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Ill-treatment and torture in demonstrations and other non-custodial settings. How can academic research help in the discussion?

Pau Pérez-Sales, MD, PhD, Psych*, Editor in Chief

The events in October 2017 in Catalonia exemplify the difficulty of establishing what 'excessive use of force' means.[1] Images of violent repression of defenceless people of all ages waiting to vote accompany the Spanish government's spokeswoman reiterating in the media that what the police force is doing is "proportional" and therefore allegedly acceptable. Can scientific research add to the debate on what is "proportional" and when an intervention in non-custodial settings enters into what is banned under the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('CAT')? This is not a minor issue. According to international databases, from an epidemiological point of view, torture happens mainly in prisons and police stations linked to marginalised populations. Ill-treatment and torture against political dissidents and protesters is less frequent, but widespread, affecting around 70% of countries across the world (Conrad, Haglund, & Moore, 2013)

The Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SRT) has recently made it clear that use of force can amount to torture. Any extra-custodial use of force that does not pursue a lawful purpose (legality), or that is unnecessary for the achievement of a lawful purpose (necessity), or that inflicts excessive harm compared to the purpose pursued (proportionality), amounts to cruel, inhuman or degrading treatment or punishment (CIDT). Additionally, if the person is powerless (that is, a person who is under direct physical or equivalent control and is unable to escape or resist), and the action is intended to inflict pain or suffering for a certain purpose, he considers that it will amount to torture irrespective of the above considerations of lawful purpose, necessity and proportionality (SRT, 2017 p 23). This should be the standard of reference from now on.

Even the failure to take all precautions practically possible in the planning, preparation and conduct of law enforcement operations with a view to avoiding the unnecessary, excessive or otherwise unlawful use of force, contravenes the State's positive obligation to prevent acts of cruel, inhuman or degrading treatment or punishment within its jurisdiction (SRT, 2017 pp 23).

Until recently, International courts have always been reluctant to take this stance. The

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[1] See for instance https://www.amnesty.org/en/latest/news/2017/10/spain-excessive-use-of-force-by-national-police-and-civil-guard-in-catalonia/

SRT follows and consolidates the doctrine stated by the European Court of Human Rights (ECHR) in *Cestaro v. Italy 2015*[2] and *Bartesaghi Gallo and Others v. Italy 2017.*[3] In both these cases, the Court found that the violent punching, kicking and beating with rubber truncheons of anti-globalisation protestors in Genova in 2001 amounted to torture. In contrast, judgments emanating from the Inter-American Court of Human Rights have, at the very most, considered such actions and even more serious physical abuse as only amounting to CIDT. In *Finca La Exacta vs Guatemala* (ICHR, 2002), the court considered "disproportionate" an intervention on peasants who were on private, occupied land[4] that ended with three persons shot dead. The long-awaited outcome of the case of the women of Atenco, admitted in September 2016, where 11 women claimed to have been sexually assaulted by the Mexican police after a demonstration and whether it will result in a finding of torture or CIDT is likely to be determinative for future similar cases.[5] Furthermore, the UN Committee against Torture has also expressed concern over the excessive use of force by law enforcement officials during the policing of demonstrations or crowd control.[6]

Can medical and psychological research contribute anything to this legal debate on the excessive use of force and its relation to torture?

Intentionality and purpose. Police brutality or police torture? Babovic (2000) argues for the need to distinguish police brutality from police "torture." He claims that excessive use of force is often caused by the need—and potentially legal right—to "establish control" and that police officers often act improperly in anger, frustration or in fear of a real or imagined aggression.[7] In such a case, there would not

2 The case involved a 62-year-old demonstrator, who was being compliant and surrendering, by an Italian police officer who beat him with a hand-held baton to the point where he suffered fractures and other injuries amounting to torture.

3 The Court noted that, although none of the victims showed violence or resistance, and although all of them were manifestly unarmed, asleep or sitting with their hands raised above their heads, the police systematically and indiscriminately subjected each of them to violent beatings, intentionally inflicting severe physical and psychological suffering for the purposes of retaliation and humiliation through the use of excessive, indiscriminate and manifestly disproportionate force.

4 A group of families occupied a landowner's property to protest over their salary and living conditions. The operation to detain three persons ordered by the local court involved 200 special agents with the use of tear gas and support by helicopters. It ended with three peasants dead and 11 severely beaten. The Court considered that the intervention was legitimate but disproportionate and amounted to CIDT.

5 There were clashes in 2002 in protests against the planned construction of a new international airport for Mexico City. In 2006, new clashes followed the expulsion of eight downtown flower vendors by the police from their traditional places in the local market. The latter confrontation marked the beginning of a series of demonstrations and riots, which lasted over a week and resulted in over 100 arrests and numerous allegations of human rights abuses committed by the police against the local population, including the detention of 40 women, 11 of whom claimed they were sexually assaulted while in detention and in transport to the police station.

6 For example, Concluding Observations of CAT: Canada, UN Doc. CAT/C/CAN/CO/6 (2012) §22. 362 Concluding Observations of CAT: Denmark, UN Doc. A/52/44 (1997) §182; Sweden, UN Doc. A/52/44 (1997) §222. Concluding Observations of CAT: Syria, UN Doc. CAT/C/SYR/CO/1/Add.2 (2012) §20(j). 364 Concluding Observations of CAT: UK, UN Doc. A/54/44 (1999) §76(g). 365 Concluding Observations of CAT: Canada, UN Doc. CAT/C/CR/34/CAN (2005) §4(i); Canada, UN Doc. A/56/44 (2001) §58(a).

7 This idea that torture and police brutality are dif-

be a clear purpose according to the examples suggested by the Convention against Torture (UNCAT) definition and it therefore should not be considered as CIDT or torture, but as "excessive use of force." This position, quite popular in local and national courts to avoid sentencing police involved in violent actions in the repression of collective movements, is misleading for the following reasons: (a) purpose is a necessary requirement for torture, but not for CIDT. It is enough to credit severe mental or psychological suffering by State agents which are not part of a lawful sanction (Neziroglu, 2007); (b) studies show that an important percentage of use of force actions are linked to officers confronted with situations that challenge their identity (e.g., displays of citizen disrespect). These actions to "defend identity" can often equate to the purposes of humiliation or punishment included in the Convention (Felson & Tedeschi, 1993); and, (c) selected jurisprudence and SRT reports have stressed the relevance of the criteria of "defencelessness" when analysing excessive use of force incidents. Defencelessness in itself might turn a CIDT situation into torture (Nowak & McArthur, 2006; SRT, 2017)

Torturing system. Repression of dissidents. Additionally, although the definition in UNCAT arguably focuses on the interaction between one person (tormenting agent) and another (tortured person), torture has an undeniable social dimension. In its extreme form, torture is a social institution of power and dominance; it is part of a torturing system that designs, plans, hides and guarantees immunity and it uses victims to threaten and demobilise every layer of society. According to this sociological model, the purpose of violent actions in assemblies, demonstrations, protests and other non-custodial collective settings are demobilisation, fear, control and submission of the individual and the collective. There surely can be a purpose in police brutality that is covered by the examples given by the Convention.

