20 Abuse, Self-Harm, Torture Signs, and PTSD

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20.1 Introduction

"The WHO Constitution was the first international instrument to enshrine the enjoyment of the highest attainable standard of health as a fundamental right of every human being ('the right to health'). The right to health in international human rights law is a claim to a set of social arrangements—norms, institutions, laws, and an enabling environment—that can best secure the enjoyment of this right" [1].

Ibrahim Salama, Director of the Human Rights Treaties Division of the Office of the High Commissioner for Human Rights of United Nations, remarked that this is a time where the human rights agenda was losing ground in many parts of the world, but also at a time of powerful movements for human rights. It was therefore essential that the human rights treaty body system was efficient and produced concrete outcomes for the victims. With the recent accession of Samoa to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the number of state parties now stood at 166. The 2020 review of the human rights treaty body system by the General Assembly was of utmost importance to ensure its sustainability and impact on the ground.

At an international and institutional level, torture has been unconditionally condemned in all international human rights documents, such as the Article 5 of the Universal Declaration of Human Rights adopted in 1948, the Article 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms adopted in 1950, and the Article 7 of the International Covenant on Civil and Political Rights adopted in 1966 [2–4].

20.2 San Gallicano Dermatologic Experience (2002–2007)

The first consideration to make is that there are no illegal migrants, because no human being can be defined as such in the universe. Gypsies and wanderers, low-income retired elderly people, women who are the victims of prostitution, unaccompanied minors, asylum seekers, and torture victims were sheltered (Table 20.1).

They are people, with their stories, illnesses, anguish, dreams, plans, and emotions. Hundreds of thousands of meetings have been held with a group of healthcare experts, physicians, nurses, psychologists, social workers, cultural mediators, sociologists, clerks, and cleaning staff—all

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Table 20.1 The experience of San Gallicano Institute Rome (reported as % lesions observed)

	Cause of scars	Reported torture
Cutting	16	–
Weapons	11	8
War	26	–
Burns	5	–
Other	42	–
Beating	–	92
Electrical	–	17
Frozen water	–	23
Sexual	–	8
Psychological	–	4
Falaka	–	14

of them have helped welcome these people, each for his or her own part—to try to understand and assess them with the respect that every human being deserves and in compliance with the different cultural and religious needs that each of them brings. The disregard of the public administration over these long years has become evident on several occasions: whenever it has been able and wanted to, the administration has stepped in by skillfully mixing threats with "administrative suggestions" to make stop any activity dubbed as "extra-institutional." The text of the Hippocratic Oath did not forbid to assess anyone. Actually the opposite was true. Thus, the initial activity was carried out in absolute secrecy, not being possible to publicize a service that was essentially not only irregular but also clandestine, within a public facility, i.e., open to everyone.

Maybe it was exactly that "extra" that eventually thrilled and involved about a hundred other specialists from the most diverse fields, without knowing at all where it would have led. It is not Odysseus' voyage, but rather Abraham's, the ongoing journey of a person who is too old to leave and who abandons his certainties and his position relying solely on an incredible promise, upon the stars.

This sea voyage allows to meet not patients but people, sometimes sick, sometimes the victims of torture or of sex trade, yet human beings. Some words have the power to kill. Drug addicts, patients, detainees, and prostitutes do not exist; they are persons addicted to drugs, sick persons, detained persons, and persons who are victims of the sex trade.

Each therapeutic relationship should be based upon the uniqueness of every human being and not upon a "diagnostic categorization" representing a "cultural and symbolic categorization."

By identifying individuals by the name of the pathology they are affected by, we do not consider them as a whole; we focus on their problem and ignore their peculiarities, resources, and potential.

The multidisciplinary and transcultural service includes not only physicians, nurses, and psychologists but also anthropologists, sociologists, cultural mediators, and the victims of torture themselves. The limit of activity often lied in the necessity for direct assistance, treatment, and study in order to attain a final report for the purpose of requesting the refugee status. This was a very important task, the only opportunity for those people to start a new life, but it risked making lose the memories of a large number of meetings, histories, thoughts, and feelings.

As Filippo Gentiloni states in his beautiful book *Abramo contro Ulisse*, indignation is today part of those minor and useless things which seem to have gone lost. Indignation is an unusual feeling today, in the age of homologation, weak thought, and fear of marginalizing differences [5].

Too many times indignation is the only solution, but it may often appear useless and personal. Indignation is today considered an outdated and ineffective feeling. It is no longer popular even among the culture and attitudes of the political

side that has apparently forgotten it, along with the rage that filled the hearts of the labor movement for decades. It is indignation at a world that is larger than imagined, which tortures its opponents, in the indifference of those governments and movements that persistently refuse to see beyond their borders.

20.3 Taking Care

"Taking care" is a more complex clinical and anthropological experience than "caring." The lack of care, or, better yet, of taking care, is a dreadful feature of present times. Especially after September 11, 2001, there are too many symptoms of the lack of civilization. Dreams of generosity are disregarded and neglected, undermined by the supremacy of a new liberalism, matched by the ensuing individualism and the extolling of private property as well as with the remarkable security issues that affect everything. Traditions of solidarity are despised. Ideals of freedom and dignity for all human beings, starting from those who appear to be useless, are not taken into account. What prevails is the society of show business, of appearing, of having, as opposed to being or knowing to be.

As stated by Leonardo Boff in *Il creato in una carezza*, this new social contract is rooted in the respectful participation of the majority of persons and peoples, in valuing differences, in the acceptance of the various complementary issues, and in the agreement built on the diversity of cultures, of means of production, of traditions, and of meanings of life [6]. We feel the urgency for a new *ethos* that, in its original ancient Greek meaning, also refers to the burrow of an animal or to the human dwelling, namely, that part of the world used to organize, take care of, and create our *habitat*.

According to Heidegger, care refers to a fundamental existential-ontological phenomenon, or, in other words, a phenomenon that provides the foundation for human existence as such, namely, in relations, as nothing exists outside them. Human beings take care, or, better yet, their essence is in the care; this is all the more true for physicians, nurses, psychologists, and healthcare practitioners [7].

Taking care of people means having intimacy, feeling them in yourself, welcoming them, respecting them, and giving them rest and peace. Taking care means establishing a synchronicity with them, listening to their rhythm, and tuning in with them. Analytical and instrumental reasoning gives way to cordial reasoning, to the *esprit de finesse*, the spirit of finesse, the profound feeling. The *logos*-rationality does not take center stage any longer, but is replaced by *pathos*-feeling. We all feel connected to one another, forming a unique whole that is diverse and always inclusive, never exclusive.

Care has been slandered as a feminization of human practices, as an obstacle to objective understanding and to efficiency. Yet this is not the case. We have lost the notion of the human being as a being of relations and unlimited relations; a being of creativity, tenderness, care, and spirituality; and a carrier of an endless project.

It is thus evident that the originary fact is not *logos*, rationality and the structures of understanding, but rather *pathos*, feeling, the ability to sympathize and empathize, dedication, kindness, and communion with others. *Pathos*, in the original meaning of the Greek word, indicates sharing of the feelings.

Surely everybody remembers the secret that the fox discloses to Antoine de Saint-Exupéry's Little Prince, before leaving for its small planet for good: "It is only with the heart that one can see rightly; what is essential is invisible to the eye." It is the feeling that makes people, things, and situations meaningful to us. This profound feeling is called "care" [8].

As pointed out by Boff, more than the Cartesian *cogito ergo sum*, i.e., "I think, therefore I am," it is *sentio ergo sum*, "I feel therefore I am," that applies.

We should increasingly develop a listening attitude and not only toward those who are speaking to us, but we should also experience a profound, attentive feeling toward the environment and, essentially, toward nature. Human beings should feel themselves as nature. The more they immerse themselves in nature, the more they feel

how much they have to change and how much they have to preserve of the vital breath of the universe in their lives and relationships. There is an aspect of human relations that is often neglected, especially among those who provide healthcare in all its meanings and the people, either the patients or the sick, who rely on us: it is tenderness.

Vital tenderness is synonymous with essential care. Tenderness is the affection that we devote to people and the care that we apply to existential situations.

Tenderness is care without obsession: it also encompasses work, not as a mere utilitarian form of production, but as workmanship that expresses the creativity and self-fulfillment of people. It does not refrain from rigor in knowledge. It is a feeling of affection that, in its own way, is also knowledge. We actually know something only when we have affection for and are involved with what we wish to know. Tenderness can and must go side by side with extreme commitment to a cause, as was perfectly demonstrated by Che Guevara. From him we inherit the inspiring phrase: *Hay que endurecer pero sin perder la ternura jamás* [9].

Blaise Pascal introduced an important distinction to help us better understand care and tenderness: *l'esprit de finesse* and *l'esprit de géometrie*. *L'esprit de finesse* is the spirit of finesse, sensitivity, care, and tenderness. *L'esprit de géometrie* is the spirit of calculations and workmanship, which is interested in efficiency and power. This fact is where the terrifying emptiness of our "geometric" culture comes from, along with its plethora of sensations without deep experiences [10].

The fundamental difference between the experience with torture victims at the "San Gallicano" and similar experiences in other places lies in the attempt to perceive the victims as fragments of the universe, of the vital energy coming from the stars that others have sought to destroy. The practice of torture entails not only the attempt to annihilate the other but also the negation of life, as it has been developing over the past billions of years, from the Big Bang. Therefore, the reception of the other and the face of the other recall the sparkle of life that blossomed with considerable difficulty on our planet 4.5 billion years ago. At any time, torture means destroying life, in all its forms.

The face of the other precludes any indifference. The face of the other forces me to take a position because it speaks, provokes, evokes, and convokes: especially the face of the poor, the sick, the marginalized, and the excluded. The face and eyes always launch a proposal in search of a response. Thus, responsibility arises, the obligation to give responses. Here we find the birthplace of ethics, which lies in the relation of responsibility when met with the face of the other, especially with the face of those who are all the more "the other," such as the oppressed, the *illegal* migrants, the homeless, asylum seekers, and victims of the sex trade and torture.

20.4 Torture in History and Nowadays

The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted in 1984, is entirely devoted to banning these practices and provides for the liability to punishment before all courts where the perpetrator is, regardless of the place where torture was committed. In addition, no exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability, or any other public emergency, may be invoked as a justification of torture.

The debate on torture probably dates as far back as the origin of humankind. This issue was discussed by philosophers since the Classical Age and Modern Age and in the twentieth and twenty-first centuries. However, the debate developed with greater continuity and incisiveness in the course of the Enlightenment.

