

# Rape as Torture: Application of the U.S. Torture Statute to the Physical and Psychological Consequences of Rape and Sexual Violence on Victims

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Rape is considered a crime against humanity and an act of torture in international law in large part due to its severe physical and psychological effects on individuals and communities. It is not the purpose of this memorandum to contrast U.S. and international jurisprudence, but rather to explore these physical and psychological effects common to incidents of sexual violence with an eye towards situating this crime within the bounds of the U.S. torture statute, 18 U.S.C. §2340. Elsewhere, we discuss the psychological motivations of the perpetrator of these crimes in the interest of satisfying the statute’s specific intent requirement. Here, our focus is on the victims—and precisely on showing that rape and sexual crimes indisputably meet Title 18’s severity standards. In this section, we will show that rape and sexual crimes: (1) have the potential to cause severe physical pain or suffering; (2) result in prolonged mental harm; and (3) cause this prolonged mental harm via circumstances enumerated under the U.S. torture statute. Points (2) and (3) are sufficient to show that rape and sexual violence amount to the “severe mental pain or suffering” stipulated by the statute.

(1) “torture” means an act committed by a person acting under the color of law specifically intended to inflict severe physical or mental pain or suffering (other than pain or suffering incidental to lawful sanctions) upon another person within his custody or physical control;

(2) “severe mental pain or suffering” means the prolonged mental harm caused by or resulting from—

(A) the intentional infliction or threatened infliction of severe physical pain or suffering;

(B) the administration or application, or threatened administration or application, of mind-altering substances or other procedures calculated to disrupt profoundly the senses or the personality;

(C) the threat of imminent death; or

(D) the threat that another person will imminently be subjected to death, severe physical pain or suffering, or the administration or application of mind-altering substances or other procedures calculated to disrupt profoundly the senses or personality;

## I. Physical Consequences of Rape and Other Sexual Crimes: Short and Long Term Effects

The standard of “severe physical pain or suffering” in §2340 is not explicitly defined in this statute. Therefore, for the purposes of this analysis, we make reference to a proximate term, “serious physical pain or suffering” from 18 U.S.C. §2441, the federal war crimes statute. According to §2441, “serious physical pain or suffering,” cited in the context of “cruel or inhumane treatment,” is defined as follows:

- (D) the term “serious physical pain or suffering” shall be applied for purposes of paragraph (1)(B) as meaning bodily injury that involves—
- (i) a substantial risk of death;
  - (ii) extreme physical pain;
  - (iii) a burn or physical disfigurement of a serious nature (other than cuts, abrasions, or bruises); or
  - (iv) significant loss or impairment of the function of a bodily member, organ, or mental faculty;

**Source: 18 U.S. Code § 2441 – War Crimes**

Of course, neither the terms of §§2340 and 2441 nor their contexts are identical, and a prudent defense counsel might point to the higher degree of gravity inherent in §2340’s term “severe” (vs. §2441’s term “serious”) or construct arguments based on contextual disparities between the two statutes. For the purposes of this discussion, in recognition of the necessity of satisfying a high burden proof, and in the absence of a clear definitional standard from §2340, we analyze the physical consequences of sexual violence by the standard borrowed from §2441.

While not every instance of sexual violence necessarily results in severe (or prolonged) *physical* harm, the medical literature points to an array of short- and long-term physical consequences that will be relevant to determining whether this standard has been met. The immediate physical effects of rape have been found commonly to include injuries to the posterior fourchette, labia minora, hymen, and navicularis, as well as perineal, hymeneal, and posterior vaginal wall tears. In a review of the literature on the physical trauma of rape, Sommers (2011)

concluded that the posterior fourchette, labia minora, hymen, and navicularis are common areas where injuries are found in victims of sexual trauma. Heppenstall-Heger et al. (2003) examined ano-genital injuries in children due to sexual assault and other traumas. The authors found evidence of bleeding, anal abrasions, anal and perianal tears, and tears of the posterior fourchette and hymen. Bowyer & Dalton (1997), in studying female rape victims between the ages of 16 and 48, found perineal, hymeneal, and posterior vaginal wall tears. They also found cuts, bruises, and grazes on victims' labia majora, fourchette, vagina, and anus.