Interestingly enough, political science has studied since the 1970's the relationship between state repression and social mobilisation.[8] The available data show that there is not a linear relationship between repression and demobilisation. In a review of studies, Davenport (2007) finds what he calls the "Punishment Puzzle": sometimes the impact of repression on dissent is negative, sometimes it is positive, sometimes it is represented by an inverted U-shape, sometimes it is dynamic and alternates between negative or positive and sometimes it is nonexistent. We still do not have a clear map of key variables that help to explain the consequences of political repression on social and political movements.

ferent things is reflected in the use of what could be considered euphemistic language. For instance, the Manual on Use of force and Detainee Injury Reporting of the Detroit Police Department labels *Serious Use of Force* to "Any action by an officer that involves: 1) The use of deadly force, including all critical firearm discharges; 2) A use of force in which the person suffers serious bodily injury or requires hospital admission; 3) A canine bite; and 4) The use of chemical spray against a restrained person." All of them actions that for an external observer could perfectly be considered as potentially amounting to ill-treatment or torture (DPD, 2012).

8 State repression is defined in political science as the actual or threatened use of physical sanctions against an individual or organization, within the territorial jurisdiction of the state, for the purpose of imposing a cost on the target as well as deterring specific activities and/or beliefs perceived to be challenging to government personnel, practices or institutions. CIDT and torture are among the most severe forms of state repression (Davenport, 2007).

Measuring use of force in citizen encounters. Use of force is difficult to demarcate and observe. It can be broadly defined as any situation where, in the execution of their duty, police use verbal or physical force or other techniques, including a weapon, instrument or implement to respond to an actual or perceived threat (Hine, Porter, Westera, & Alpert, 2016).

There have been several attempts to measure it for academic research. Alpert and Dunham (1997) developed the Relative Force Factor Model (RFFM) to measure the proportionate use of force by control agents. In the model, both officer's force and level of suspicion of resistance is measured in a continuum. The relative force factor score is calculated by subtracting the suspect's highest level of resistance to the force used by police. Terrill, Alpert, Dunham, & Smith (2003) refined this model in the RCFS (Resistance Force Comparative Schema) model. The RCFS model tries to define proportionality not as a static variable (the maximum level of force used by actors in a certain encounter), but in a dynamic way by which a comparison is made at different time points.[9] For example, if a police officer uses pepper spray on a calm person, this is likely to provoke an aggressive reaction in the person and bystanders may react, which may in turn lead to the police using maximum force, physically threatening the bystanders and beating and handcuffing the originally calm person. The RFFM model, based on its maximum measure, would set out that such a reaction is a proportionate intervention, as the detainee used physical resistance and the police answered with pain compliance. The RCFS measure would split the interaction in a sequence of events, measure proportionality in each moment of the sequence and obtain an overall score of whether the intervention was proportionate.

Using this dynamic model, Paoline and Terrill (2011) raise different scenarios of resistance of a citizen (verbal resistance, passive physical resistance, non-assaultive physical reaction (i.e. going away; hiding parts of their body to avoid arrest), and assaultive physical reaction). They analyse the response considered appropriate by the police in a coercive escalation (verbal threats, verbal commands and threats, pain compliance techniques (e.g., pressure point control), soft empty-hand techniques (e.g., grabbing, shoving), hard empty-hand techniques (e.g., striking with fists), chemical-irritant sprays (e.g., oleoresin capsicum), electronic devices (e.g., TASER gun), baton, and projectile launchers (e.g., beanbag)). In a research study with a sample of more than 1000 police officers from different areas of the US, they found that most of the respondents self-declared very conservative responses (zero to negative values in RCFS measures), although between 5% to 10% of police officers depending on geographical area, reported escalating to forms of maximum aggressiveness in the face of comparatively minor events (scores of +2 to +6) without the authors being able to define a clear sociodemographic pattern of the "high risk" policemen.[10] Academic research clearly points

9 By using this dynamic measure, the *immediacy criteria*, a fundamental criteria in some penal codes, would be included: If a threat to police has not yet materialised, a forcible response is too early and constitutes pre-emptive force; if the threat has passed, a forcible response is retaliation.

10 Klahm & Tillyer (2010) reviewed all available research on use of force published in peer-reviewed journals between 1995 and 2008. Most of the variables used throughout the literature seem to have a mixed relationship with or appear to be poor predictors of use of force by police. For

Table 1 Resistance/force continuum and Resistance Force Comparative Scheme (RFCS)

Resistance/force continuum	
Levels of suspect resistance	Levels of police force
1: No resistance	1: No force
2: Passive	2: Command
3: Verbal	3: Threat
4: Defensive	4: Restraint and control
5: Active	5: Pain compliance/takedown
	6: Impact

	Resistance Force Comparative Scheme (RFCS)		
Suspect resistance	Less force	Commensurate force	More force
1	-	1, 2	3, 4, 5, 6
2	1	2, 3	4, 5, 6
3	1, 2	3, 4	5, 6
4	1, 2, 3	4, 5	6
5	1, 2, 3, 4	5, 6	-

Source: Terrill, Alpert, Dunham, & Smith (2003)

out the need for clear regulations in all kind of scenarios and for political decisions on accountability in cases of abuse.

Research using the relative force model is just beginning and has relied mostly on samples from the US and Australia (Hine et al., 2016). It is promising not only as a measurement tool for force (Hickman, Atherley, Lowery, & Alpert, 2015) but also as a tool for policing agencies to identify 'high at risk' officers (Bazley, Mieczkowski, & Lersch, 2009).

In a summary of available studies on violent interactions, results point to that police officers tend to use more physical violence when (a) the offence is perceived as more serious, (b) when they perceive the suspect to have less authority than themselves, (c) the subject is verbally but not physically aggressive, (d) a greater number of officers are involved in the situation, and, (e) the policemen have extra resources available to control the subject. Police officers are less likely to resort to physical violence (a) if the person is exceedingly resistant, (b) looks fit, (c) the officer perceives environmental risks, (d) bystanders are present (Alpert, 2004; Bolger, 2015; Terrill, 2005; Weisburd, Greenspan, & Hamilton, 2000).

example, analysis of available evidence regarding officer experience and use of force shows that in some studies more experienced police were less likely to de-escalate, in others more experienced police recommended using less physical violence while some studies suggest that more experienced police were simply less investigated by internal affairs.

We need more refined and ecological models, which take into account the fact that police behaviour is not only based on personal characteristics but also on a constellation of factors ranging from patterns of encounters and personal experiences to community, political and work contexts. Stewart (2013) has tried to build such a model by measuring use of force through a scale that takes into account what he calls circumstantial evidences: information that the police had previous to the intervention, characteristics of the citizen involved (age, mental health status etc), measures of threat that the citizen poses against himself or others, severity of the alleged offence etc. The result is the Constitutional Force Analysis Tool (CFA) a very complex integrative measure of use of force by state agents. Although this is a very comprehensive tool, the data are so specific that it can only be carried out through an administrative self-report done by the agents after an intervention.