Nowadays plenty of issues have radically changed if compared with the eighteenth century. The historical context is different. The jurists and the philosophers of the eighteenth century worked in a context where criminal procedure in both the civil and the ecclesiastical courts set detailed rules for the practice of torture and considered it, first of all, legitimate and useful. Today human rights

documents and international legislation openly and unanimously condemn these practices. However, torture is forbidden but not prevented. The cultural context is extremely different if compared with the eighteenth century, but not a day has passed without the international debate being focused on security issues, prevailing over the respect and protection of human rights. After the 9/11, there has been a debate in the USA and throughout the world on the use and legitimacy of torture in the framework of state security and war against and roused by terrorism.

In the eighteenth century, too, the debate was very intense between those considering torture useful for the security of society, though submitted to procedural rules limiting and regulating it, and those advocating its complete abolition. In fact, the victory of the abolitionist theory that acknowledged the unlawfulness of torture led to its elimination. Torture was abolished in 1740 in Prussia under Frederick II; in 1776, in Austria under Maria Theresa; in 1780 in France under Louis XVI, at least for some of its manifestations; and in 1784 by Joseph II in the Duchy of Milan. In Russia, too, under Catherine II, its elimination was called for in 1765.

Many authors, through their own texts and the debate following their publication, have contributed to spreading the culture of tolerance and led sovereigns to a greater attentiveness for the individual's reasons, human rights, and the unlawfulness of torture. It is impossible to forget Christian Thomasius in Prussia and his dissertation *De tortura ex foris Christianorum proscrivenda* in 1705; Cesare Beccaria and his dissertation *Dei Delitti e delle Pene* in 1764; Pietro Verri and his dissertation *Osservazioni sulla tortura* in Italy; Voltaire and his *Treaty on Tolerance* in 1767; and Montesquieu and Joseph von Sonnenfels among others [11–16].

In the past, torture had the function to certify and confirm the truth of the perpetrating power. Therefore, the person submitted to torture had to confess what he was accused of. The perpetrating power claimed to own the truth that had to be confirmed also through torture. Little mattered whether it was the sovereign's or the Church's power or both. The power of torture consisted in making the person confess the "truth" that the power already thought it possessed. Torture was not inflicted without distinctions, and its function was discretionary, extraordinary, and selective. In ancient Greece it was not known and in ancient Rome it was not inflicted on free-born men, but only on slaves who were considered neither as citizens nor as human beings. Historically, the practice of torture would spread later on, to coincide with the concentration of power in the emperors, followed by the progressive corruption of the republican political system that led to despotic governments.

At the end of the eighteenth century, when the practice started to be eliminated, there were social categories, such as magistrates, that were exempted from it, regardless of the offence. Torture and murder were turned into a spectacle, shown to the masses in order to deliver them that exemplary, symbolic, and dreadful message that exalted the sovereign's power. Punishment had to comply with a particular requirement: it had to be exemplary and evident. However, the exemplary ad evident character of the punishment contributed to showing the inherent partiality, that is to say the unfeasibility to punish everybody. In fact, the sovereign could not punish everybody; it was not in his power, interests, and wishes. He had to show that he could virtually punish everybody, and he demonstrated it in a clear and exemplary way, punishing someone with torture, extreme suffering, and finally death. Torture not only confirmed and certified the truth of the power, but it also possessed the power of truth. In some legal systems, this power was legalized to the point that the person resisting torture was considered innocent and hence released. Torture coincided with the punishment. The penal system was not characterized by detention centers that started to spread in the course of the nineteenth century. At a certain point, the evidence of the punishment started to lose importance, and torture started being abrogated, but this practice was not entirely eradicated. Being abrogated implies that it is not inflicted in a legal, exemplary, and evident way.

Torture starts being inflicted in a covert manner, hidden from the legality of the systems of power. What makes torture disappear from laws

and what leads it to hide in the niches of the criminal system? Absolute powers, both of the sovereign and of the Church, show signs of faltering. The powers that have gradually been legitimated no longer need to demonstrate their cruelty to subjects; rather, they have to prove their legality, normality, and rehabilitation to citizens. It is no coincidence that the reformation movement spread from the top, that the abolition of torture was endorsed by sovereigns themselves, and that it was not infrequent for intellectuals and magistrates to be adamantly opposed to such claims. The system of power changes, along with the system of punishments, and terror is replaced by discipline and thus by control, which is perhaps an even more subtle and fearful tool, as it is duly camouflaged.

The relationship between authority and control, between barbarism and civilization, was further examined by Alessandro Manzoni: while paying tribute to Verri's remarkable work and to the aim pursued in *Observations on Torture*, Manzoni also warned against a hasty dismissal of the problematic relationship between violence and power. Manzoni forcefully drew attention to a much needed recourse to more refined analytical tools, in order to avoid the risks of conceiving history as too linear [17]. Accordingly, the nonrational components of action should be taken into account in a holistic view of human nature while being aware of the unfathomable human soul as well as of the role played by passions. Manzoni's criticism foreshadows an explanation for the inhuman events of barbarism and torture that extensively occurred again in the civilized world during the twentieth and twenty-first centuries.

Nowadays, torture has made a powerful comeback on the world stage, especially with the pictures of the naked bodies in the Abu Ghraib prison. This worked as a sort of massmedia wakeup call for a distracted society that did not want to see and had already forgotten Via Tasso in Rome; Franco's Spain; Salazar's Portugal; the war in Algeria with the statements by General Massu; the Colonels' Greece; Pinochet's Chile; Videla's Argentina; former Yugoslavia with Srebrenica, Tuzla, and Mostar; and today's Myanmar of the coup generals and Libya's detection centers.

Books such as *The Question* (1958) by Henri Alleg, on the war in Algeria; *The Confession* (1970) by Artur London, on Czechoslovakia in the 1950s; or *La Punition* by Tahar Ben Jelloun seem to belong to a different time and to a different world [18–20]. Yet the debate over torture, which was triggered by the shameful images from Abu Ghraib, is looming on the horizon.

When the pictures of the naked, humiliated bodies piled in the Abu Ghraib prison were released in 2004, it could no longer be denied that US Armed Forces in Iraq used torture, but attempts were made to downplay and minimize it. Donald Rumsfeld stated: "My impression is that what has been charged thus far is abuse, which I believe technically is different from torture." Because of these "abuses," only few soldiers were identified and mildly punished, while General Janis Karpinski was demoted to colonel. The shame was due to not only the torture carried out in the Abu Ghraib and Guantanamo prisons but also the fact that official, secret prisons existed in many countries around the world.

On September 18, 2006, Gustavo Zagrebelsky stated in the Italian newspaper *La Repubblica* "Torture and death penalty turn men into mere living matter, without any defence, and consenting to the use of violence on reasons of security means allowing for the development of hate and barbarism" [21]. Irene Khan of *Amnesty International* wrote that torture "dehumanizes the victim and the perpetrator. It is the ultimate corruption of humanity"; the constantly vigilant fight against the practice of torture is the foundation of civilization. "If the international community allows this fundamental pillar to be eroded, it cannot hope to salvage the rest" [22].

20.5 Security and Freedom

After 9/11, the strategists of the war on terrorism have once again raised the age-old controversy on the legitimacy of torture and supported the need for a lenient—if not tolerant—conception of the rule of law, in which the relationship

between security and freedom has increasingly more ambiguous contours. Usually, security and freedom are inversely proportional. Where there is more security, there is less freedom. Thus, those who want freedom are to provide security and, conversely, those who want to take freedom away start spreading insecurities and fears. It is absolutely true that this relationship exists at a largely complex level.

Can the relationship between security and freedom justify surveillance of communications, investigations into the origin and destination of wealth of unknown origin, restrictions to the movement of people, searching of houses, use of public force, detention of suspects, and prison isolation for certain periods, and to what extent? It could be discussed, but, as pointed out by Zagrebelsky, “when it comes to torture, it is not possible to talk of striking a balance for two main reasons concerning morality and effectiveness. For once, they go along with one another” [21, 23, 24].

Torture is usually associated with slavery and genocide, and, along with them, it is condemned as a crime against humanity. There is crucial common ground between these crimes, which explains and justifies why they are commonly abhorred. Borrowing Giorgio Agamben’s words, they are forms of degradation of the human being to “naked” biological “life,” to mere living matter, without any autonomy and protection, helpless facing the authority of those who exert unlimited and unrestrained power for their own purposes. For those who believe in the “moral progress of humanity,” rejecting slavery, genocide, capital punishment, and torture is the minimum—and thus inalienable—proof of civil conscience in progress. Capital punishment, too, is to be included in this list: the last moments before the execution are the most morally hideous, as the convicts, lacking any defense and hope, made unconscious by the drugs administered, become mere organic matter, and inert in the hands of human beings who decide upon their death. Accepting moral compromises and justifying the condition of people completely bereft of any dignity and literally left in the hands of others who can do whatever they please would mean going back to the time of slavery and mass exterminations, when the agonies and barbarities of torture were not only tolerated, but even imposed and justified as natural rights of the strongest. It would be like betraying humanity, its efforts, and the sufferings endured in order to step out of a condition ruled only by the law of the strongest. Those who try to relativize torture by allowing for its limited use against terrorists do not understand that crimes against humanity include also those concerning terrorism, and even terrorists regard human beings as naked life, to be destroyed for their own purposes. Nevertheless, one abomination (terrorism) does not justify another (torture).

The other major issue that has been raised with increasing force, especially after 9/11, concerns the role that torture could play to extort information from a terrorist who knows where and when a bomb has been placed to explode among the crowd, thus preventing a slaughter. What if many innocent lives could be saved from an attack, thanks to a confession extorted by violence? Undoubtedly, this is a serious and complex issue. These questions pose inevitable ethical dilemmas, but, at the same time, they do not prove what they planned to, namely, that the rule of law, in these cases, is powerless and, therefore, its principles have to be curtailed to the benefit of security. The presence of grave and imminent dangers for oneself and others justifies the acts that are deemed necessary to prevent them, including what would otherwise be serious crimes, not only morally but also legally. This is based on the principle of the “state of necessity,” which is common to all legal systems. Therefore, it is totally useless, in these cases, to call for legality to be suspended or mitigated. However, these questions tend to justify another one: they talk about violence to foil present and certain dangers (because of which the legal system does not need to be modified) and aim at justifying violence as a tool for inquisition to extort information and bring about confessions to be used during trials. Violence as defense caused by pressing actual circumstances is one thing, yet it is another as a device to carry out police investigations. But is torture really effective

for the latter purpose? Historically, the likely gray and ambiguous areas have been extremely significant.