Injuries (e.g. bruises, cuts, grazes) reported by victims of rape have been evidenced in other parts of the body as well (Bowyer & Dalton, 1997). Out of 83 women who reported being raped, only 15 (18.1%) reported no severe physical injuries. The remaining women reported some combination of injuries to their arm (50.6%), thigh/upper leg (43.4%), neck (26.5%), breast/chest (20.5%), calf/shin/lower leg (19.3%), face/head (18.1%), back, knee (16.9%), shoulder (16.9%), hand (15.7%), and/or buttocks (8.4%).

In a conflict setting, the act of rape itself is often paired with other forms of bodily and sexual torture, includes gang rape, and may end in murder to many victims. Beating, machete wounds, burning and mutilation of the genitals, and penetration by a host of objects such as rifle barrels, chili peppers, bottles, and sticks have all been reported to occur during conflict rapes. A recently published study on refugees in Uganda, many of whom were the subjects of sexual violence, noted prolapsed uteruses, irregular or incessant vaginal bleeding, and infection among female study participants; male participants reported genital, anal, and abdominal injuries and pain; and both genders described chronic back pain (Smith-Khan, 2015).

When assessing whether the immediate physical effects of sexual violence constitute serious or severe physical pain or suffering in accordance with the federal statute, primary considerations should include whether the infliction of these immediate injuries would reasonably have resulted in extreme physical pain ((D)(ii)) and whether the battery of injuries sustained constituted a substantial risk of death ((D)(i)). In such cases, where the evidence itself is not primarily physical and a substantial amount of time may have passed from the original incident, either counsel might wish to invoke the testimony of an expert medical witness to evaluate immediate injuries in light of these standards. Here we also note the possibility that individual bruises, cuts, or grazes described by the medical literature cited above may not in isolation fulfill these standards, but may, when assessed in totality, amount to extreme physical

pain or substantial risk of death. Finally, while (2)(D)(iii) (burns and disfigurements) and (2)(D)(iv) (losses or impairments) are more likely to be present in the context of the long-term injuries discussed below, it bears mentioning that shorter-term burns, physical disfigurements, or bodily and mental impairments may not be out of scope of this definition if they are severe enough. For example, genital disfigurement by burning with a flame has also been reported in conjunction with rape in a conflict setting. In addition, counsel may wish to explore the short-term impairment of mental faculties after an instance of sexual violence.

The long-term physical consequences of rape are well known within the medical community, profoundly disturbing, and fall under all four categories of §2441's definition of serious physical harm. Rapes regularly result in gynecologic fistula—a complete disruptive rendering of the woman's vagina and bladder and/or rectum (Bastick, Grimm, Kunz, 2007), which constitutes a physical disfigurement of a serious nature as stipulated in D(iii). Gynecologic fistula can also lead to urinary and fecal incontinence, a disturbing condition, which in addition to creating severe cultural and marital stigma for victims, is in clear accordance with D(iv)'s significant impairment of the function of a bodily member or organ. Also falling under this impairment provision, women's reproductive systems are often severely and permanently damaged as a result of rape (Golding, 1996), and infertility can result (Bastick, et al., 2007). Additionally, for women, experiences of rape and sexual assault are linked to excessive menstrual bleeding, genital burning, painful intercourse, menstrual irregularity, and lack of sexual pleasure (Bastick, et al., 2007). Finally chronic pelvic pain is a common effect of sexual violence (Dossa, Zunzunegui, Hatem & Fraser, 2014; Mukanangana, Moyo, Zvoushe & Rusinga, 2014), which can in severe cases entail extreme physical pain (D(ii)).

In addition to the direct physical harm discussed above, sexual violence can result in sexually transmitted diseases which can themselves cause extreme physical pain (D(ii)) or a significant risk of death (D(iv)). Given that sexual assaults are violent and often lead to wounds with exposed mucosa, rates of disease transmission can be elevated, particularly with respect to HIV. During the Rwanda genocide of 1994, it is estimated that of the 500,000 women who were raped; over 70% contracted HIV (Reid-Cunningham, 2008 & Amnesty International, 2004). It may take years for HIV to transform into AIDS, and thus the estimate of women killed due to sexual violence in Rwanda continues to grow with each passing year. In the DRC, researchers estimate that when a woman is raped, she has a 60% chance of contracting HIV (Brown, 2012).