It seems logical to assume that a report that can have legally and administratively adverse consequences for the security agents involved probably is a poor source of reliable information. In CFA, no contrast with witnesses, other officers or the alleged victims is carried out. In relation to that, one of the black holes in academic research are estimates of the reliability of police reports of incidents. Klinger & Brunson (2009) offer some preliminary studies on a high frequency of perceptual distortions potentially leading to erroneous decisions and erroneous reporting during critical incidents. But as these same authors recognise "police officers have been known simply to lie" (Klinger & Brunson, 2009 p 135) to protect themselves. The extent of such lying is also one of the great unknowns within the policing world. A reliable measure of inaccuracy of police declarations in excessive use of force incidents would be of great help for an overall picture of the problem.

Bad apples or bad orders. A balanced use of force may well be the norm in non-custodial interventions, especially in democratic countries (Harris, 2009). The idea that typically only a small number of officers account for a disproportionate percentage of the total number of complaints of use of excessive or unnecessary force was already suggested by the General Force Research, a multicentre US study in the 1990's (Adams, 1996) and has consistently been confirmed since (William Terrill & Ingram, 2016).

These data do not however show whether there are simply always a number of "bad apples" in any given group, or whether there is a small trained group of officers (quite often not publicly recognised and recognisable) that is "allowed" to use excessive force and subsequently protected, or there is a lack of adequate control of violent units. Available academic data seems to give more support to this latter systemic hypothesis. Terril (2005) analysed 3,340 use of force incidents from three US agencies with the focus on policy direction and restrictiveness. The results show that officers working within the most restrictive policy framework used force less readily than officers who operated within more permissive policy environments. Data suggest it is a problem of environment and orders, not of bad apples. Chappel and Lanza (2009) used an anthropological observational methodology in a US police academy and found out that despite the philosophical emphasis on community policing and its themes of decentralisation and flexibility, the most salient lessons learned in police training were those that reinforced the paramilitary structure and culture.

Non-lethal weapons. The debate on excessive use of force as CIDT or torture is necessarily linked to the debate on the use of the so-called non-lethal weapons. Interestingly, in Terrill and Paoline's study (2012) police officers considered the use of chemical and electronic weapons at very early stages in a process of escalation of conflict, before physical force. This shows the widespread idea that these weapons are a legitimate way of avoiding violence, while in fact they are a very violent way to solve a conflict.

Amnesty International (AI) (2015) has recently produced a manual that endorses the use of the so-called less-lethal weapons to control riots and public demonstrations (chemical irritants, sound devices, electric shock devices (either projectiles or stun batons), kinect impact weapons (and special rubber balls and pellet firing shot guns) and water cannons). Amnesty's position is that, if properly regulated, their use is an advantage over conventional firearms. Having different types of devices to confront a threat, in their view, would minimise the use of firearms and suggests they must be available as a standard for law enforcement agencies. The AI report is focused on the legal perspectives and does not develop in-depth social, medical or psychological considerations, where arguably the debate on CIDT/torture should. Even the expression less-lethal weapons recognises the fact that no technology can be guaranteed to be non-lethal. They are weapons that are sold as having low risk of permanent injury or death, as if this were the only relevant criteria.

The truth is that besides being humiliating, some of them are considered extremely dangerous, and that the available epidemiological evidence shows that their use entails a higher risk of injury to citizens than traditional use of force (Crowley, 2016; Haar, Iacopino, Ranadive, Weiser, & Dandu, 2017) due to at least four reasons: (a) it is very difficult to respect instructions of use amidst the chaos of an intervention (i.e. minimum distance at which a human being can be shot safely with a rubber ball); (b) some of them constitute collective punishments as it is almost impossible to act selectively and bystanders, third persons or even demonstrators who are trying to help in keeping an action as a non-violent movement will be equally affected; (c) there are always especially vulnerable populations (i.e citizens with cardiac vulnerabilities, asthma or others); (d) it is very difficult to control abusive use (i.e. using electric shots in a defenceless person as a punishment). The use of body-worn cameras solves some but not of all these problems.

Additionally, some of these implements (especially electric-shock devices) can be used as torture tools in the interrogation of detainees and their availability in countries where no control can be guaranteed is a real risk.

The necessity and legitimacy criteria. Reasons for using force against citizens. Felson & Tedeschi (1993) defined from a set of interviews with police officers three reasons for use of force against citizens: (1) to establish control of a situation; (2) to desire to achieve or restore justice according to an assessment of blameworthiness; (3) for self-presentation or "to establish or to protect identities."[11] According to this classification, only control situations would

[11] This concern for self- presentation is even greater in the presence of third parties. Officers are socialised to "maintain the edge" and be "one up" on citizens not only to establish control, but to ensure proper respect. As a result, officers confronted with situations that challenge their identity (e.g., displays of citizen disrespect) may be countered by a more forceful response.

Table 2: *Less-lethal weapons as related to CIDT and torture*

Humiliating or Degrading	• Malodorant water cannon • Color painting cannon
Highly likely that third persons or bystanders are affected	• Pellet firing shot guns • Sonic weapons, chemical irritants, water cannons
Likely that vulnerable citizens might be badly damaged	• Gas and chemical irritants (asthma, hyper sensibility to components). Deaths have been reported • Electric devices (cardiac patients). Deaths have been reported • Sonic weapons (sonic bullets, cannons etc). Damage to internal organs, hearing loss, eye damage. Deaths have been reported
Highly likely that instructions of use regulations cannot be followed in a stressful situation eventually provoking severe damage or lethal consequences	• Rubber coated metal bullets (eye loss / brain concussions, kidney damage) • Water cannons (eye loss, head concussion)
Highly likely facilitating CIDT/ Torture by the level of suffering inflicted	• Electric shock devices that do not have a cut-off point • Electric gun that acts as a direct contact weapon • Thumb-cuffs • Spiked batons, extendible defences • Whips
Inherently considered CIDT/ Torture	• Body-worn electric shock belts

Source: Re-working of information included in AI (2015).

allow for force to be legitimate, while achieving justice and establishing identity should be considered as an unlawful use of force.

Since disrespectful behaviour should not form the basis for a legal response, while resistance does, some countries have legislated to consider "disrespect" as legally punishable. If the measure of excessive use of force and the measure of resistance are complex, the measure of "disrespect" is simply impossible, opening a space for arbitrary actions from police. Even more concerning and objectionable is the fact that in some national penal codes offences linked to Disrespect or Resistance to Authority have severe penalties including sometimes measures of deprivation of liberty, the purpose of which is too often to deter social activists. This can also lead to police charging on these grounds to avoid accusations of excessive force particularly when, in the absence of witnesses or video-recordings, the police version of the encounter always prevails.

From the citizen's point of view. Protests entail many emotions in participants. There are at least three objects of emotion: the opponent, the in-group, and contentious

issues. Protesters are likely to experience negative emotions towards their opponent and the contentious issue, while they most likely feel positive emotions towards the group they identify with. The analysis of individual and collective emotions during protest have shown a direct relationship between police actions, collective positive or negative emotions and escalation of conflict potentially leading to violence (Troost, Stekelenburg, & Klandermans, 2013).[12]

Using data from the UK, where there are strong supervision mechanisms, Smith (2009) found out that only 7% of citizens suffering police misconduct filed a complaint (and an additional 6% tried unsuccessfully and gave up), while less than 5% of these complaints where substantiated after investigation. In a review of US studies Terrill and Ingram (2016) showed that only between 0 and 12% of complaints against police use of excessive use of force were later sustained by investigative bodies when the case was considered by an internal process of the police.