The notorious manual on interrogations, "Kubark manual," compiled by the CIA back in 1963 and declassified in 1977, made one thing clear to everyone: regardless of the drug or pseudo-scientific method used during interrogations, their outcomes were different for every subject. It was important for US experts to define specific personality types and find out what methods worked best for each of them, but the division into categories or groups of prisoners was a ridiculous approximation. The categories were useless, as each person and each situation are different. The "Kubark manual" indirectly confirmed the risk that torture set free those terrorists who were particularly strong while condemning weak innocents, as Verri or Beccaria had claimed. Saint Augustine himself motivated the denunciation of torture by shifting the attention of the debate from the unreliability of the findings to the unacceptability of torture at a juridical and philosophical level. In *De Civitate Dei*, he made reference to the inequality between a generic allegation with insufficient evidence to prove the guilt of a defendant and the painful reality of the corporal punishment inflicted in order to fill, through that procedure, the gap of doubt and uncertainty that made conviction possible [25]. This reversed the rationale, as the punishment inflicted became a direct consequence of the inadequate evidence:

He is tortured to discover whether he is guilty, so that, though innocent, he suffers most undoubted punishment for crime that is still doubtful, not because it is proved that he committed it, but because it is not ascertained that he did not commit it. Thus the ignorance of the judge frequently involves an innocent person in suffering.

Beccaria, too, was against the use of torture as an instrument of inquisition and evidence and regarded it as an expression of a force that was legitimated by law, as he stated that "No man can be judged a criminal until he be found guilty; nor can society take from him the public protection until it have [*sic*] been proved that he has violated the conditions on which it was granted. What right, then, but that of power, can authorize the punishment of a citizen so long as there remains any doubt of his guilt?" [12].

Torture would not only absolve but also give value to violence and sadism that debase the victims and all the more the perpetrators; it entails that people are illegally taken and segregated in secret detention places (the "black holes"); it requires "experts" trained in the technical use of violence; it needs special courts, trials without audience, and defendants without any defense and faced with "evidence" obtained through inquisition methods; it often ends with the physical elimination of the subjects at the end of the procedures, when they are no longer useful: all these implications show how absurd and dangerous it is to accept "torture with legal guarantees."

The purposes would thus be perverted: torture, justified by security reasons, would end up instilling violence and terror; those who were not terrorists before are likely to become such afterward. Torture seems to aim precisely at increasing hatred, spreading it also among those who did not feel it, and turning it against those who brought it up. It is true that, when flags are waved and trumpets are played, minds are no longer able to think rationally.

Zagrebelsky concludes by saying "It is an immoral stupidity. Yet there are people who do not withdraw, scared, when faced with the idea of a power with license to torture, perhaps because they believe, either consciously or unconsciously, that this will not concern themselves or their beloved ones, but just the 'others', people like them, but of other ethnic groups, creeds, or political beliefs. It is just under these terms that 'cold' speeches can be delivered about violence and its usefulness. If this is the case, we should realize that behind the apology of torture there is a false notion: it is a matter of security, as much as of racist, religious, class, or ideological discrimination. Thus an even more ominous light would ignite" [21].

20.6 Laws of Torture in Italy: Between Hypocrisies and Lack of Interest

Italy ratified the United Nations Convention against torture in 1988. The obligations to be fulfilled following the ratification included the immediate introduction of a specific crime of torture in the Italian criminal code [26].

This obligation has explicitly been pointed out to the Parliament by *Amnesty International* since 1992. Italy is not beyond suspicion, as shown by annual reports and other periodic documents published, in particular, by Amnesty International: abuses are reported to this organization on an annual basis, and in some cases, they emerge as torture proper. Between 2002 and 2004, most of these cases concerned blows and beatings during demonstrations, inside police and *Carabinieri* stations, and, increasingly, in centers for the reception of foreigners.

Concerns were also raised by the treatment of convicts in some prisons; there have been striking cases, such as the beating that occurred in the "San Sebastiano" jail in Sassari in April 2000. Following this event, the judge for the preliminary hearing, who examined the position of the defendants who had chosen the summary trial, delivered sentences ranging from a fine to an 18-month sentence. Serious events also took place in the detention facility in Bolzaneto (July 2001), as a result of which a trial started, despite considerable difficulties, with 47 defendants including police officers and physicians, alongside 28 policemen involved in the night raid on the "Diaz" school. This is a key occasion to look for the truth and trigger a wider debate in Italy on institutionalized violence and torture.

Faced with such cases, the reaction of Italian institutions is undoubtedly inadequate. The poor outcomes of the trials, also as a result of the mild charges, further show that the present system does not work properly. Many organizations, such as *Medici contro la Tortura* and *Amnesty International*, have frequently voiced their concerns about the fact that different penal procedures, concerning alleged abuses by police and prison officers, were excessively long and, in some cases, the relevant investigations were not exhaustive enough. In addition, when law enforcement officers were deemed responsible of abuses suffered by convicts, sentences were often symbolic.

The Law introducing the crime of torture in the Italian Penal Code was approved just in 2017 (Law 110/2017) and considered crime both of torture and of incitement to torture [27].

The UN Committee expressed its "concern about the detention policy applied to asylum seekers and other non-citizens, also based on reports by which these people often have to face long detention periods in Temporary Stay Centres (*Centri di Permanenza Temporanea*—CPT)."

20.7 Toward a Law on the Right to Asylum in Italy

Italy still has no organic law on the right to asylum. Yet a major step forward was taken on November 9, 2007, thanks to the decrees that implemented two European Directives, namely, 2004/83/CE and 2005/85/CE, on the procedures and recognition of the refugee status. These decrees abolish the role of filter currently played by the police and police headquarters, which will now have to accept the applications of asylum seekers in any case, while the assessments will be carried out by the territorial commissions.

In addition to "humanitarian protection," there will be "subsidiary protection" for those who would risk suffering "serious harm" if they returned to their countries of origin, although they are not eligible for asylum. Both protections will entitle to 3-year residence permit, reunification, and engagement in employed and self-employed activities, as well as to the enrolment in professional boards. The refugee permit will last 5 years instead of 2 and will also grant access to public employment under the same terms as EU citizens.

At the moment, all the patterns of the arrivals seem to have radically changed, as increasingly more complex routes are adopted: Libya-Lampedusa-Sicily, Egypt-Sicily, and Turkey-Calabria.

The project named SPRAR (*Sistema di protezione per richiedenti asilo e rifugiati*, i.e., Protection System for Asylum Seekers and Refugees) has been joined by more than 100 municipalities and coordinated the reception activities of local bodies.

How can we assert the superiority of the Western world, if any war—localized, ethnic or not, inter-African, and inter-European—uses military technology and weapons banned or not

by the Geneva Convention, devised and produced in highly civilized Europe or in the USA, China, and Russia?

It is the same old paradox. When it comes to declaring important, basic principles and uttering noble statements, no institutional representative steps back, especially under the spotlight of the mass media. When it comes to reassembling characters and life stories already destroyed and when it comes to giving hope and trust back to the victims of war, ideological oppressions, and racial discriminations, we are alone, terribly alone, without any facilities, without any investments, and, in particular, without any network, constantly running the risk of burn-out, solitude, and bitterness.

What happens to asylum seekers, refugees, and torture victims when their applications are rejected? What happens to their lives?

The percentage of rejected applications out of those submitted in 2006 was 40.3%, while 44.5% were rejected yet with humanitarian protection. Months of anguish and commitment pass, in order to organize thoughts, testimonies, and evidence of the life threats at home, as well as of the brutalities and persecutions suffered; yet it often happens that the future is lost during the few minutes of the interview in which it is impossible to "persuade" the commission of the risks. After some time, the letter, notifying refusal, arrives.

Now, the current Italian "Yellow-Green" Government (President of the Council of the Ministers Giuseppe Conte, Minister of Internal Affairs Matteo Salvini) aims to limit the access to the recognition of asylum seeker or refugee and invokes the national security as an excuse to close SPRAR and to not receive people migrants.

The asylum seeker people in Italy are 95,000 in 2018, but the 66% of the requests are rejected, with the peak of 82% at December 2018. Currently, the refugees and the asylum seekers in the world are 68,500,000.

20.8 Some Critical Situations

20.8.1 Afghanistan

The UNAMA (UN Assistance Mission in Afghanistan) report stressed as conflict-related detainees in Afghanistan continue to face torture and ill-treatment in government detention facilities. The report also says that the Government of Afghanistan has committed to fully eliminating the practice according to the national plan promulgated in 2015, as reported by Tadamichi Yamamoto, the Secretary-General's Special Representative for Afghanistan [28].

The report by the UNAMA and the OHCHR (UN Human Rights Office) is based on interviews with 469 conflict-related detainees conducted from January 1, 2015, to December 31, 2016, in 62 detention facilities administered by the National Directorate of Security (NDS), Afghan National Police (ANP), and other Afghan National Defense and Security Forces (ANDSF) across the country.

Among other findings, 45% of those interviewed who had been detained by police said they had been tortured or ill-treated—the highest level documented since UNAMA began its current monitoring program in 2010. Of 85 child detainees interviewed, 38 gave credible accounts of being subjected to torture or ill-treatment while in the custody of the Afghan security forces.

Overall, the majority of detainees said they had been tortured to force them to confess and that the torture and ill-treatment stopped once they did so. "Many of those interviewed stated that they did not understand or could not read what was written on the 'confession' which they signed or thumb-printed," the report notes.

"As this important report makes clear, torture does not enhance security. Confessions produced as a result of torture are totally unreliable. People will say anything to stop the pain," said UN High Commissioner for Human Rights Zeid Ra'ad Al Hussein. "It is essential that there is proper monitoring of detention facilities in Afghanistan and meaningful investigations to ensure that those accused of torture are brought to trial and held accountable for this abhorrent crime. Ensuring accountability for such acts sends a strong message and helps to prevent future violations," he added.

The report contains several key recommendations from UNAMA to the Government of Afghanistan, focusing on compliance (prohibition of torture), accountability (prompt impartial,

independent, and thorough investigations of all reports of torture or ill-treatment), effective remedy (access to an effective domestic legal remedy and reparation), prevention (establishment of National Preventive Mechanism foreseen under the *Optional Protocol on the Prevention of Torture*), and training and capacity building (technical skills to carry out detection, investigation, and prosecution of conflict-related crimes in accordance with international human rights standards) [28].