Because medical care and antivirals are often not available, the transmission of HIV can amount to a gradual death sentence in a post-conflict setting. Increased rates of cervical cancer from the Human Papillomavirus (HPV) acquired during a sexual assault have also been reported (Hynes, 2004). These diseases, their frequency of transmission, and their often fatal outcomes, particularly in the low-resource contexts where such atrocities often occur, constitute a substantial risk of death, as well as potential for extreme physical pain during the course of their development.

Psychiatric conditions caused by rape also have harmful physical consequences on the victim. PTSD has been linked to heart disease (Boscarino, 2008), chronic pain (Moeller-Bertam, Keltner & Strigo 2012), coronary artery disease, and higher mortality rates (Boscarino, 2011). There also appears to be some level of immune impairment that occurs when someone is the victim of abuse, as women subjected to domestic violence are less able to resist the herpes simplex virus (Garcia-Linares, Sanchez-Lorente, Coe & Martinez, 2004).

Finally, as will be discussed in the next section in greater detail, sexual trauma results in dysregulation of the stress response and disrupts the balance between the sympathetic nervous system and parasympathetic nervous system. Whereas a normal stress response involves the release of biological “stress-signals”— including catecholamines, glucocorticoids, and pro-inflammatory cytokines—the literature shows that sexual assault and abuse corresponds with higher catecholamine activity and elevated levels of pro-inflammatory cytokines (DeBellis, 1996; Kendall-Tackett, et al., 2007). In turn, heightened activity and unregulated secretion of these proteins and hormones is the mechanism by which trauma and stress exposure results in negative health outcomes such as obesity, cardiovascular disease, cancer, coronary problems, and metabolic disease. The risk of arthritis and breast cancer in women is correlated with a history of sexual assault, increasing among victims of multiple acts of sexual abuse (Stein & Barrett-Connor, 2000). Thus in addition to the neurological impairment caused by rape and sexual assault, these diseases may lead to a significant risk of death, extreme physical pain, and the significant impairment of additional organ systems, bodily members, and mental faculties.

## II. Psychological Consequences: Prolonged Mental Harm

As the preceding section has demonstrated, the direct physical effects of rape and sexual crimes on women are by no means inconsequential and are in many cases severe. But to confine a consideration of these crimes' atrocities to their physical damage would be to turn a blind eye to some of the most horrific and long-lasting effects of sexual violence, as well as the vast medical literature undergirding them. The examination of this literature that follows demonstrates that these crimes result in the prolonged mental harm stipulated by Title's 18 standard of "severe mental pain or suffering."

The gravity that sets these crimes apart from even other severe traumatic incidents is the unique disruption of personhood that results from a deprivation of agency and control over one's own body. In addition, sexual violence causes terror and destabilization by undermining feelings of individual and community safety and security (Lee Koo, 2002), while the victim is held captive and is rendered powerless to control what is happening to him or her. This effect of defenseless incapacity may become a chronic state. Long-standing psychological literature confirms an intuitive supposition that a sense of safety and security is a basic human need, essential for individuals to perform daily functions and to engage in activities that promote growth and development (Maslow, 1943). When an individual does not perceive that she or he is safe, even basic daily activities such as feeding, sleeping, and self-care are undermined and dysregulated.

Feelings of danger, threat, and helplessness are not only experienced at the time of the rape itself and in its immediate aftermath, but also resurface well into the future, even when objective safety is re-established (DSM-IV; DSM-5). Survivor testimony bears out this psychological research. A 23 year-old Congolese woman described being "scared to go out alone to collect water - I am scared I may be tortured or sexually abused." Another woman described the effect of sexual violence on her life: "I fear any man and hide [from] my husband...when he touches me...my mind bring those bad people who raped me and I [run] and shout...Many times I sleep outside the house" (Smith-Khan, 2015).