According to the UK data, the main reason (62%) for those who did not complain was finding it a useless action. This was not far from reality as in those cases where the officer was found guilty, the research showed that this led to no more than a conversation with a supervisor or a minor administrative sanction. The second more frequent reason not to complain was that it took a lot of time and work. In other countries, it must be added that, as stated above, filing a complaint can have strong negative consequences for the person if she is counter-denounced by disrespect or resistance to authority.

Additional ways to discourage or discredit citizen allegations of excessive use of force is to detain the person, which also presents the police with an occasion to negotiate with the potential complainant and suggest not to bring charges if a legal claim is not already made (Smith, 2009) or to inform through the media only of violent intentions or behaviours in demonstrators creating a social climate of fear and a social narrative prone to social rejection of demonstrators and justification of ill-treatment (Bolshia, Gautier, & Flores, 2016).

Additionally, participation in social movements is a stressful event in itself (Lau et al., 2017; Matthies-Boon, 2017) and suffering police violence can be an extremely disturbing experience. In the short-term, acute stress disorders, post-traumatic stress disorder (PTSD) and depression are common among victims (Unuvar et al., 2017) with in some cases a shattering of one's assumptive world in the long term (Matthies-Boon, 2017) precluding legal actions in the initial weeks after the clash, when the legal claim must be done. Psychosocial and psycho-legal accompaniment might help in this case, although non-governmental organisations also face the risk of being stigmatised or prosecuted (INCLO, 2013). Finally, sometimes complainants lack support—and are even accused of deserving prosecution—from relatives or friends due to it being a free choice to participate in a social and political action when knowing the risks potentially involved. However, more research is necessary.

More studies are needed generally on the physical and mental suffering caused by police violence in non-custodial settings and more particularly, research is clearly needed to document cases of potential

[12] This is why some scholars propose that any measure of excessive use of force should also include a scale of de-escalating of conflict to analyse tactics used by police to prevent use of violence (Stewart, 2013).

CIDT or torture.

Who controls the controllers? The jurisprudence of the European Court of Human Rights (ECHR) uses the terms 'hierarchical and institutional' and 'practical' independence (or 'organisational' and 'functional' independence) when CIDT and torture claims are investigated in a national system. Claims that are investigated by a non-police institution are not necessarily done in an independent way. Even if the process goes beyond administrative assessment, it is not an exception that police officers and local courts work together cooperatively on a day-to-day basis. We only have preliminary data and also need more studies on systems of independence indicators that allow for an organisational analysis of different schemas of complaints (Smith, 2009). Non-independence of review procedures has led to some favourable judgments of the ECHR related to excessive use of force (e.g., *Ramsahai v The Netherlands,* 2007).

A series of studies compared whether there were differences in the number of allegations of citizens depending on the investigative body. Overall, if allegations were investigated by commanding officers, the odds of a positive outcome decreased by a 39%. Success was only slightly better with allegations examined by either an internal affairs department or by an external civil committee (probably due to difficulties in overcoming pacts of silence). The best results were obtained by those administrations where internal research was overseen by an external committee, which increased the likelihood of the allegations being considered by 76%. These research data might importantly illiminate how to adequately deal with citizens' complaints to guarantee fair consideration of allegations of the use of force (Terrill & Ingram, 2016).

A good example of how accountability can decrease CIDT and torture at the hands of the police is found in Brazil. Police in the state of Rio de Janeiro killed more than 8,000 people living in *favelas* in the decade between 2005 and 2015. Human Rights Watch conducted in-depth interviews with more than 30 police officers, who attributed the excessive use of lethal force to a pervasive "culture of combat" and corruption within military police battalions (Human Rights Watch, 2016). In São Gonçalo, the state's second largest city, between 2008 and 2010, a judge, a prosecutor, and civil police officers made a concerted effort to address extra-judicial killings and filed charges against 107 military police officers—about 15 percent of the troops in the military police battalion in São Gonçalo—during that period. The number of police killings in the city subsequently dropped by 70%. Some police officers had warned that this effort to promote accountability would impede police work and result in a rise in crime, but the number of robberies and overall homicides in São Gonçalo also declined. Progress came to a halt when the judge was murdered by some of the police officers who were facing prosecution. In the absence of accountability, the number of police killings climbed again and is now higher than in 2008 (Human Rights Watch, 2016).

Media tolerance towards CIDT and torture. Finally, qualitative content analysis research has also shown that uncritical newspaper coverage of police-perpetrated ill-treatment may reflect and promote public and official tolerance for police violence (Gamal, 2017; Hirschfield & Simon, 2010)

Conclusion. In summary, the academic world provides very interesting and largely unknown data relevant to the debate on CIDT and torture in non-custodial settings.

Surely more data is necessary to confirm and expand what has been reflected upon here. Especially relevant would be studies on criteria for assessing necessity, legitimacy and proportionality, elements that foster police misconduct and ways to prevent it using ecological models based on the interplay of the political, social, group, individual and interactive variables involved in these kind of situations.

The recent report of the Special Rapporteur underlines the fact that the medical and psychosocial field has much to offer the legal world in better defining these not uncommon cases. It also gives food for thought regarding the need to increase the use of science in courts e.g. moving from a judge or internal review body deciding what is proportionate based on statements, to the potential use of more academic and evidence-based models assisting judges' decisions.

Repression is not a thing of the past. Carey (2006) has studied the dynamic relationship between protest and repression using data from six Latin American and three African countries from the late 1970s to the early 1990s. The results suggest that democracies were least likely to display continuous repressive behavior. However, if faced with popular dissent, democracies were just as likely to respond with coercion and negative sanctions as other regime types (restrictions on free speech, violations of life integrity rights, such as torture and political imprisonment, or other forms of state violence). In the end, repression has wide-reaching and negative consequences on society in terms of social control in that it can radicalise a minority, thus legitimise more violent actions and repression from the State and wide-spread political demobilisation of the majority due to fear.

This issue

This issue includes two papers that provide a more thorough understanding of the scientific basis for psychotherapeutic work with torture survivors, one of the priorities of the Journal (see editorial in issue 2017/1). This is especially important in certain contexts – like Africa - where very scarce information is available. We include the paper 'Towards a contextually appropriate framework to guide counseling of torture survivors in Sub-Saharan Africa' building on research carried out by Craig Higson-Smith and Gillian Eagle and 'Efficacy of evidence-based psychosocial model for the rehabilitation of torture suvrivors' by Domininique Dix-Peek and Merle Werbeloff from the South African Centre for Study of Violence and Reconciliation. Although not from the same geographical region, these studies are complemented by Karen Fondacaro and Emily Mazulla's paper on a proposed Chronic Traumatic Stress Framework.