20.8.2 Libya

Libya has long been a destination for migrants seeking work as well as a transit country for migrants, asylum seekers, and refugees seeking to reach the EU. People with different backgrounds and motivations travel together along the same routes, often with the help of ruthless people, smugglers, and criminal gangs. They include refugees, asylum seekers, economic migrants, unaccompanied minors, environmental migrants, victims of trafficking, and stranded migrants, among others.

A study of mixed refugee and migrant flows by UNHCR, the UN Refugee Agency, has found that around half of those traveling to Libya do so believing they can find jobs there, but end up fleeing onward to Europe to escape life-threatening insecurity, instability, difficult economic conditions, plus widespread exploitation and abuse.

In recent years, the number of people crossing by sea from North Africa to Southern Europe has increased. The indications are that this trend is likely to continue. Of the three main routes used by refugees and migrants to reach Europe—the Western Mediterranean route, the Central Mediterranean route, and the Eastern Mediterranean route—Libya has become the most commonly used one and also the deadliest.

The study commissioned by UNHCR found that the profiles and nationalities of people arriving in Libya have been evolving over the past few years, with a marked decrease in those originating in East Africa and an increase in those from West Africa, who now represent well over half of all arrivals to Europe through the Central Mediterranean route from Libya to Italy (over 100,000 arrivals in 2016).

Refugees and migrants in Libya are predominantly young men (80%), aged 22 on average, and traveling alone (72%). Women tend to transit toward Europe over a short period of time, and many of them, particularly those from West and Central Africa, are victims of trafficking. The number of unaccompanied and separated children traveling alone is rising and now represents 14% of all arrivals in Europe via the Central Mediterranean route. These children come mainly from Eritrea, The Gambia, and Nigeria.

Refugees and migrants in Libya tend to have a low level of education, with 49% having little or no formal education and only 16% having received vocational training or higher education. They come mainly from Niger, Chad, Sudan, Egypt, and Tunisia. Most of them travel to Libya for economic reasons, and many engage in seasonal, circular, or repetitive migrations. Nationals of West and Central Africa countries are mainly from Nigeria, Guinea, Côte d'Ivoire, Gambia, Senegal, Ghana, Mali, and Cameroon. They report having left largely for economic reasons. Some are victims of trafficking, in particular Nigerian and Cameroonian women, and some might be in need of international protection.

People of Eastern Africa countries are from Eritrea, Somalia, Ethiopia, and Sudan, making the journey for political persecution, conflict, and poverty.

Individuals from other regions are Syrians, Palestinians, Iraqis, Moroccans, and Bangladeshis. Some flee conflict and violence, while others are looking for livelihood opportunities.

In addition to Libya's strategic location, the conflict and instability in the country have contributed to create an environment where human smuggling and criminal networks flourish. At the same time, the collapse of the justice system has led many armed groups, criminal gangs, and individuals to participate in the exploitation and abuse of refugees and migrants [29].

Human Rights Watch stated without compromise that European Union policies contribute to a cycle of extreme abuse against migrants in Libya.

The EU and Italy's support for the Libyan Coast Guard contributes significantly to the interception of migrants and asylum seekers and their subsequent detention in arbitrary, abusive detention in Libya.

In July 2018, Human Rights Watch researchers visited four detention centers in Tripoli, Misrata, and Zuwara where they documented inhumane conditions that included severe overcrowding, unsanitary conditions, poor-quality food and water that has led to malnutrition, lack of adequate healthcare, and disturbing accounts of violence by guards, including beatings, whippings, and use of electric shocks.

Migrant children are as much at risk as adults of being detained in Libya. Human Rights Watch witnessed large numbers of children, including newborns, detained in grossly unsuitable conditions in Ain Zara, Tajoura, and Misrata detention centers [30]. They and their caretakers, including breast-feeding mothers, lack adequate food. Healthcare for children, as for adults, is absent or severely insufficient. There are no regular, organized activities for children, play areas, or any kind of schooling. Almost 20% of those who reached Europe by sea from Libya in the first 9 months of 2018 were children under the age of 18 years. Because it is indefinite and not subject to judicial review, immigration detention in Libya is arbitrary under international law.

Already in November 2017, EU migration commissioner Dimitri Avramopoulos said "We are all conscious of the appalling and degrading conditions in which some migrants are held in Libya." He and other senior EU officials have repeatedly asserted that the EU wants to improve conditions in Libyan detention in recognition of grave and widespread abuses. However, Human Rights Watch interviews with detainees, detention center staff, Libyan officials, and humanitarian actors revealed that EU efforts to improve conditions and treatment in official detention centers have had a negligible impact.

Instead, EU is providing support to the Libyan Coast Guard to enable it to intercept migrants and asylum seekers at sea; they take them back to Libya to arbitrary detention, where they face inhuman and degrading conditions and the risk of torture, sexual violence, extortion, and forced labor.

Since 2016, the EU has intensified efforts to prevent boat departures from Libya. EU policymakers and leaders justify this focus as a political and practical necessity to assert control over Europe's external borders and "break the business model of smugglers." Italy, the EU country where the majority of migrants departing Libya arrive, has taken the lead in providing material and technical assistance to the Libyan Coast Guard and abdicated virtually all responsibility for coordination of rescue operations at sea in a bid to limit the number of people arriving on its shores.

While Mediterranean departures have decreased since mid-2017, the chances of dying in waters off the coast of Libya significantly increased from 1 in 42 in 2017 to 1 in 18 in 2018, according to UNHCR.

Clashes in Tripoli between competing armed groups in August–September 2018 presented further problems and risks for detained migrants. During the clashes, which illustrated the Government of National Accord's fragile hold on power and caused civilian deaths and destruction to civilian structures, guards abandoned at least two detention centers as fighting drew near, leaving detainees unprotected inside. Authorities eventually transferred hundreds to other detention centers in the capital, contributing to even greater overcrowding in those centers. The current (Spring 2019) very serious political and military status in Libya represents further risk for the safety of detained migrants and for all the people trapped in Libya during the journey toward Europe and other countries.

Since the end of 2017, the UNHCR and the International Organization for Migration (IOM), also a UN agency, have accelerated EU-funded programs to help asylum seekers and migrants safely leave Libya, a country with no refugee law and no asylum system [31]. By the end of November 2018, UNHCR had evacuated 2069 asylum seekers from Libya to a transit center in Niamey, Niger, for refugee status determination and, ultimately, resettlement to Europe and other

countries. However, the program suffers from UNHCR's limited capacity and mandate in Libya as well as from a gap between the number of resettlement places and the number of refugees in need.

The IOM had assisted over 30,000 to return from Libya to their home countries through its "voluntary humanitarian program" between January 2017 and November 2018. While the program can be valuable in assisting people without protection needs who wish to return home safely, it cannot be described as truly voluntary as long as the only alternatives are the prospect of indefinite abusive detention in Libya or a dangerous and expensive journey across the Mediterranean.

However, at July 2018, there were between 8000 and 10,000 people in official detention centers, up from 5200 in April 2018.

In addition to the migrants and asylum seekers in official detention, the UN estimates that more than 680,000 migrants and asylum seekers live in Libya outside detention, while an unknown number are held in warehouses and other informal detention centers operated by smuggling networks and militias. The UN refugee agency UNHCR had registered 55,912 asylum seekers and refugees in Libya, primarily from Syria, Iraq, and Eritrea, as of mid-October 2018.

Human Rights Watch has documented abuses by smugglers, militias, and criminal gangs against migrants in Libya for over a decade, including rapes, beatings and killings, kidnapping for ransom, sexual exploitation, and forced labor.

There is significant evidence that smugglers operate in varying degrees of collusion with government officials and militias. In September 2018, the UNHCR reiterated its call on all countries "to allow civilians (Libyan nationals, former habitual residents of Libya, and third-country nationals) fleeing Libya access to their territories." The refugee agency urged all countries to suspend forcible returns to any part of Libya, including anyone rescued or intercepted at sea, and stated that Libya should not be designated as a "safe third country" for the purpose of rejecting asylum applications from people who have transited Libya. UNHCR has not, however, taken a clear position on EU capacity-building programs for the Libyan Coast Guard. Foreigners, regardless of age, without authorization to be in Libya are detained on the basis of laws dating back to the Gaddafi era that criminalize undocumented entry, stay, and exit punishable by imprisonment, fines, and forced labor.

The EU has allocated €266 million from the EU Emergency Trust Fund for Africa for migration-related programs in Libya and an additional €20 million through bilateral assistance. EU financial assistance has supported positive efforts including training, improved registration of migrants and asylum seekers, and help getting a limited number of people out of abusive detention. Nevertheless, this funding has not helped to diminish the widespread and systematic violence and abysmal conditions in migrant detention centers. Building the capacity of the Libyan Coast Guard and Navy is a central plank in the EU's containment policy. The EU's anti-smuggling operation EUNAVFOR MED, also known as "Operation Sophia," included a training program, begun in October 2016, for Libyan Navy and Coast Guard officers, petty officers, and sailors at least nominally under the Libyan Government of National Accord's Defense Ministry. As of June 2018, 213 Libyan Coast Guard and Navy personnel had participated in training courses, out of 3385 total personnel. However, a classified 2018 report from the EU's Border Assistance Mission to Moldova and Ukraine (EUBAM) in Libya indicated that LCG staff includes an "unknown number" of former revolutionary fighters. None of them had any training at all, according to the report.

Italy has taken the lead in EU efforts to build the capacity of Libyan authorities to secure Libya's borders and patrol the Mediterranean. Italy has deep historical, political, and economic ties with the country and engaged in significant migration cooperation agreements with the Gaddafi government. The majority of migrants and asylum seekers departing Libya reach Italian shores. More than any other EU country, Italy is investing significant material and political resources to enable and legitimize Libyan authorities to intercept and subsequently detain anyone trying to leave the country by sea.

Italy is carrying out an EU-funded project to assist Libya in setting up a maritime rescue coordination center (MRCC), which is expected to be operational in 2020. In the meantime, a Libyan operations room has been set up aboard an Italian Navy ship docked in Tripoli. The Libyan Coast Guard does not have capacity to provide continuous coverage or rapid response in every case of distress in the entire area that Libya unilaterally delineated as its search and rescue zone. Libyan units have inadequate and insufficient boats, chronic maintenance problems, and fuel shortages that limit their ability to patrol even Libyan territorial waters and quickly reach boats in distress. Relying heavily on technical and surveillance assistance from Italy, the LCG increased the number of interceptions in the first half of 2018. The LCG intercepted 12,490 people in the first 7 months of 2018, a 41% increase over the same period in 2017. By the end of 2018, the LCG had intercepted 15,235 people according to UNCHR data, a slightly lower number than in the preceding year.