In part for these reasons, the psychiatric literature predicts very poor functional outcomes for victims of sexual assault. The resulting myriad of individual consequences includes psychiatric disorders such as posttraumatic stress disorder, depression, and anxiety (Heim, Shugart, Craighead & Nemeroff, 2010; DSM-III; DSM-IV; DSM-5; Sadock, Kaplan & Sadock, 2007). Outside of these named mental health diagnoses, which are discussed below in greater

detail, individuals suffer from abject feelings of hopelessness (Muhwezi et al., 2011), spiritual degradation (Messina-Dysert, 2012), heightened suspiciousness, persistent confusion, and fear (Kilpatrick, Resick & Veronen; 1981). Victims of trauma see themselves as vulnerable, view the world as lacking meaning, and view themselves as lacking worth (Janoff-Bulman & Frieze, 1983).

### *Posttraumatic Stress Disorder (PTSD)*

Posttraumatic stress disorder (PTSD) is a chronic and debilitating mental illness, and one of the most common diagnoses linked to sexual assault (Holmes & St. Lawrence, 1983). This association has been known for decades, as recognized in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), published in 1980 by the American Psychiatric Association. Women exposed to sexual assault are 5.5 times more likely to develop PTSD as compared to victims of other types of trauma (Kilpatrick, Edmunds & Seymour, 1992). Indeed, the National Comorbidity Study—a massive epidemiological study that surveyed 5,877 individuals in the United States—indicated that among women, rape is the most commonly associated index trauma with PTSD (Kessler et al., 1995). When women had experienced rape as their only lifetime traumatic experience, or named rape as their most distressing trauma out of many, 45.9% developed PTSD (Kessler, et al, 1995). In an urban sample in the United States, among individuals diagnosed with PTSD, sexual assault and rape were the top two index traumas (49% of individuals with PTSD were victims of sexual assault, and 23% were victims of rape) (Breslau, Davis, Andreski & Peterson, 1991). In other words, victims of sexual assault and rape comprised nearly  $\frac{3}{4}$  of all individuals who were diagnosed with PTSD. Further research demonstrates that prevalence rates of PTSD range from approximately 30-70% in sexual assault victims (Dunmore, Clark & Ehlers, 1999; Kilpatrick, Edmunds & Seymour, 1992). The DSM-5, published in 2013, continues to indicate that sexual assault greatly increases the chances of developing PTSD.

Even in light of this medical data, the evaluation of PTSD symptomatology likely does not fully capture or characterize the entire range of psychological consequences of trauma exposure (van der Kolk, Pynoos, et al., 2009; D’Andrea, Ford, Stolbach, et al., 2012; Cloitre, Stolbach, Herman, et al., 2009)—particularly in the context of widespread violence. Strikingly,

100% of the women treated at the Department of Psychiatry at Bangui National University Hospital in the Central African Republic suffered from posttraumatic stress symptoms (Tabo, 2011). This overabundance of PTSD suffered from rape in the Central African Republic setting may be explained in part by examining the circumstances which compound the trauma.

In particular, psychiatric sequelae of trauma may extend beyond the classic symptoms of PTSD when (1) the victim is a child and still undergoing development, (2) the victim has experienced more than one traumatic event in his or her lifetime, and/or (3) the trauma is experienced within the context of a caregiving or support system that does not ensure safety and stability. A large percentage of victims of sexual assault and rape in the Central African Republic likely meet at least one, if not all, of these criteria. 19% of victims treated at Bangui Hospital were under the age of 20 (Tabo, 2011). In addition, sexual assault was experienced within the context of military action in an area historically affected by conflict and violence; therefore, the current instances of sexual assault were not the only traumatic experiences that individual victims had undergone across their lifetime. Finally, because of the nature of the crime and conflict, the caregiving, support, and safety systems in communities were undermined at the time of the assault, leaving individuals without a safety net to support adequate coping. Based on these considerations, there is strong reason to believe that the range and severity of psychological distress suffered by victims and communities in conflict settings is not captured by the concept of a PTSD diagnosis.