Reparation and Transitional Justice is a topic rarely addressed in the Journal. Vera Vital-Brasil describes the *Clínicas do Testemunho*, a pilot project carried out in Rio de Janeiro, which was supported by the Amnesty Commission of the Brazilian Ministry of Justice. The paper gives food for thought regarding the connection between individual and collective healing in transitional justice processes. Laurence Kirmayer and James Jaranson contribute an essay on 'Cultural logics of emotion: Implications for understanding torture and its sequalae' that provides a useful and broad insight into the cultural meaning of emotions as linked to the experience of torture survivors.

The Debate in this issue concerns the APT-sponsored research (and book) *Does torture prevention work?* The book is an analysis of data collected from 13 countries regarding whether the implementation of the

National Prevention Mechanisms (NPM) have been useful in the prevention of torture worldwide. Hans D. Petersen summarises the book and presents a critical paper questioning key aspects of the methodology and results. Carver and Handley, authors of the original book, respond, with a final right of reply given to the author of the paper.

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Torture Journal Annual Report 2017 - excerpts

A note from the editor and an update from the team

Dear reader,
Thanks to all our readers and authors for making this journal—your journal—a true space of exchange. It belongs to you and those that contribute by sharing their research and reflections, by contributing to debates and reviews. We are especially thankful to our peer-reviewers, who silently and invisibly work behind the scenes, and are committed to helping authors in refining data and re-writing papers (see page 17 for a special thank you).

The Torture Journal seeks to be the place of reference for academia as well as field research within the disciplines of medicine and psychology while taking an interdisciplinary view. As an exercise in accountability, we would like to provide our readers with a summary of key elements from the journal's Annual Report. Your feedback will be welcomed.

*Pau Pérez-Sales, Editor in Chief**

Aims and objectives

Academia and funding bodies often require publication in journals with the highest Impact Factor and field workers and clinicians often seek practical dissemination methods. We continue to strive to fulfil these two parallel and we think not mutually exclusive aims.

Torture Journal is a medical and psychological publication that aims to serve all professionals working with the rehabilitation of victims and prevention of torture. Its objectives are to:

- be a reference source for practitioners;
- promote and lead research in the field;
- foster debate on key topics within the scope of the journal; and,
- be a collective expression of the whole sector and to facilitate networking.

Additionally, the Torture Journal has always played and continues to play a crucial part of fulfilling the strategy of its publisher, the International Council for Rehabilitation for Torture Victims. This is most recently set out in one of the key outputs agreed by the IRCT Council in December 2017, the Global Knowledge Platform.[1]

Indicators

Key points of interest

- The number of submissions has increased by four times in 2017, the highest number of submissions in its historical series.
- The time from submission to publication

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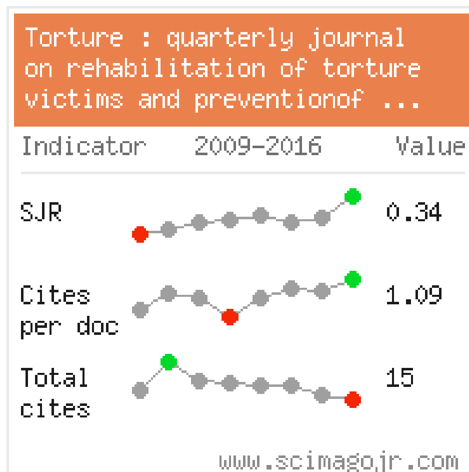
[1] Please see https://irct.org/media-and-resources/latest-news/article/948 for more information

reduced from 9 months (2016) to 12 weeks (2017).

- There remains a low rejection rate (18%) due to the strategic decision of the Board to strongly support authors in their work, especially with contributions from Low and Middle Income countries.
- DOI has been introduced and the journal has become more searchable on the internet. The number of citations per document has increased from 0.47 (2016) to 1.09 (2017)
- SJR Impact factor has doubled from 0.18 (2016) to 0.34 (2017).
- The journal has a leading role in the field. 29.4% of all papers included in Medline in the 2016-17 period with the word 'torture' in the title were published in Torture Journal.
- The number of authors submitting papers from a country from the Low and Middle Income Countries increased threefold. Over 25 authors who had never published before, but who had presented ground-breaking work in formal or informal spaces, have been contacted and encouraged to submit papers. 14 of these contacts ended in submissions, some of them through a mentoring process with the support of the Editorial Advisory Board.
- The journal would like to be a space for the entire anti-torture sector and continues to welcome papers from authors who do not belong to IRCT member centres. 60% of papers published by the journal are from authors that do not belong to an IRCT member centre.
- The journal has worked with partners, such as the International Society for Health and Human Rights and the European Network of Centers for Rehabilitation of Torture Survivors to provide space for highlights of their symposiums and conferences. Similar agreements with other networks or organisations are considered a priority.



Contents

- The journal now accepts a variety of contributions and maintains a wider number of sections, including an editorial, research and scientific papers, review articles, case reports, perspectives, news, statements, book reviews, letters to the editor and invites comments on scientific papers.[2]
- In 2017, papers included essays, personal reflections or conceptual debates (32%), systematic reviews or meta-analyses (5%), experimental studies (50%), including psychometric studies (50%); epidemiology (10%); clinical cases—medical documentation (5%), monitoring and evaluation of rehabilitation programmes (20%), other (10%) and anthropological or qualitative studies (15%).

[2] Intructions for authors can be found here: https://tidsskrift.dk/torture-journal/information/authors

Improvements to the Journal

- A new Open Journal Systems platform is now used in addition to the IRCT website to allow for better usability and a more professional interface for communication between the editors and authors and peer reviewers.[3] The new platform importantly allows for back copies to be more searchable both directly and via Google and other search engines.
- Importantly, the platform allows for additional materials to papers (i.e. translations, databases, videos or other materials) to be uploaded. Authors are encouraged to submit, along with their papers, all the additional material they would like to be considered. We especially encourage authors to submit papers in the *original language* in addition to the English version.
- We promote issues and specific articles through press releases, social media and author networks.

The Delphi Study

A modified Delphi study with three rounds of consultation was carried out in 2017 to reach a consensus of expert panellists with respect to the top research priorities in the field of torture rehabilitation and prevention (see the last issue of Torture, 2017-3). Aims were to stimulate an interdisciplinary debate, foster research and inform the future publishing priorities of the Torture Journal. The results help to draw up a road map for the journal to be following in the coming three to five years.

The future

The following topics are to be the focus of issues or sub-sections in the coming year and a half. We encourage readers to submit articles and/or read them!:

- Forced Migration and Torture: challenges and solutions in rehabilitation and prevention, kindly subsidised by the Danish Research Ministry (May/June).
- Perspectives on sexualized torture and gender-based torture in the anti-torture sector (September/October).
- Long-term efficacy of torture rehabilitation, with a focus on the Balkans (first priority of the Delphi Study) (tbd).

Financial situation

Torture Journal is the leading journal in medical and psychological research related to the work with torture survivors. It remains open access and free to subscribers and readers. The Torture Journal, kindly supported by the International Rehabilitation Council for Torture Victims, faces serious funding issues.