In June 2018, the International Maritime Organization (IMO), a UN inter-governmental organization, acknowledged a vast Libyan SAR (Search and Rescue) region. In April 2018 a senior IMO official argued that coordination among MRCCs was sufficient and that "you can't make a blanket statement that Libya is not a place of safety" under the terms of existing maritime law. He explained that the IMO's role was to register declared SAR regions when the declaration is in conformity with IMO stipulations and is agreed to by neighboring states.

Statistical analysis carried out by the Italian Institute for International Political Studies (ISPI) on the basis of IOM and UNHCR data demonstrates that the rate of deaths at sea compared to the number of people attempting the voyage rate surged in the absence of NGO rescue patrols from 2.3% to 7%. Moreover, some interviewees described acts of intimidation or violence by members of the Coast Guard during interceptions.

Children represent a small but particularly vulnerable part of the migrant population in Libya, in detention centers, and on the sea crossing. A UNICEF survey among children along the Mediterranean migration route through Libya found that 75% reported experiencing violence, harassment, or aggression by adults. Most reported verbal and emotional abuse; half reported physical abuse. Almost 20% of those who reached Europe by sea from Libya in the first 9 months of 2018 were children under the age of 18 years [32].

Exposure to the harsh conditions in detention, in addition to traumas experienced in their home countries and along the migration journey including abuses by smugglers and traffickers, can have a profound impact on children's mental health (see "Post-traumatic Stress Disorder").

In March 2018, the IOM tracked 29,370 unaccompanied children in Libya but said the real figure could be "much higher." UNICEF, IOM, and UNHCR established in 2018 a protocol for joint protection of unaccompanied children in Libya. The agencies set up a Best Interest Determination (BID) panel to address particularly complex cases of children outside detention.

Article 16 of the International Law Commission's Articles of Responsibility of States for Internationally Wrongful Acts provides that a state is accountable for human rights violations if it knowingly aids or assists another state to commit abuses. Explanatory notes clarify that assistance can trigger state responsibility if it contributes "significantly" to the commission of a wrongful act and when a state provides material aid subsequently used to commit human rights violations. Providing substantial assistance to the Libyan Coast Guard units to intercept people in international waters, when it is known that they will return those people to cruel, inhuman, or degrading treatment in arbitrary detention in Libya or, for children, where there are substantial grounds for believing that there is a real risk of irreparable harm, can constitute aiding or assisting in the commission of serious human rights violations.

Nils Melzer, UN special rapporteur on torture, has noted that "any participation, encouragement, or assistance provided" for pullback operations leading to exposure to the real risk of torture and ill-treatment "would be irreconcilable with a

good faith interpretation and performance of the prohibition of torture and ill-treatment, including the principle of non-refoulement." Melzer has also said that "If European countries are paying Libya to deliberately prevent migrants from reaching the safety of European jurisdiction, we're talking about complicity in crimes against humanity because these people are knowingly being sent back to camps governed by rape, torture and murder."

The EU and some of its member states, in particular Italy, are providing substantial support to Libyan authorities to enable them to intercept migrants seeking to leave Libya by sea. The support is given with the purpose of enhancing the capacity of Libyan authorities to intercept such migrants. The support comes in the form of equipment, funding, training, surveillance, intelligence, and coordination assistance. The EU and states including Italy know that migrants intercepted by Libyan authorities who are returned to detention in Libya are arbitrarily held in inhumane conditions, at risk of further prohibited abuses. Indeed, they acknowledge this in providing funds to ameliorate conditions in detention, but such funds have had minimal impact on the situation.

Stricter standards apply for children, including a prohibition on the detention children for migration-related reasons. The Committee on the Rights of the Child has reaffirmed time and again that children should not be detained on the basis of their or their parents' migration status. The absolute prohibition on torture and cruel, inhuman, or degrading treatment in international law is articulated in multiple treaties by which Libya is bound, in particular the UN Convention Against Torture (CAT), the Convention on the Rights of the Child, the African Charter on Human and Peoples' Rights, and the International Covenant on Civil and Political Rights (ICCPR) [33–35].

The Nelson Mandela Rules, the revised UN Standard Minimum Rules for the Treatment of Prisoners, call for, among other things, a limit to the number of people held in a room, depending on its size, appropriate sleeping arrangements, adequate facilities for personal hygiene, clothing and bedding, adequate food, and access to medical services. Women should be held in premises entirely separate from men and guarded by female staff. UN rules specifically for children in deprived of their liberty stipulate that children should never be detained with adults [36, 37].

The UNHCR guidelines, in conjunction with the UN Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders, stipulate that facilities should accommodate women's specific hygiene needs, including the provision of sanitary pads, and ensure safeguards against sexual and gender-based violence. The use of female guards should be promoted, and there should clear remedies and protection measures for women in detention who report abuse. As a general rule, pregnant women and nursing mothers should not be detained. Survivors of sexual violence should have access to appropriate medical and psychological care, including pregnancy tests [29, 30].

20.8.3 Greece Experience

Doctors in Greece face the possibility of encountering a person that has suffered torture, especially since the high rates of refugees and migrants inflows that took place over the last years [38].

20.8.4 USA

"The USA government does not torture anybody. We respect the law and our international obligations," declared George Bush, former US President, during an unexpected speech delivered at the White House Oval Office, on Friday, October 5, 2007. After widespread accusations following *The New York Times* revelations on secret authorizations given by the former Justice Secretary, George Bush tried to defend his detention procedures and his administration's methods of interrogating terror suspects.

On Thursday, October 4, 2007, *The New York Times* newspaper revealed two top-secret Justice Department briefs dated 2005 [39]. In the first

one, then US Attorney General Alberto Gonzales, very loyal to Bush, authorized using head slaps, simulated drowning known as waterboarding, and freezing temperatures (below 0 °C) during the interrogation of terror suspects; these were a clear denial of the administration's official position, which in December 2004 defined torture as "detestable." The other brief confirmed the former, because it affirmed that CIA interrogation methods did not violate the law banning "cruel, inhuman, and degrading treatments."

In 2004, it was necessary to see the horrifying images of the Abu Ghraib prisoners in the media, to dramatically understand that torture, revenge, and use of inhuman and degrading actions are still relevant in our lives.

20.8.5 Argentina

Argentina is very sensitive to torture and violence. Plaza de Mayo is still the evidence of the mothers and grandmothers who, for many years, bravely struggled against the Argentine generals' dictatorship who turned torture, kidnapping, and murder into a daily practice, thanks to the silence of the governments of many, too many, world countries. Millions of Argentines who lost their *desaparecidos* mothers, wives, brothers, sisters, and children will remember General Videla as the perverse example of wickedness. This *Homo sapiens/demens* is so great in studies and scientific research, yet so contemptible in the use of scientific and torture techniques, implemented to destroy the lives and dignity of people, sometimes also with the involvement of physicians.

20.9 Post-traumatic Stress Disorder (PTSD)

Loss of social structures, cultural values, community rituals, relationships, and material features were experienced by forced migrants. Meeting the healthcare needs of those affected can help achieve safety and rehabilitation [40].

Individuals who have experienced multiple traumatic events in their home country, in transition to, and within the hosting country undergo elevated levels of stress linked with unmet basic needs and uncertainty about their own future and the safety of loved ones. Traumatic experience includes landmines, torture, or violent trauma, which may result in long-term disability.

Psychosocial stressors, experienced by many forced migrants, can increase pain intensification and sensitivity. Although somatic symptoms may be caused by underlying stress, it is important to rule out other causes. For example, headaches could be due to a neck injury, post-concussion syndrome, traumatic brain injury, or post-traumatic epilepsy, and abdominal pain could be a consequence of *H. pylori* disease or sexual assault. Integrating physical, psychological, sociological, and cultural models into a therapeutic approach to chronic pain and weakness (massage, physiotherapy, non-steroidal analgesics, and training in self-help techniques) can help with pain management [41].

These experiences cause huge personal losses, which are a major threat to identity. Accordingly, refugees and asylum seekers have higher rates of mental health conditions, particularly PTSD, anxiety, depression, and psychoses [42].

PTSD is a mental health condition triggered by a terrifying event—either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event. Most people who go through traumatic events may have temporary difficulty adjusting and coping, but with time and good self-care, they usually get better. If the symptoms get worse, last for months or even years, and interfere with day-to-day functioning, he/she may have PTSD.

Post-traumatic stress disorder symptoms may start within 1 month of a traumatic event, but sometimes symptoms may not appear until years after the event. These symptoms cause significant problems in social or work situations and in relationships. They can also interfere with the ability to go about your normal daily tasks.

PTSD symptoms, varying over time or from person to person, are generally grouped into four

types: intrusive memories, avoidance, negative changes in thinking and mood, and changes in physical and emotional reactions.

Symptoms of *intrusive memories* may include:

- Recurrent, unwanted distressing memories of the traumatic event
- Reliving the traumatic event as if it were happening again (flashbacks)
- Upsetting dreams or nightmares about the traumatic event
- Severe emotional distress or physical reactions to something that reminds of the traumatic event

Symptoms of *avoidance* may include:

- Trying to avoid thinking or talking about the traumatic event
- Avoiding places, activities, or people that remind you of the traumatic event

Symptoms of *negative changes* in thinking and mood may include:

- Negative thoughts about yourself, other people, or the world
- Hopelessness about the future
- Memory problems, including not remembering important aspects of the traumatic event
- Difficulty to maintaining close relationships
- Feeling detached from family and friends
- Lack of interest in activities you once enjoyed
- Difficulty experiencing positive emotions
- Feeling emotionally numb

Symptoms of *changes in physical and emotional reactions* (also called arousal symptoms) may include:

- Being easily startled or frightened
- Always being on guard for danger
- Self-destructive behavior, such as drinking too much or driving too fast
- Trouble sleeping
- Trouble concentrating
- Irritability, angry outbursts, or aggressive behavior
- Overwhelming guilt or shame

For children 6 years old and younger, signs and symptoms may also include:

- Re-enacting the traumatic event or aspects of the traumatic event through play
- Frightening dreams that may or may not include aspects of the traumatic event

PTSD symptoms can vary in intensity over time, also depending on environmental condition. Post-traumatic stress disorder can disrupt whole life, relationships, health, and enjoyment of everyday activities.