### *Anxiety Disorders*

Rape victims experience a significantly greater number of anxiety symptoms and specific phobias (Kilpatrick, Resick & Veronen, 1981, Ellis, Atkeson, and Calhoun, 1981). Anxiety symptoms and disorders have numerous debilitating effects and consequences for the individual. The experience of fear, avoidance, panic, and uncontrollable arousal are common symptoms of anxiety disorders that can lead to significant functional impairment (DSM-5). These symptoms not only affect the individual, but also have repercussions for family and community. For example, children of mothers with panic disorder are 6.8 times more likely to develop the disorder themselves, and children of mothers with phobic disorders are 3.1 times more likely to be diagnosed with the disorder at some point in their lives (Merikangas & Pine, 2002).



### *Mood Disorders*

Mood disorders are a common outcome for rape survivors (Steketee & Foa, 1987). Major depressive disorder or depressive symptomology is associated with a history of sexual abuse (Becker-Lausen, Sanders, & Chinsky, 1995; Beitchman, Zucker, Hood, DaCosta, & Cassiva, 1992; Gold, 1986; Kendall-Tackett, 2007; Morof et al., 2014; Trickett, Noll, & Putnam, 2011). In a sample of 5,877 individuals, the National Comorbidity Study results indicated that 39.3% of women sexually abused as a child developed depression (Molnar, Buka, & Kessler, 2001). In a sample of 3,001 women (The National Comorbidity Study-Replication), 22% of women who were forcibly raped experienced a major depressive episode (Zinzow et al., 2012). Female survivors of rape are 5.46 times more likely to experience a major depressive episode compared to non-sexual assault victims (Zinzow et al., 2012). Children of depressed mothers also experience mental and motor developmental issues, self-regulation problems, and increased negative affect (Goodman & Gotlib, 1999).

### *Dissociation*

Dissociative symptoms include an unawareness of one's present state, flashbacks, out-of-body experiences (depersonalization), or feeling as if the world around one is surreal or artificial in some way (derealization). The DSM-5 also defines a dissociative amnesia wherein an individual is unable to remember events from the trauma. Dissociative responses can cause significant impairment in functioning when they become pathological (Freyd, 1996).

### *Other Co-Morbid Mental Health Disorders*

The comorbidity of psychiatric disorders is thought to be the rule rather than the exception in cases of interpersonal trauma and abuse. Forty percent of children exposed to trauma are diagnosed with at least two psychiatric disorders (Copeland, Keeler, Angold & Costello, 2007). Major depression, dysthymia (chronic but less severe depression), bipolar disorder, generalized anxiety disorder, panic disorder, agoraphobia, social phobia, and obsessive-

compulsive disorder have all been linked to PTSD (Creamer, Burgess & McFarlane, 2001). In the 1995 National Comorbidity Study, which established a historical precedent for understanding PTSD and comorbid disorders, PTSD was found to be comorbid in 47.9% of individuals with a history of major depression, 21.4% with dysthymia, 16.8% with generalized anxiety disorder, 31.4% with specific phobia, and 27.6% with social phobia (Kessler et al., 1995). More recently, in a study of 3,199 individuals, 1% of individuals were diagnosed with only PTSD; 5.8% of individuals with PTSD were diagnosed with only co-morbid internalized disorders (e.g. depression, anxiety); 1.5% of individuals diagnosed with PTSD were diagnosed with externalizing disorders (e.g., oppositional defiant disorder) only; 19.5% of individuals with PTSD were diagnosed with two co-morbid internalizing disorders (e.g. depression and dysthymia); 14.1% of individuals were diagnosed with one externalizing and one internalizing disorder; 22.8% of individuals with PTSD had major depressive episodes and at least two more disorders; and 54.8% of individuals with PTSD also had bipolar disorder and at least two other disorders (Kessler, Chiu, Demler & Walters, 2005).

Another common form of mental health comorbidity involves co-occurrence of substance-use disorders with PTSD (Kessler et al., 1995). Kessler et al. (1995) found that among individuals with PTSD, 51.9% were diagnosed with alcohol use/dependence, and 34.5% were diagnosed with drug abuse/dependence. In regard to severe trauma, like rape, psychiatric comorbidity is the rule, not the exception.