The following measures are therefore being considered:

- Introducing a fee for up-to-date and back print copies for subscribers in the Global North and libraries and institutions globally.
- Asking IRCT member centres, academic institutions and organisations or others for contributions to the running costs. If you think you can contribute to this collective endeavour and help keep the Journal free and open access, please, contact us at irct@irct.org or donate via the link on the IRCT's website.[4]

Many thanks for your continued interest in the Torture Journal and we hope you enjoy reading this issue!

[3] See https://tidsskrift.dk/torture-journal

[4] See https://irct.org/support-the-irct/regular-donation

On behalf of the Editorial Team and Editorial Advisory Board

Many thanks to our peer reviewers!

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Towards a contextually appropriate framework to guide counseling of torture survivors in Sub-Saharan Africa

Craig Higson-Smith,* ** Gillian Eagle*

Key points of interest:

- There remains a significant gap between those treatment approaches currently described as evidence-based, and the needs and experiences of torture survivors and their counselors in sub-Saharan Africa;
- Careful, gradual exposure to traumatic memories is confirmed by both torture survivors and their counselors as the most impactful component of counseling interventions;
- Counseling interventions designed to strengthen family bonds and support torture survivors in coping with current daily stressors and threats are also felt to be highly impactful;
- Mixed methods research drawing on treatment records and personal experiences of current torture survivors offer valuable supplementary insights with respect to the delivery of evidence-based treatments in different contexts.

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Abstract

Introduction: If the right to rehabilitation is to become a meaningful reality for torture survivors in sub-Saharan Africa, it is necessary that counseling practice be responsive to the contextual and cultural demands of the region. Recent reviews of evidence-based practice with torture survivors are discussed with a focus on those approaches developed and/or tested with torture survivors in sub-Saharan Africa. **Methods:** The results of a mixed methods study of ongoing torture rehabilitation work are reported. This study incorporated a review of 85 case files of torture survivors treated at torture rehabilitation centers in three countries in sub-Saharan Africa, and in depth interviews with fifteen counsellors and fourteen clients at those same centers. Quantitative data are presented in tabular form supported by uni- and bi-variate statistical analyses as appropriate. Qualitative data are presented in terms of themes identified through emergent coding. **Results and discussion:** Help-seeking torture survivors in this region are a diverse and highly symptomatic group, often struggling to survive with their families in precarious circumstances and under ongoing threat. In addition to incorporating key aspects of existing evidence-based practice, counselors also use a range of psychosocial approaches to assist torture survivors to protect

and support their families in the face of seemingly overwhelming life challenges. We propose that more systematic methodologies that facilitate the inclusion of the voices of clients and clinicians in ongoing international debates relating to evidence-based practice with torture survivors will enhance the application of such practices in diverse contexts.

Keywords: torture counseling; trauma; rehabilitation; mixed-methods; sub-Saharan Africa

Torture is practiced in many countries in sub-Saharan Africa, a problem greatly exacerbated by ongoing civil and cross-border conflicts in the region (Amnesty International, 2014; Human Rights Watch, 2017). Most countries in the region fall into the low-income bracket and have extremely limited mental health services (World Health Organisation, 2010). These countries host millions of refugees and displaced persons, including many torture survivors in desperate need of effective mental health intervention (United Nations High Commission for Refugees, 2016). In these contexts, survivors turn to a broad range of health systems, often in parallel. Such medical pluralism includes traditional and faith-based healing systems, public and private health services, as well as more specialist clinics designed to meet the particular needs of torture survivors (Olsen & Sargent, 2017). It is essential that African researchers and practitioners adapt their models of intervention with torture survivors to the particular demands and resources of our continent while remaining cognizant of the available evidence-base on effective practice.

In this paper we summarize previously published findings from a mixed-methods study of the client populations and counseling work of three specialist torture rehabilitation centers in Cameroon, Kenya and South Africa. To this summary we add a qualitative analysis of the specific therapeutic interventions noted by torture surviving clients and their counselors as having been particularly effective in furthering rehabilitation. The results show some significant divergence from currently accepted evidence-based practice, divergence that we argue springs from the particular context of torture survivors in sub-Saharan Africa. We note that much of what we discuss in this paper might have relevance for other parts of the developing world but leave it to practitioners and researchers from other regions to assess the value of our work in their contexts.

Article 14 of the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (United Nations General Assembly, 1984) promises torture survivors the right to redress including rehabilitation, specifically:

> *… the restoration of function or the acquisition of new skills … to enable the maximum possible self-sufficiency and function … and may involve adjustments to the person's physical and social environment. Rehabilitation should aim to restore … independence, physical, mental, social and vocational ability and full inclusion and participation in society.* (United Nations Committee Against Torture, 2012, Paragraph 11)

The question then arises as to the most effective means by which this restoration of function might be achieved in different contexts. At least within the mental health and counseling arenas, answering this question relates to what is most strongly indicated in terms of evidence-based practice (EBP), or,

> *… the integration of the best available research with clinical expertise in the*

> *context of patient characteristics, culture, and preferences.* (American Psychological Association, 2005, p. 5)

This definition requires that empirical evidence be weighed within the parameters of various contextual features, including the availability of skilled practitioners, economic and security conditions, and local attitudes and norms.

Evidence-based practice for rehabilitation of torture survivors

A Cochrane Review of research on interventions for the psychological health and well-being of torture survivors lists only nine randomized control trials (RCTs) that met standard inclusion criteria (Patel, Kellezi & De C. Williams, 2014). The reviewers found no immediate benefits from psychological therapies in comparison with control groups, but noted some moderate benefits in reducing PTSD symptoms and distress six months after the end of treatment. They concluded that the evidence does not support the use of any particular intervention over others.

Another review of torture treatment outcomes cast a broader methodological net and included 88 treatment outcome studies (Weiss et al., 2016). These reviewers concluded that cognitive behavior therapy (CBT) that included exposure components was best supported by the research for reducing symptoms of post-traumatic stress disorder (PTSD), depression and anxiety in survivors of torture. They noted that Narrative Exposure Therapy (NET), Interpersonal Therapy (IPT), pharmacotherapy (alone or in combination with CBT), and multi-disciplinary approaches also showed promise, warranting further research.

Some treatment outcomes studies have been conducted in sub-Saharan African contexts. Igreja, Kleijn, Schreuder, van Dijk, and Verschuur (2004) demonstrated the positive impact of a single session testimony approach with rural survivors of the Mozambican civil war. Studies have examined the efficacy of NET for the treatment of PTSD in various populations in Uganda (Neuner et al., 2008), Rwanda (Schaal, Elbert and Neuner, 2009) and South Africa (Hinsberger et al., 2017) with encouraging results. In the Democratic Republic of Congo (DRC), cognitive processing therapy was shown to reduce the incidence of depression, anxiety and PTSD symptoms among female survivors of sexual violence (Bass et al. 2013). Mpande et al. (2013) tested the Tree of Life intervention, an approach that draws heavily on Zimbabwean cultural beliefs and practices, and demonstrated positive impact.