Having PTSD may also increase risk of other mental health problems, such as:

- Depression and anxiety
- Issues with drugs or alcohol use
- Eating disorders
- Suicidal thoughts and actions

The occurrence of PTSD in people refugees or asylum seekers affects in turn their ability to cope with the difficulties depending on unknown language, environment, laws, and habits of the countries of arrival. Moreover, considering the duration of the journey, it is possible the occurrence of the PTSD even in the transit country impairing the overall ability of the people to gain the final country. Finally, PTSD may further compromise the health and the life of the affected people because it impairs just the memories of the traumatic accident (frequently abuse or torture) even during the interview with physician or UN worker, lowering the possibility of obtaining the status of refugee. The rejected application will further affect the health and life itself of asylum seeker.

The conflict and forced migration disrupt several core elements, according to the ADAPT model: safety and security, interpersonal bonds and networks, justice, roles and identities, and existential meaning and coherence.

Depression among forced migrants is closely linked with poor social support, as well as with immigration processes, racial discrimination, and homelessness. A systematic review of the mental health implications of detaining asylum seekers

confirms that child, adolescent, and adult immigration detainees experience high levels of anxiety, depression, post-traumatic stress, self-harm, and suicidal ideation.

As already underlined, the events able to make refugees vulnerable to develop mental disorders may occur before or during migration.

Traumatic events experienced before migration may be related to exposure to war, persecution, or economic hardship and account for the decision to leave their home. Refugees can be exposed to war directly or indirectly, witnessing destruction and death, or have had traumatic experiences including torture and personal combat involvement. Persecution for political, ethnic, religious, or other reasons may involve torture, imprisonment, violations of human rights of the person, or death of family members. The psychological consequences of torture are more evident when the people fear for their life or if torture is enduring for a long time. Refugees may also have experienced extreme levels of poverty and economic hardship, including a lack of food, water, shelter, and other basic needs and resources. During migration many refugees have traveled in unsafe boats or in enclosed trains or trucks and may have walked on dangerous land routes. During their journey refugees have frequently experienced physical harm, sexual violence, infectious diseases, extortion, and human trafficking. Finally, displacement in itself is a risk factor for mental health.

Poor social integration will worsen risk for PTSD. In some cases, forced separation from family members and support networks occurs during migration or after resettlement, which further reduces social support for some refugees. This is particularly relevant for children and adolescents. The social isolation is linked with the poor acculturation, the cultural changes due to moving from one culture to another. This concerns mainly the refugees who have not chosen the country where they are displaced. The unemployment is itself a risk for mental disorders.

Refugees frequently encounter difficulties in accessing healthcare. This can result in delayed diagnostic assessments and treatments of mental disorders, which can then lead to a deterioration or chronicization of the condition.

Moreover, experiences of persecution before migration and fear of being reported to authorities in the host country may lead refugees—particularly asylum seekers and irregular migrants—to avoid accessing care or mistrust services and clinicians [43].

20.10 Self-Harm

In the literature, deliberate self-harm is often used interchangeably with the term "non-suicidal self-injury" (NSSI) and indicates the intentional injuring of own body without suicidal intentions. However, in some instances the term also includes possible suicidal intentions. Epidemiology of suicidal ideation, suicide attempts, and direct self-injurious behavior in adolescents with a migration background reported a higher prevalence of all three investigated variables than adolescents without a migration background.

Female adolescents reported a higher prevalence of suicidal ideation, suicide attempts, and direct self-injurious behavior [44].

20.11 How to Approach the People Alleged Victim of Torture

Physicians are involved in the investigation of torture or ill-treatment. They must act at all times in conformity with the highest ethical standards and, in particular, must obtain informed consent before any examination. The examination must conform to established standards of medical practice. In particular, it must be conducted in private under the control of the medical expert and outside the presence of security agents and other government officials. The medical expert should promptly prepare an accurate written report. This report should include at least the following items:

(a) The circumstances of the interview. The name of the subject and name and affiliation

of those present at the examination; the exact time and date, location, nature, and address of the institution (including, where appropriate, the room) where the examination is being conducted (e.g., detention center, clinic, house, etc.); and any appropriate circumstances at the time of the examination (e.g., nature of any restraints on arrival or during the examination, presence of security forces during the examination).

(b) The background. A detailed record of the subject's story as given during the interview, including alleged methods of torture or ill-treatment, the time when torture or ill-treatment was alleged to have occurred, and all complaints of physical and psychological symptoms.

(c) A physical and psychological examination. A record of all physical and psychological findings upon clinical examination including appropriate diagnostic tests and, where possible, color photographs of all injuries.

(d) An opinion. An interpretation as to the probable relationship of physical and psychological findings to possible torture or ill-treatment. A recommendation for any necessary medical and psychological treatment or further examination should also be given.

(e) A record of authorship. The report should clearly identify those carrying out the examination and should be signed. The report should be confidential and communicated to the subject or his or her nominated representative. The report should be provided in writing, where appropriate, to the authority responsible for investigating the allegation of torture or ill-treatment. It is the responsibility of the state to ensure that the report is delivered securely to these persons.

Because of the possible devastating sense of powerlessness, it is particularly important to show sensitivity to the alleged torture victim and other witnesses. The state must protect alleged victims of torture, witnesses, and their families from violence, threats of violence, or any other form of intimidation that may arise pursuant to the investigation.

Investigators should explain to the person the part of the procedure that will be public or confidential.

Special consideration should be given to the victim's preference for a person of the same gender, the same cultural background, or the ability to communicate in his or her native language. Consequently, this preferred person will be the referent for the alleged person victim of torture. If people are still imprisoned or in similar situations in which reprisals are possible, the interviewer should use care not to put them in danger. In situations where talking to an investigator may endanger someone, a "group interview" may be preferable to an individual interview. In other cases, the interviewer must choose a place for the private interview where the witness feels comfortable to talk freely.

Sufficient time should be allotted to interview the alleged torture victim. It is usual that not full story is reported during the first interview. The investigator must be sensitive in tone, phrasing, and sequencing of questions, given the traumatic nature of the alleged victim's testimony. The witness must be told of the right to stop the questioning at any time, to take a break if needed, or to choose not to respond to any question.

Most people consider sexual assault as meaning actual rape or sodomy. Verbal assaults, disrobing, groping, lewd or humiliating acts, or blows or electric shocks to the genitals are often not taken by the victim as constituting sexual assault. These acts all violate the individual's intimacy and should be considered as being part of sexual assault.

Very often, victims of sexual assault will say nothing or even deny any sexual assault. It is often only on the second or even third visit, if the contact made has been empathic and sensitive to the person's culture and personality, that more of the story will come out.

People may report physical injuries sustained in the course of the torture, and they may provide a description of weapons or other physical objects used. It is relevant to identify witnesses to the events. However, the investigator must use care in protecting the safety of witnesses. The investigator must encourage the person to use all

his/her senses in describing what has happened to him or her. Moreover, it is useful to ask what he or she saw, smelled, heard, and felt. This is important in situations where the person may have been blindfolded or experienced the assault in the dark. If the torture has allegedly taken place recently enough for such evidence to be relevant, any samples found of body fluids (such as blood or semen), hair, and fibers should be collected, labeled, and properly preserved. The investigator must consider whether the physical and psychological findings are consistent with the alleged report of torture, whether physical conditions contribute to the clinical picture, whether the psychological findings are expected or typical reactions to extreme stress within the cultural and social context of the individual, what is the time frame in relation to the torture events, and what other stressful factors are affecting the individual (e.g., ongoing persecution, forced migration, exile, loss of family, and social role). Color photographs should be taken of the injuries of persons alleging that they have been tortured.

A medical examination should be carried out regardless of the length of time since the torture, but if it is alleged to have happened within the past 6 weeks, such an examination should be arranged urgently before acute signs fade. The examination should include an assessment of the need for treatment of injuries and illnesses, psychological help, advice, and follow-up. A psychological appraisal of the alleged torture victim is always necessary. If it is evident that a large number of prisoners have been tortured in a given place, but they all refuse to allow investigators to use their stories because of fear, it is useful to set up a "health inspection" of the whole ward in full view in the courtyard. The physician and interpreter should provide their names and explain their role in conducting the evaluation. When the people have been tortured on multiple occasions, they may be able to recall what happened to them, but often they cannot recall exactly where and when each event occurred.

Forensic medicine and dermatology are often complementary sciences. A minimum knowledge of forensic terminology is useful in order to describe the process and mechanisms of injury resulting in the acute or healed skin signs of torture. Dermatologic description of primary and secondary skin lesions delivers additional information and clues to diagnoses.

During medical examination, for each form of abuse, it is relevant to note body position, restraint, and nature of contact, including duration, frequency, anatomical location, and the area of the body affected. In addition, it is relevant to take into account any bleeding, head trauma, or loss of consciousness and whether the loss of consciousness was due to head trauma, asphyxiation, or pain. The investigator should also ask about how the person was at the end of the "session" (Could he or she walk? Did he or she have to be helped or carried back to the cell? Could he or she get up the next day? How long did the feet stay swollen?). Disorientation of time and place during torture is a generally observed finding. Torture survivors may have difficulty recounting the specific details of the torture for several important reasons, such as blindfolding; drugging; lapses of consciousness; fear of placing themselves or others at risk; lack of trust in the examining clinician or interpreter; psychological impact of torture and trauma (PTSD); neuropsychiatric memory impairment from beatings to the head, suffocation, near drowning, or starvation; protective coping mechanisms, such as denial and avoidance; and culturally prescribed sanctions.

Survivors may be victims of physical and/or psychological torture (Table 20.2). The presence of psychological sequelae in torture survivors, particularly the various manifestations of PTSD, may cause the torture survivor to fear experiencing a re-enactment of his or her torture experience during the interview, physical examination, or laboratory test.

While it is essential to obtain accurate information regarding a torture survivor's experiences, open-ended interviewing methods require that patients should disclose these experiences in their own words using free recall. An individual who has survived torture may have trouble expressing in words his or her experiences and symptoms.