### *Psychological Distress without a Formal Diagnosis*

Self-esteem and self-efficacy are severely affected by acts of sexual violence. In fact, a longitudinal study showed decreased self-esteem in rape victims when compared to non-rape victims a full 18 months after the event (Murphy et al., 1988). Evidence shows that human psychological defenses are significantly affected after traumatic experiences (Edmondson et al., 2011). Associated with sexual assault are interpersonal issues, anger, suicidality, and a lack of self-identity (Neumann, Houskamp, Pollack, & Briere, 1996) that may or may not be a part of a formal diagnosis.

Dr. André Tabo, a Central African Republic psychiatrist who treated many women, testified in the case of *The Prosecutor v. Jean-Pierre Bemba*, Case No. ICC-01/05-01/08-T, that

psychological trauma is a lifelong experience: the memories of this event do not go away. Even if these memories are alleviated, they never fully leave and a “residual” effect remains. He stated that based on his years of experience of general practice, “the patient kills himself, or herself, if the case is particularly bad; either the patient gives up and stays home with his or her disorder, or the person...no longer agrees to keep on living and falls silent with his or her suffering.”

### *Neurobiological Effects*

Knowledge of the underlying physiological and neurobiological responses to extreme stress provides further support for the links between experiences of sexual assault and the negative, psychological, and physical outcomes described above. A review of the psychophysiology and neurobiology of trauma describes the mechanisms by which sexual assault and rape result in immediate and lasting consequences for victims—this extreme trauma and the body’s helplessness in countering it can cause neurologic impairment of functional systems, as well as the organs of the brain itself. In particular, the over-elevated stress response to this trauma is associated with: (1) damage to psychological and physiological systems through increased stress hormone secretion; (2) a disruption of the important “allostatic” balance of physiological systems that control automatic processes such as digestion; and (3) lasting negative modifications to physical organs of the brain (with potentially severe psychological consequences). Finally, because this extreme stress response also warps the way the brain forms memories, victims can relive not only the experience of the trauma, but all of these negative neurological consequences as well—over and over again—with lasting physical, psychological, and social consequences.

The autonomic nervous system—composed of the sympathetic nervous system (SNS) and parasympathetic nervous system (PNS)—is the part of nervous system responsible for regulating bodily functions such as breathing, heart rate, and digestion, which are not under conscious direction. Disruption to and dysregulation of this system can result in lasting and severe consequences including effects on blood pressure, bodily temperature control, digestion, bladder function, and sexual function (Mayo Clinic). During a severe trauma such as rape, the SNS triggers the “fight or flight response” —a secretion of adrenergic hormones that increase heart rate and dilate blood vessels in muscles and the bronchi in the lungs. When this response is

unsuccessful in removing the threat, as in the case of rape, the SNS “doubles-down” on its response, leading to an over-secretion of these adrenergic hormones that are toxic to psychological and physiological systems when produced in large amounts (Bremner, 2006; Gunnar & Vasquez, 2001; 2006; McEwen, 2007; Sapolsky, 2005; 2012). This increased adrenergic activity, when coupled especially with the extra stress hormone cortisol released during the trauma results in dysregulated functioning and indiscriminate action of the autonomic nervous system.

Second, this prolonged activation of the SNS during sexual trauma disrupts the “allostatic balance” between the sympathetic and parasympathetic nervous systems, resulting in “allostatic overload”, which is the dysregulation and disruption of physiological systems that leads to pathophysiological states and negative physical and mental health outcomes (McEwen, 1998; McEwen & Wingfield, 2003; Sapolsky et al., 2000; Boyce & Ellis, 2005; Herbert et al., 2006).