Despite these and other studies, it is disappointing that after decades of treatment outcome research, the guidance to practitioners working with torture survivors in sub-Saharan African remains equivocal. The global literature is sparse and dominated by studies of refugees resettled in Europe and North America, not the contexts in which the majority of torture survivors are located. Many interventions have not been rigorously tested and the existing studies have significant methodological flaws (Patel et al., 2014). Most importantly, the focus on symptom reduction falls short of the vision of rehabilitation described in UNCAT. In this paper we hope to contribute to the development of treatment approaches by examining the characteristics of torture survivors seeking treatment in sub-Saharan Africa, and by exploring what they and their counselors experience to be the most helpful therapeutic interventions.

Method

This mixed-methods study consisted of two distinct parts which are combined during analysis and interpretation. The first part was a quantitative and qualitative analysis of randomly selected case files documenting the mental health treatment of 85 torture survivors. The second was a qualitative analysis of semi-structured narrative interviews with 15 counselors and 14 torture surviving clients (see Table 1 below). Case files, counsellors and clients were selected from three specialist torture rehabilitation centers in sub-Saharan Africa: the Centre for Rehabilitation and Abolition of Torture (CRAT) in Cameroon; the Independent Medical Legal Unit (IMLU) in Kenya; and the Centre for the Study of Violence and Reconciliation (CSVR) in South Africa. By selecting centers in diverse parts of the continent we hoped to capture something of the political, economic, cultural and linguistic breadth of sub-Saharan Africa.

The Ethics Committee for Research on Human Subjects of the University of the Witwatersrand, South Africa approved the research protocol. Some results from this study have been published previously (Higson-Smith, 2013; Higson-Smith, 2014; Higson-Smith & Eagle, 2017).

Case file review

Clinical records for 33 clients were selected from each of the three centers, on an interval basis from consecutive lists. Fourteen cases did not meet the UNCAT definition of torture and were excluded, producing a final combined sample of 85 cases.

Case files included a comprehensive psychosocial intake assessment that included demographic details such as legal status, work authorization, past and current occupations, income and housing situation, family structure and dependents, as well as brief summaries of current medical conditions, injuries, and prescription medications. A brief history of traumatic experiences, including torture, was also recorded, as well as items relating to the clients expressed needs and reasons for seeking treatment. Centers routinely administered clinical assessment measures and practitioners documented subsequent meetings with clients whether for the purposes of counseling or associated tasks such as referral or assessment. These

Table 1: *Sociodemographic characteristics of the three study samples*

	Case files reviewed	Key respondent interviews	
		Counselors	Clients
Total N	85	15	14
Gender			
Men	39 (46%)	4 (27%)	8 (57%)
Women	46 (54%)	11 (73%)	6 (43%)
Country of contact			
Cameroon	30 (35%)	6 (40%)	4 (29%)
Kenya	23 (27%)	5 (33%)	6 (42%)
South Africa	32 (38%)	4 (27%)	4 (29%)

annotations also mentioned major events in the client's life including changes in asylum status, housing conditions, bereavements, illnesses and medical care, and further experiences of victimization.

Case files were analyzed using a range of quantitative and qualitative codes that encompassed demographic indicators; duration and frequency of counseling sessions; the current status of the therapeutic work; key features of reported torture, trauma, and loss; expressed reasons for seeking assistance; the range, severity and number of psychological and somatic symptoms reported; as well as observations regarding obstacles or advances in therapeutic progress. Using iterative thematic analysis (Braun and Clarke, 2006) we searched across individual case files to identify repeated patterns of meaning or themes in an inductive manner. Themes were coded at an explicit (or semantic) level to ensure that the coding system remained strongly "data-driven." Initial codes were developed on site in the three torture treatment centers where the original analysis was conducted. Codes were subsequently reviewed and refined across the entire data set to ensure standardization of coding. Where appropriate, basic uni- and bivariate statistics were calculated to describe the composition of the sample and to highlight differences between groups within the sample.

This adult sample ranged from 18 to 66 years (mean=33.9, sd = 10) with no significant difference between the samples from the three centers. Further demographic details are presented in Table 2.

Interviews with counselors

The first author invited staff who provided counseling at the centers to participate in semi-structured interviews relating to their counseling practice. All 15 counselors working at the centers accepted this invitation. Interviews were conducted in English and included questions about counselor's training and experience, personal motivation for work with torture survivors, emotional well-being, and approaches and methods used in counseling. Average interview length was 57 minutes. During the interviews counselors were asked to think of two or three specific clients for whom they considered the therapeutic work to have been particularly helpful. They were then asked to narrate the story of their work with those clients. In the course of their narrations, respondents were asked to identify particularly helpful therapeutic interventions that enabled the client to take a significant step forward in his or her recovery.

The counselors interviewed ranged in age from 25 to 65 years and all but one were citizens of the country in which they were working. Six were clinical psychologists, four were general nurses, three were social workers, one was a psychiatric nurse, and one was a general medical practitioner. The aggregate term "counselor" is used to describe this diverse group and the activity that is the focus of this study. These counselors had a median of ten years work experience (ranging from one to thirty years). Their experience in torture rehabilitation specifically was shorter (one to 22 years with a median of 6 years). In addition to their professional training, all had participated in one or more shorter training courses on evidence-based approaches to counseling people who have survived torture. The first author had worked for several years with the selected centers in a capacity building role, covering topics including evidence-based treatments for PTSD, effects of trauma on the brain, arousal regulation skills, CBT and trauma-focused counseling skills, treatment planning, conducting clinical

Table 2: *Demographic characteristics of case review sample by participating center*

	CRAT n=30	IMLU n=23	CSVR n=32	Total Sample N=85
Gender				
Men	14 (47%)	12 (52%)	13 (41%)	39 (46%)
Women	16 (53%)	11 (48%)	19 (59%)	46 (54%)
Country of origin				
Kenya		22 (96%)		22 (26%)
Democratic Republic of Congo (DRC)	9 (30%)		11 (34%)	20 (24%)
Zimbabwe			14 (44%)	14 (16%)
Central African Republic (CAR)	9 (30%)			9 (11%)
Rwanda	7 (23%)		2 (6%)	9 (11%)
Chad	4 (13%)			4 (5%)
Other	1 (3%)	1 (4%)	5 (16%)	7 (8%)
Family situation				
Married/partnered	15 (50%)	17 (74%)	13 (43%)	45 (54%)
Single	10 (33%)	2 (9%)	9 (30%)	21 (25%)
Widowed	5 (17%)	1 (4%)	5 (17%)	11 (13%)
Divorced/separated		3 (13%)	3 (10%)	6 (7%)
Caring for children (median children = 3)	20 (67%)	19 (83%)	21 (70%)	60 (71%)
Education				
Primary incomplete	2 (7%)	2 (11%)	1 (3%)	5 (6%)
Primary complete	10 (34%)	9 (50%)	9 (29%)	28 (36%)
Secondary complete	13 (45%)	6 (33%)	10 (32%)	29 (37%)
Tertiary qualification	4 (14%)	1 (6%)	11 (36%)	16 (21%)
Current employment				
Unemployed	18 (60%)	6 (31%)	15 (50%)	39 (49%)
Informal employment	8 (27%)	10 (53%)	5 (17%)	23 (29%)
Artisans / skilled labor	3 (10%)	3 (16%)	8 (27%)	14 (18%)
Professional			1 (3%)	1 (1%)
Student	1 (3%)		1 (3%)	2 (3%)

assessments, and ethical concerns in the treatment of torture survivors. Although this existing relationship must influence counselors' responses it also provides a foundation of trust necessary for counselors to describe their true experiences of this challenging work.

