawful executions, but as well in how data of judicial procedures were registered. In this official hand-written paper several prisoners are named. The column no. 11 explains their fate; 'vdekje' means 'dead; numerical figures show the respective prison sentences in years (thus 25 vj. means 25 years of prison; Column 11, Row 3). [The photo is illustrative and the list is actually not presumed to correspond with the skeletons of the Linza secret cemetery discussed herein].*

nature of the findings in the skeleton of Linza secret cemetery is a forensic osteological proof of cruelty and ill-treatment of the executed victims, mainly young adult males (12 out of 13), executed more than twenty years before, during the communist period.

Acknowledgments

The authors would like to thank the reviewers of 'Torture' for their valuable comments and suggestions. Jens Modvig, PhD, RCT Denmark also offered us his help toward improving the quality of the manuscript.

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Photo 1: *A whole skeleton reconstructed.*

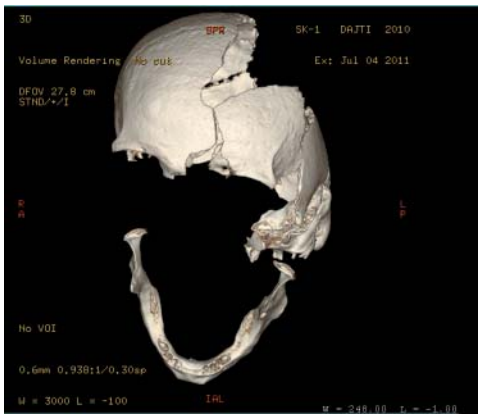

Photo 2: *CT-scan reconstruction of the trajectory and bullet exit wound.*

Photo 3: *Case 1.*

Photo 4. *Case 2.*

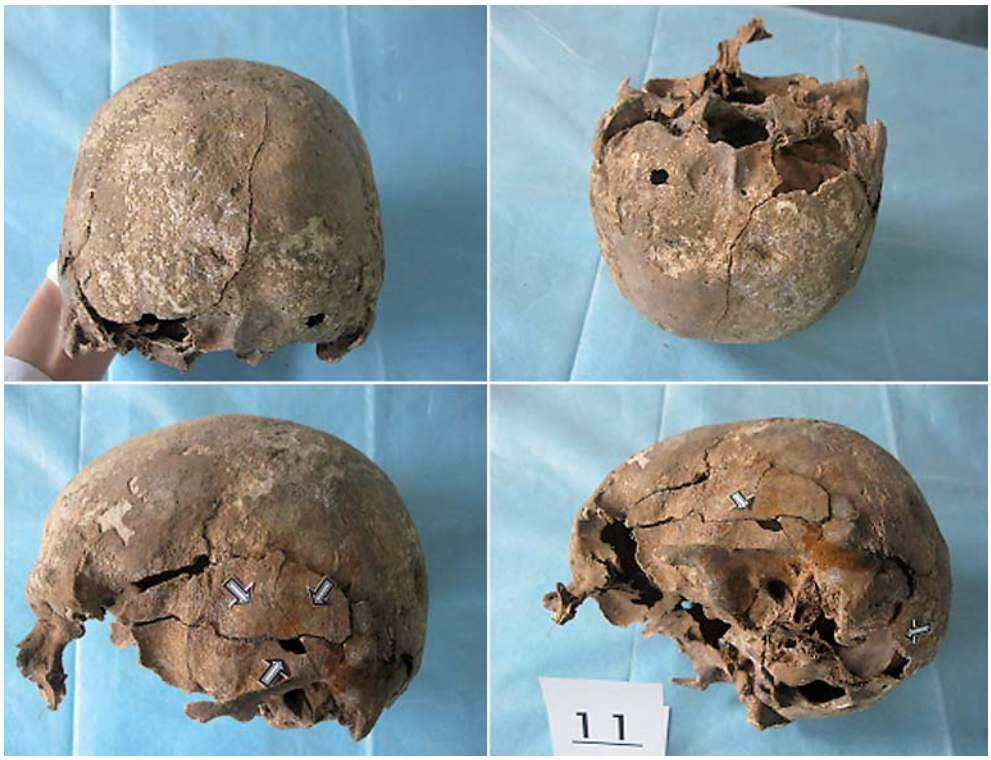

Photo 5: *Case 11.*

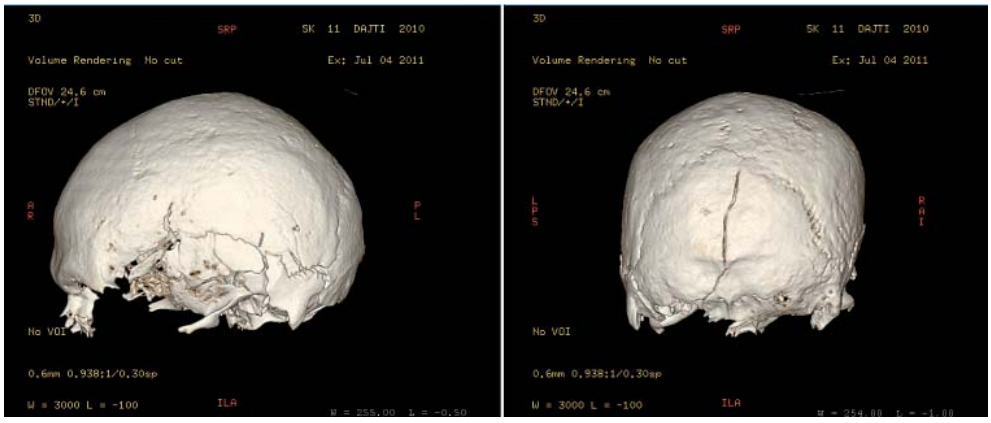

Photo 6: *CT reconstruction of the skull depicted in photo 5.*

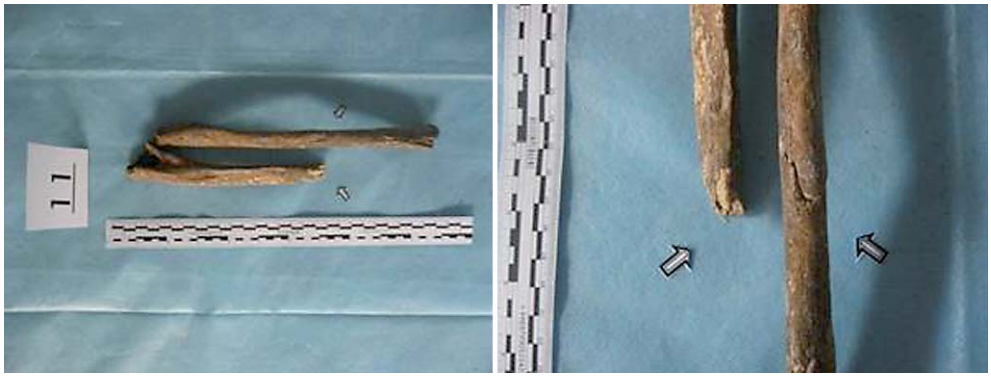

Photo 7: *Signs of perimortal trauma in the right radius and ulna.*

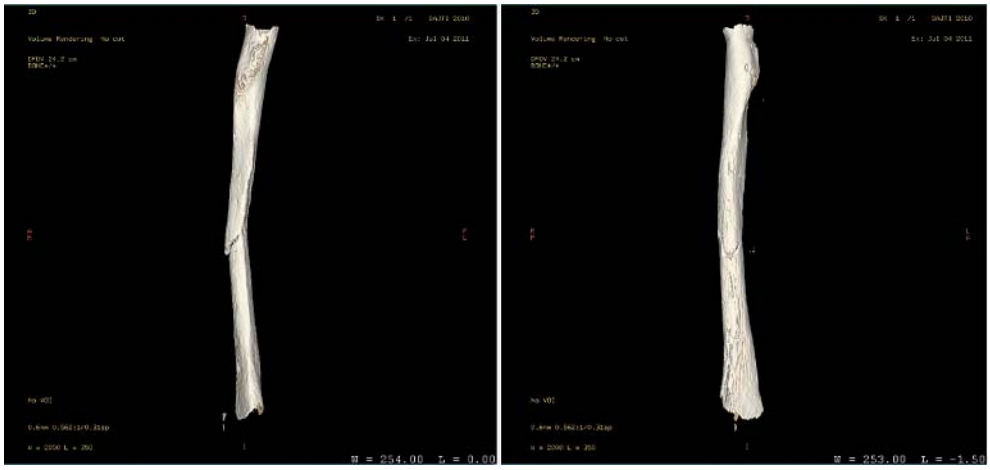

Photo 8: *CT reconstruction of the radius as depicted in photo 7.*