Third, the dysregulation and allostatic overload described above can result in immediate and long-term impairment of brain function through reduced activity of the prefrontal cortex, which is responsible for regulating many of the brain’s vital organ systems. The prefrontal cortex is involved in executive functions that monitor, regulate, inhibit, and organize the otherwise automatic responses of lower-order brain and body systems, and so prefrontal cortical areas thus perform a crucial role in maintaining awareness and regulation of emotional and behavioral responses and are particularly relevant for social and interpersonal interactions. During extreme trauma such as rape, a “shut down” of these higher-order prefrontal cortical systems serves an adaptive function of preserving resources in the face of threat or danger (Damasio, Grabowski, Bechara, et al., 2000). However, this response leaves lower order neural structures, such as the limbic system, unregulated and disorganized. The limbic system, for example, is the set of evolutionarily older brain structures including the hippocampus, the amygdala, the hypothalamus, that are implicated in the experience of emotions, reward, motivation, and some types of memory formation. Not only does the reduction of higher-order prefrontal cortical activity lead to unregulated emotional and behavioral responses and patterns of learning, but this dysregulation can have lasting effects on the brain’s organ themselves, including reductions in the volume of limbic structures (such as the hippocampus and amygdala) and lasting changes in patterns of their activation and sensitivity (Bremner, 2006). Consequently, the changes in brain structure and function that are associated with traumatic

stress exposure can result in the cognitive, emotional, and behavioral difficulties that constitute the symptoms of disorders such as PTSD, depression, anxiety, dissociation, and others.

Finally, the release of neurotransmitters and hormones involved in the stress response alters patterns of memory formation (McGaugh & Hertz, 1972; Cahill & McGaugh, 1998). Memories formed during traumatic experiences are often more vivid and visceral (due to the impact of adrenaline secretion on memory formation), but are also formed in the context of disintegrated and dissociated functioning and communication across neural systems. The result is that, when reminders of a traumatic experience (images, sounds, sensations) activate the trace of the memory, the individual returns to the disorganized, dysregulated state that she or he experienced at the time of the trauma. Again, this state involves reduced prefrontal activation, unregulated limbic activity, and overstimulation of the stress response system. In this way, the neurologically destructive experience of trauma is often “re-lived” or “re-experienced” repeatedly in the life of a victim, even when she or he has returned to a relatively safe and stable environment. That is, even when safe, victims of rape and sexual assault may have conditioned psychophysiological and neuroendocrine responses to reminders of the trauma. These “re-experiencing” events involve a cyclical and potentially exacerbating activation of the stress response system that corresponds with lasting physical, psychological, and social consequences.

The detailed neurobiological explanation presented of the impacts of severe trauma on the autonomic system can be taken both as evidence of §2340’s prolonged mental harm, as well as a medical explanation for how sexual violence explicitly can cause this harm. Likewise, the litany of psychological diseases discussed demonstrate that rape and sexual violence are indisputably injurious to the mind in ways that often last for the course of the victim’s lifetime—incontestably sufficient to meet the criterion of “prolonged mental harm” stipulated in Title 18.

### III. Psychological Consequences: Application to the Torture Statute

Finally, in order to show that the prolonged mental harm inherent in many of the psychological effects described above constitutes “severe mental pain or suffering,” we recall that definition from Title 18:

“severe mental pain or suffering” means the prolonged mental harm caused by or resulting from

(A) the intentional infliction or threatened infliction of severe physical pain or suffering;

(B) the administration or application, or threatened administration or application, of mind-altering substances or other procedures calculated to disrupt profoundly the senses or the personality;

(C) the threat of imminent death;

(D) the threat that another person will imminently be subjected to death, severe physical pain or suffering, or the administration or application of mind-altering substances or other procedures calculated to disrupt profoundly the senses or personality

*(A) the intentional infliction or threatened infliction of severe physical pain or suffering*

Section I of this paper describes the severe physical pain and suffering which can result from rape and sexual violence, and it is clear that much of this suffering and indeed the threat of this and more suffering causes the prolonged mental harm discussed in Section II. The discussion of the overactive stress response, neurological damage, and alternate memory-formation process described earlier provides a causative explanation for how this infliction or threatened infliction results in severe mental pain and suffering. Similar reasoning can be applied to show a causative link in section (B) through (D). It also bears noting that the “intentional infliction” here appears as a general intent requirement. A defense counsel might point out the possibility that the assailant might have been reasonably unaware of the extent of the physical pain or suffering caused by his act. However, even if the infliction of severe pain or suffering fails to satisfy this lower general intent requirement, inherent in acts of rape and sexual violence is a threatened infliction of severe physical pain or suffering. In fact, it is precisely this threat of severe physical pain (or even death) which is thought to contribute to the deleterious stress response at the root of many psychological conditions. In the context of an armed conflict, where an assailant carries a weapon and implicitly threatens lethal force, this statement is even