Table 20.2 Main types of physical and psychological torture

Physical	Positional	Suspension, stretching limbs apart, prolonged constraint of movement, forced positioning
	Burns	Cigarettes, heated instruments, scalding liquid or a caustic substance
	Electric shocks	
	Asphyxiation	Wet and dry methods, drowning, smothering, choking, or use of chemicals
	Crush injuries	Smashing fingers or using a heavy roller to injure the thighs or back, traumatic removal of digits and limbs, medical amputation of digits or limbs, surgical removal of organs
	Penetrating injuries	Stab and gunshot wounds, wires under nails
	Chemical	Salt, chili pepper, gasoline in wounds or body cavities
	Sexual	To genitals, molestation, instrumentation, rape
	Pharmacological	Toxic doses of sedatives, neuroleptics, paralytics
	Conditions of detention	Small or overcrowded cell, solitary confinement, unhygienic conditions, no access to toilet facilities, irregular or contaminated food and water, exposure to extremes of temperature, denial of privacy, and forced nakedness
	Deprivation of normal sensory stimulation	Sound, light, sense of time, isolation, manipulation of brightness of the cell, abuse of physiological needs
	Restriction	Sleep, food, water, toilet facilities, bathing, motor activities, medical care, social contacts, isolation within prison, loss of contact with the outside world
Psychological	Humiliation	Verbal abuse, performance of humiliating acts
	Threats	Death, harm to family, further torture, imprisonment, mock executions, attack by animals (dogs, cats, rats, or scorpions)
	Helplessness	Forced betrayals, accentuating feelings
	Exposure to ambiguous situations or contradictory messages	
	Violation of taboos	
	Behavioral coercion	Forced engagement in practices against the religion of the victim, forced harm to others through torture, forced destruction of property, betrayal of someone placing them at risk of harm, forcing the victim to witness torture or atrocities being inflicted on others

Table 20.3 Acute symptoms

Crush and beatings	Bleeding, bruising, swelling, open wounds, lacerations, fractures, dislocations, joint stress, hemoptysis, pneumothorax, tympanic membrane perforation
Burn	Erythema, bulla or necrosis, sores
Electrical	Color and surface characteristics
Chemical	Color, signs of necrosis
General	Pain, numbness, constipation, and vomiting

The individual should be asked to describe any symptoms that may have resulted from the specific methods of alleged abuse (Table 20.3). The intensity, frequency, and duration of each symptom should be noted. The development of any subsequent skin lesions should be described indicating whether or not they left scars. The people may also present chronic symptoms (Table 20.4). Although acute lesions may be characteristic of the alleged injuries, most lesions heal within about 6 weeks of torture, leaving no scars or, at the most, non-specific scars. This is often the case when torturers use techniques that prevent or limit detectable signs of injury.

During the physician examination (Tables 20.5, 20.6, and 20.7), facial tissues should be pal-

Table 20.4 Chronic symptoms

Crush and beatings	Skeletal deformities, incorrect healing of fractures, dental injuries, loss of hair, and myofibrosis
Electrical or chemical	Scars
Common to several different injuries	Headache, back pain, gastrointestinal symptoms, sexual dysfunction, and muscle pain
Common to several different injuries	Depressive affect, anxiety, insomnia, nightmares, flashbacks, and memory difficulties

Table 20.5 Physician examination of the skin

	Acute	Chronic
Beatings and blunt trauma	*Abrasions:* scratches, brush-burn type or larger scraped lesions. Pattern reflecting the contours of the instrument or surface that inflicted the injury. Hypo- or hyperpigmentation after repeated or deep abrasions	Cicatricial alopecia: linear circular zone (with few hairs or hair follicles) around the arm or leg, usually at the wrist or ankle after prolonged application of tight ligatures
	Contusions and bruises (hemorrhage into soft tissue due to the rupture of blood vessels). Extent and severity depending on applied force, structure, and vascularity of the contused tissue. Their absence, however, does not exclude violence. Contusions may reflect the contours of the inflicting instrument	Bruises initially dark blue, purple, or crimson, gradually changing to violet, green, dark yellow, or pale yellow and then disappearing. It is very difficult, however, to date accurately the occurrence of contusions. Contusions in deeper subcutaneous tissues may not appear until several days after injury, when the extravasated blood has reached the surface
	Lacerations (tearing or crushing of skin and underlying soft tissues by the pressure of blunt force) on the protruding parts of the body, but with sufficient force, the skin can be torn on any part of the body	Scars, when resulting from whipping (depigmented and often hypertrophic, surrounded by narrow, hyperpigmented stripes), represent healed lacerations
Burns	Erythema. Edema	Cigarettes leave 5–10 mm, circular orovoid, macular scars with a hyper- or a hypopigmented center and a hyperpigmented, relatively indistinct periphery. Burning with objects (electrically heated metal rod or gas lighter) produces markedly atrophic scars reflecting the shape of the instrument and sharply demarcated with narrow hypertrophic or hyperpigmented marginal zones corresponding to an initial zone of inflammation. Hypertrophicor keloid scars (burning rubber) may appear. When the nail matrix is burnt, subsequent growth produces striped, thin, deformed nails, sometimes broken up in longitudinal segments
Nail lesions		If a nail has been pulled off, an overgrowth of tissue may be produced
Cutting	Stab wounds, incised or cut wounds, and puncture wounds by knife, bayonet, or broken glass	If pepper or other noxious substances are applied to open wounds, the scars may become hypertrophic
Asphyxiation	Petechiae	

pated for evidence of fracture, crepitation, swelling, or pain. The motor and sensory components, including smell and taste of all cranial nerves, should be examined. Computed tomography (CT) should be performed to diagnose and characterize facial fractures, determine alignment, and diagnose associated soft tissue injuries and complications. There are many forms of trauma to the eyes,

Table 20.6 Physician examination of the bone

	Acute	Chronic
Fractures	Direct fracture at the site of impact or at the site where the force was applied. Location, contour reflect the nature and direction of the applied force	Lesions vary according to age, sex, tissue characteristics, condition and health of the patient, and severity of the trauma
Direct head trauma	Scalp bruises are frequently invisible externally unless there is swelling	Possible cortical atrophy and diffuse axonal damage. In cases of falls, countercoup (in opposition to the trauma). Continuous headaches (initial symptom of an expanding subdural hematoma)
Violent shaking (usually brief, only a few minutes or less, but may be repeated many times over a period of days or weeks)	Edema, subdural hematoma, and retinal hemorrhages without any external marks Bruises on the upper chest or shoulders where the victim has been grabbed	Recurrent headaches, disorientation, or mental status changes
Chest and abdominal trauma	Rib fractures. If displaced, lacerations of the lung and pneumothorax. Gross hematuria if kidney contusion. Occult abdominal hemorrhage at peritoneal lavage. On a CT, acute abdominal hemorrhage is isointense (acute central nervous system hemorrhage is hyperintense). Free air, extraluminal fluid, or areas of low attenuation represent edema, contusion, hemorrhage, or laceration. Peripancreatic edema as sign of acute pancreatitis. Ultrasound useful in detecting subcapsular hematomas of the spleen. Renal failure	Renal hypertension as a late complication of renal injury
Feet (falanga: repeated application of blunt trauma to the feet, or to hands or hips, usually with a truncheon, a pipe, or similar weapon)	CT or MRI for radiological documentation, but physical examination in the acute phase is diagnostic. On palpation, the entire length of the plantar aponeurosis tender and distal attachments of the aponeurosis torn, partly at the base of the proximal phalanges, partly at the skin. If aponeurosis is intact, the beginning of tension is felt when the toe is dorsiflexed to 20°; maximum normal extension is about 70°. Higher values suggest injury to the attachments of the aponeurosis	Closed compartment syndrome: muscle necrosis, vascular obstruction, or gangrene of the foot distal or toes Fractures of the carpal and metacarpal bones and phalanges. Walking is painful and difficult. Tarsal bones fixed (spastic) or increased motion. Crushed heel and anterior foot pads: elastic pads under calcaneus and proximal phalanxes crushed directly or as result of associated edema; torn connective tissue bands through adipose tissue connecting bone to skin; atrophic adipose tissue deprived of blood supply; lost cushioning effect Rigid and irregular scars involving skin and subcutaneous tissues due to partial or complete destruction of connective bands Rupture of the plantar aponeurosis and tendons of the foot Planter fasciitis

(continued)

Table 20.6 (continued)

	Acute	Chronic
Suspension: Cross suspension (by spreading the arms and tying them to a horizontal bar) Butchery suspension (by fixation of hands upward, either together or one by one) Reverse butchery suspension (by fixation of feet upward and the head downward) "Palestinian" suspension (by suspending with the forearms bound together behind the back, the elbows flexed 90°, and the forearms tied to a horizontal bar, alternatively from a ligature tied around the elbows or wrists with the arms behind the back) "Parrot perch" suspension (by suspending by the flexed knees from a bar passed below the popliteal region, usually while the wrists are tied to the ankles)	Extreme pain but little, if any, visible evidence (brachial plexopathy). If "Palestinian" suspension, rapid permanent brachial plexus. If "parrot perch," tears in knees cruciate ligaments. Victims will often be beaten while suspended or otherwise abused. Weakness of the arms or hands, pain and paresthesias, numbness, insensitivity to touch, superficial pain, and tendon reflex loss. Intense deep pain may mask muscle weakness If "Palestinian" suspension, lower (deficiencies localized in the forearm and hand muscles; sensory deficiencies on the forearm and at the fourth/fifth fingers of the hand's medial side), middle (forearm, elbow, and finger extensor muscles; weak pronation of the forearm and radial flexion of the hand; sensory deficiency on forearm and dorsal aspects of the first/second/third fingers of the hand in radial nerve distribution; lost triceps reflexes), and upper (shoulder muscles affected, deficient abduction of the shoulder, axial rotation and forearm pronation-supination; sensory deficiency in deltoid region and outer parts of the forearm) plexus fiber involvement. If "crucifixion" suspension, without hyperextension, damage to middle plexus fibers due to hyperabduction	For pain and tenderness around the shoulder joints to persist, as the lifting of weight and rotation, especially internal, will cause severe pain many years later Weakness continues and progresses to muscle wasting. Numbness and paresthesia. Tears of the ligaments of the shoulder joints, dislocation of the scapula, and muscle injury in the shoulder region "Winged scapula" (prominent vertebral border of the scapula) with injury to the long thoracic nerve or dislocation of the scapula
Other positions: "Parrot suspension," "banana stand," "banana tie" over a chair just on the ground or on a motorcycle, forced standing, forced standing on a single foot, prolonged standing with arms and hands stretched high on a wall, prolonged forced squatting, and forced immobilization in a small cage	Pain in a region of the body, limitation of joint movement, back pain, pain in the hands or cervical parts of the body, and swelling of the lower legs	

Table 20.7 Physician examination of electric shock signs

	Acute	Chronic
Electrodes placed on a toe of the right foot and on the genital region	Pain, muscle contraction, and cramps in the right thigh and calf muscles; excruciating pain will be felt in the genital region. Tetanic contraction of all muscles along the electric field route with dislocation of the shoulder, lumbar, and cervical radiculopathies. Burns as reddish brown circular lesion (1–3 mm) usually without inflammation. Biopsy controversial	Hyperpigmented scars
Use of water or gels (to increase the efficiency of the torture and expand the entrance point of the electric current on the body)	Undetectable electric burns	

including lens dislocation; conjunctival, subhyaloid, retrobulbar, or retinal hemorrhage; and visual field loss. Nuclear magnetic resonance imaging (MRI) may be an adjunct for identifying soft tissue injury.