more evident. In a 2003 survey of 492 rape victims in the Democratic Republic of the Congo's South Kivu province, 71.7% of those interviewed were tortured while being raped, particularly when they resisted (Women's bodies, 2005).

*(B) the administration or application, or threatened administration or application, of mind-altering substances or other procedures calculated to disrupt profoundly the senses or the personality*

As seen, rape and sexual violence do disrupt profoundly the senses or the personality through neurological, behavioral, social, and other means. In fact, the utilization of sexual violence as a weapon of war—to destroy communities—reveals just such a calculation. Calling for an end to sexual violence in armed conflict, the unanimously adopted United Nations Security Council Resolution 1820 noted that sexual violence is in some cases used as “a tactic of war to humiliate, dominate, instill fear in, disperse and/or forcibly relocate civilian members of a community or ethnic group” (United Nations, 2008). When women of a community are too afraid to step outside alone, too ashamed to enter public food markets, and too damaged psychologically and socially to marry and give birth to the next generation, this calculated disruption of senses and personality results in both severe mental harm and the destruction of fabric of the community. Acts of mass rape impact the development and functioning of the individual and the community across multiple generations (Reid-Cunningham, 2008; Seifert, 1994; Wax, 2004).

*(C) the threat of imminent death*

Extensively prevalent in an armed conflict, the threat of imminent death may be readily shown by the presence of a lethal weapon and/or the proximate killing of family or community members. Second, because violent rapes often result in death, even in situations in which the physical damage ends up less apparent or less severe, one may argue that a threat of imminent death to the victim was present at the time of the rape. Finally, inherent in any forced sexual acts between community members is the threat of imminent death for noncompliance.

*(D) the threat that another person will imminently be subjected to death, severe physical pain or suffering, or the administration or application of mind-altering substances or other procedures calculated to disrupt profoundly the senses or personality;*

In a study conducted among disabled refugees in Uganda (many of whom suffered from sexual violence in the past) one male participant from Burundi explained: “[b]eing the sexual violence survivor, I always feel depressed...death of my mother while three men raping her [which I saw with my own eyes].” In another survey of victims in Rwanda, one woman recounts horrifically the experience of watching her daughter (age 17) being sexually tortured to death:

“... my daughter refused to obey the order to get undressed. So they ordered her to choose between rape and death. She chose death. So they started to torture her, cutting off her breasts one at a time with a knife, then her ears and then they completely cut open her belly... after a time, my daughter breathed her last... I was powerless, I wasn’t able to protect her. Since then I haven’t been able to do anything, I’m ill, suffering extreme trauma” (Women’s bodies, 2005).

Not only is the threat of imminent death (C) clearly present in these two testimonies, they illustrate the severe mental harm resulting from the threat (often carried out) that a loved one will be subjected to death and severe physical pain or suffering.

International criminal law has a tendency to focus on harm to the individual victim at the hands of an individual perpetrator. However, research conducted in situations of mass violence (such as Bosnia Herzegovina and Rwanda (Kumar, 2001)), coupled with the science of human psychology, teaches us that the consequences of sexual violence deployed on a massive and systematic scale are far more extensive, far more pervasive, and far more devastating than can be measured in an assessment of an individual victim (Reid-Cunningham, 2008; Seifert, 1994; Wax, 2004). In particular, the purposeful commission of rape in front of husbands, children, and community members is a specific means of causing added terror, humiliation, and degradation for victims, their families, and their communities.



While the analysis of this paper has demonstrated the horrendous effects of rape and sexual violence on individuals, particularly in reference to the prosecution of this crime under the U.S. torture statute, evaluations of individual victims cannot fully capture the extent of damage inflicted upon communities by massive human rights violations as these.

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