The ear canals and tympanic membranes should be examined with an otoscope and injuries described. A common form of torture, known in Latin America as *telefono*, is a hard slap of the palm to one or both ears, rapidly increasing pressure in the ear canal, thus rupturing the drum. It is relevant to note that tympanic membrane ruptures less than 2 mm in diameter may heal within 10 days. However, fluid may be observed in the middle or external ear. If otorrhea is confirmed by laboratory analysis, MRI or CT should be performed to determine the fracture site. The presence of hearing loss should be investigated. The nose should be evaluated for alignment, crepitation, and deviation of the nasal septum. For simple nasal fractures, standard nasal radiographs should be sufficient. When the cartilaginous septum is displaced, CT should be performed. If rhinorrhea is present, CT or MRI is recommended. Mandibular fractures or dislocations may result from beatings. Temporomandibular joint syndrome is a frequent consequence of beatings about the lower face and jaw. The patient should be examined for evidence of crepitation of the hyoid bone or laryngeal cartilage resulting from blows to the neck. Gingival hemorrhage and the condition of the gums should also be noted. During application of an electric current, the tongue, gums, or lips may be bitten. Lesions might be produced by forcing objects or materials into the mouth, as well as by applying electric current. X-rays and MRI are able to determine the extent of soft tissue, mandibular, and dental trauma. Examination of the trunk, in addition to noting lesions of the skin, should be directed toward detecting regions of pain, tenderness, or discomfort that would reflect underlying injuries of the musculature, ribs, or abdominal organs. The examiner must consider the possibility of intramuscular, retroperitoneal, and intra-abdominal hematomas, as well as laceration or rupture of an internal organ. Ultrasonography, CT, and bone scintigraphy should be used, when realistically available, to confirm such injuries.

Complaints of musculoskeletal aches and pains are very common in survivors of torture. They may be the result of repeated beatings, suspension, other positional torture, or the general physical environment of detention. They may also be somatic. While they are non-specific, they should be documented. They often respond well to sympathetic physiotherapy. Injuries to tendons, ligaments, and muscles are best evaluated with MRI. In the acute stage, this can detect hemorrhage and possible muscle tears. Muscles usually heal completely without scarring; thus, later imaging studies will be negative. Under MRI and CT, denervated muscles and chronic compartment syndrome will be imaged as muscle fibrosis. Bone bruises can be detected by MRI or scintigraphy. Bone bruises usually heal without leaving traces.

Genital examination should be performed only with the consent of the patient and, if necessary, should be postponed to a later examination. A chaperone must be present if the examining physician's gender is different from that of the patient. Ultrasonography and dynamic scintigraphy can be used for detecting genito-urinary trauma.

The neurological examination should evaluate the cranial nerves, sensory organs, and peripheral nervous system, checking for both motor and sensory neuropathies related to possible trauma, vitamin deficiencies, or disease. Cognitive ability and mental status must also be evaluated. Radiculopathies, other neuropathies, cranial nerve deficits, hyperalgesia, paresthesias, hyperesthesia, change in position, temperature sensation, motor function, gait, and coordination may all result from trauma associated with torture. In patients with ahistory of dizziness and vomiting, a vestibular examination should be conducted, and evidence of nystagmus noted. MRI is preferred over CT for radiological evaluation of the brain and posterior fossae.

For each lesion and for the overall pattern of lesions, the physician should indicate the degree of consistency between it and the attribution given by the patient. It is the overall evaluation of

all lesions and not the consistency of each lesion with a particular form of torture that is important in assessing the torture story.

Near asphyxiation by suffocation is an increasingly common method of torture, widely used in Latin America, that its name in Spanish, *submarino*. It usually leaves no mark, and recuperation is rapid. Normal respiration might be prevented through covering the head with a plastic bag, closure of the mouth and nose, pressure or ligature around the neck, or forced aspiration of dust, cement, hot peppers, etc. This is also known as "dry *submarino*." Beyond the cutaneous skin, nosebleeds, bleeding from the ears, congestion of the face, infections in the mouth, and acute or chronic respiratory problems occur. Forcible immersion of the head in water, often contaminated with urine, feces, vomit, or other impurities, may result in near drowning or drowning. Aspiration of the water into the lungs may lead to pneumonia. This form of torture is called "wet *submarino*." In hanging or in other ligature asphyxiation, patterned abrasions or contusions can often be found on the neck. The hyoid bone and laryngeal cartilage may be fractured by partial strangulation or from blows to the neck.

Sexual torture (Table 20.8) begins with forced nudity, which in many countries is a constant factor in torture situations. Nudity enhances the psy-

Table 20.8 Physician examination after sexual assault

	Acute	Chronic
Ano-genital area	Bleeding, vaginal or anal discharge, and location of pain, bruises, or sores If clear evidence of rape on external inspection, unnecessary internal pelvic examination. Genital lesions include: (i) Small lacerations or tears of the vulva (by excessive stretching), normally healing completely; if repeated trauma, scarring (ii) Abrasions (by contact with rough objects such as fingernails or rings) (iii) Vaginal lacerations (associated with tissue atrophy, by inserted sharp objects) Men may show hyperemia, marked swelling, and ecchymosis. Urine containing erythrocytes and leucocytes. Hydrocele (excessive accumulation of fluid within tunica vaginal is due to testis inflammation), hematocele (blood accumulation due to a trauma), or inguinal hernia. If inguinal hernia, impalpable spermatic cord above the mass. Unlike the hydrocele, hematocele does not transilluminate. Testicular torsion from trauma to the scrotum: testis twisted at its base, obstructing blood flow to the testis, causing severe pain and swelling (surgical emergency; alternatively infarction of the testis) Anal examination, beyond visual inspection, with local or general anesthesia	Urinary frequence, incontinence, or dysuria; irregularity of menstruation; pregnancy; abortion or vaginal hemorrhage; problems with sexual activity, including intercourse and anal pain; bleeding; or constipation Where the alleged assault occurred more than a week earlier, lost signs of bruises or lacerations. Even when the woman has had subsequent sexual activity, whether consensual or not, or given birth, it may be almost impossible to attribute any findings to a specific alleged abuse If scrotal torture, chronic urinary tract infection, erectile dysfunction, or atrophy of the testes Anal scars of unusual size or position. Anal fissures persisting for many years. Rectal tears with or without bleeding. Disruption of the rugal pattern as smooth fan-shaped scarring out of midline. Purulent discharge from the anus
Skin	Bruises, lacerations, ecchymoses, and petechiae from sucking or biting	Scars on the skin of the scrotum and penis very difficult to visualize
Laboratory support	DNA testing on sperm for up to 5 days from samples taken with a deep vaginal swab and after up to 3 days using a rectal sample	Gonorrhoea, chlamydia, syphilis, test for HIV, hepatitis B and C, herpes simplex, and *Condyloma acuminatum* (venereal warts), trichomoniasis, *Moniliasis vaginitis*, *Gardnerella vaginitis*, and *Enterobius vermicularis* (pinworms), as well as for urinary tract infections

chological terror of every aspect of torture, as there is always the background of potential abuse, rape, or sodomy. Furthermore, verbal sexual threats, abuse, and mocking are also part of sexual torture, as they enhance the humiliation and its degrading aspects. The groping of women is traumatic in all cases and is considered to be torture. Rape is always associated with the risk of developing sexually transmitted diseases, particularly human immunodeficiency virus. Currently, the only effective prophylaxis against HIV must be taken within hours of the incident, and it is not generally available in countries where torture occurs routinely. Electricity and blows are generally targeted on the genitals in men, with or without additional anal torture. Prisoners may be placed naked in cells with family members, friends, or total strangers, breaking cultural taboos. This can be made worse by the absence of privacy when using toilet facilities. Additionally, prisoners may be forced to abuse each other sexually, which can be particularly difficult to cope with emotionally. The fear of potential rape among women, given profound cultural stigma associated with rape, can add to the trauma. Not to be neglected are the trauma of potential pregnancy, the fear of losing virginity, and the fear of not being able to have children [45].

Not all skin lesions in patients alleging torture or ill-treatment are due to their treatment in detention. A comprehensive history is essential in order to differentiate inflicted from non-inflicted injuries. Moreover, knowledge of folk remedies and cultural practices is useful to avoid mislabeling those physical findings as abuse (additional photographs, see online repository material). Blue coloration of the skin can be drug-induced or hereditary. Drug-induced sideeffects are typically seen after treatment with minocycline, phenothiazines, amiodarone, or antimalarials and may leave a blue macula on the face. Hereditary causes, such as nevus of Ota, nevus of Ito, and Mongolian spots, might not always be clearly visible at birth as they are predominantly seen in darker skin types such as in Asian and Latino populations. Nevus of Ota is typically located around the eyes. Clues to differentiate them from bruises are indistinct borders, lack of inflammatory erythema, and absence of typical color changes associated with ecchymoses. Senile purpura, typically located on chronic sun-exposed areas, appears on the extensor surface of forearms. Steroid purpura is a direct consequence of skin atrophy due to prolonged intake or topical use of glucocorticoids. In both of the above, purpura is limited to the area of exposure, which makes it less likely to be mistaken for an inflicted injury.

Coin rolling is a commonly used practice in Southeast Asia to clear the body of "bad winds." Medicated coins are rubbed onto the skin until petechiae and purpura occur. Currently, it is a widely accepted form of alternative medicine practiced across the world as a remedy against various diseases.

The most important cutaneous infections caused by *S. aureus* and/or streptococci, which can mimic burns, are bullous impetigo, characterized by fragile bullae, erosions, and honey-colored crusting.

Scars from varicella, scabies, or other infections or secondary to acne can appear similar to cigarette burns. If scars are located on the calf, they should be differentiated from skin alternations due to venous insufficiency. Keloid scars following electrocution can be mistaken for a chondrodermatitis helicis, which is more painful and pale compared to postelectrocution scars.

Diseases such as lichen planus, lichen simplex chronicus, or allergic contact dermatitis can cause severe pruritus and erosions in the genital area and should be differentiated from the sexual assault. In chronic settings, caution is required not to overlook a squamous cell carcinomas when erosive mucosal lesions are long-lasting and nonpruritic [46].

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