Interviews with clients
Participating counselors invited clients to take part in a similar interview concerning their experience of counseling (and explicitly not about the traumatic experiences that led them to seek assistance). We invited adult clients who had experienced torture and who were at a point in their therapeutic work where counselor and client agreed that the client could participate in the interview without undue risk of re-traumatization. Fourteen clients accepted the invitation. Eight were interviewed in English and six in French with the assistance of an interpreter, a post-graduate psychology student. Average interview length was 45 minutes and included questions about access to services, obstacles in attending counseling, frequency and duration of sessions, length of intervention, as well as therapeutic experience. In particular, clients were asked to describe therapeutic moments which they felt had been most helpful to them. The first author had no previous relationship with these clients. His being a professional man of European descent associated with an international organization is likely to have influenced clients' responses in important ways.

Participating clients ranged in age from 25 to 63 years. The eight clients treated in South Africa and Cameroon were refugees or asylum seekers from other African countries. The six interviewed in Kenya were all Kenyan citizens.

Qualitative analysis of interviews
Both counselor and client interviews were translated where necessary and transcribed verbatim. For the purposes of this analysis, any content relating to successful therapeutic intervention was extracted for independent thematic analysis. A total of 125 incidents (75 from counselors and 50 from clients) ranging in length from a couple of sentences to several paragraphs were identified. Using an iterative thematic analysis process the material from the two groups was initially analyzed independently. The two sets of themes were then integrated into a final set of the 15 most salient emergent themes. These themes were labeled and described with respect to the intervention itself and the associated therapeutic intention. Thereafter, the combined set of incidents was analyzed using the 15 thematic categories. Due to the interconnected nature of the themes (and the therapeutic work itself) some incidents were coded under more than one theme. Since most counselors described successful work with several clients, the same theme sometimes emerged repeatedly in a single interview. Clients described only their own experience and so each theme was only counted once. In the final analysis we recorded how often each theme was mentioned by the two groups of respondents and how those responses were distributed across the three centers (see Table 2).

An independent researcher coded a sample of 50 incidents which were then checked for reliability against the authors' coding. Percentage agreement was 86%.

Results and discussion

Results of case file review
The review of a representative sample of 85 case files showed that clients came from a wide range of countries and represented a

broad range of ethnicities, cultural traditions and languages. Such diversity demands a high degree of cultural competence from counselors, as well as the capacity to work effectively with interpreters. In some cases interpreters were employed by the centers, but at times interpretation was provided by friends or family of the client. This has important consequences for what is possible in counseling.

An analysis of the specific torture experiences reported divided clients into several groups. Approximately 40% were people who had been caught up in a civil conflict in the region. They were tortured as part of forced conscription, as punishment for alleged support of the enemy, to coerce them into providing supplies to militias, or because of their ethnic or religious identity. Approximately 35% self-identified as activists and included political and community leaders, as well as journalists targeted by oppressive regimes. A third group comprised spouses, parents and children of activists and accounted for 18% of the sample. This group was tortured to punish their family members or to extract information about those peoples' whereabouts or activities. Finally, the sample included several people (7%) who had been accused of a crime and tortured as part of a police investigation or as punishment. The varied circumstances under which torture occurred has profound implications for counseling, impacting the possibility of finding safety, the availability of support within families and communities, as well as ways in which clients are able to construct meaning.

Fifty-five percent of clients receiving counseling did not originally approach the centers for mental health care. More commonly clients sought medical or social welfare assistance. This has profound implications for the manner in which clients are introduced to mental health services, their understanding and expectations of services, the way in which initial assessments are conducted, as well as for sustained client engagement.

The course of treatment recorded in the client files varied greatly in complexity and length. The number of counseling sessions attended ranged from 1 to 60. However, the distribution was highly skewed with a median of 3.5 sessions. Very few clients (11%) received the 12 or more sessions of treatment found to be optimal (Weiss et al., 2016) and only 39% of the files reviewed reported the counseling process ending in a planned or negotiated manner. Most clients stopped attending counseling without explanation after fewer than three meetings. A range of explanations for such low completion rates have been advanced, including difficulties in reaching service delivery sites, the cost of transport, challenges in managing the care of small children, moving away to pursue employment or safer living conditions, and the loss of time to income generating activities. Nevertheless, we must also consider the possibility that some clients felt that the benefit of the first few sessions of counseling was not worth the effort of attending. Counseling models adapted to the sub-Saharan African context must grapple with questions of motivation for counseling, and develop strategies to increase access and engagement.

Regardless of engagement, clients reported high levels of distress and symptomatology relating to depression, anxiety and PTSD. The most common complaints included pervasive worries (72%), intrusive thoughts and memories (70%), sleep difficulties (69%), and low mood (59%). Many clients (66%) reported somatic complaints without a clear medical

cause. It can be difficult to determine whether non-specific but chronic somatic complaints (including generalized pain, weakness and fatigue, and a weakened immune response) arise from physical damage caused by prolonged torture and incarceration in poor conditions, or have their origins in emotional distress (de C Williams & Baird, 2016). Such determinations are further complicated in sub-Saharan Africa where emotional distress is often communicated through idioms rooted in the body (Ventevogel, Jordans, Reis & de Jong, 2013).

The majority of case files reviewed was of younger adults, married and/or caring for children. Twenty-eight percent were citizens of the country in which they sought help, but many more were refugees (25%), asylum seekers (32%), or undocumented persons (15%). Citizens were also often displaced, having been driven out of rural communities and forced to seek refuge in the relative anonymity of larger urban areas. Refugees, asylum seekers and undocumented people reported many more symptoms than citizens and we speculate that this is due to the confluence of past traumatic experiences and ongoing threat. Asylum seekers and undocumented people must cope with the continuous fear of being incarcerated and/or returned to the country where they were originally tortured. Refugees and internally displaced people must at times cope with being an outsider in openly hostile host communities. This hostility is expressed on a daily basis in interactions with neighbors, as well as service providers and police. At times it spills over into physical attacks on foreigners, their homes and businesses.

An analysis of accounts of current danger identified five types of continuing threat: harassment by the original torturers or their colleagues; harassment by government officials unrelated to the original torture; threats from neighbors and other members of the community; domestic violence; and gender-based violence. The presence of ongoing threat in all these forms is another important consideration in counseling torture survivors, one that is often neglected in counseling models developed in more protective contexts.

Forty-six percent of the cases reviewed disclosed a significant recent bereavement, the majority of which were violent (85%). Thirty-nine percent of the bereaved group reported being directly victimized during the event in which their loved one died. Such victimization included torture, rape, and intimidation. In many cases the client was directly implicated in the violent death of their loved one. For example, the loved one died trying to protect the client,from torture linked to the client's political activism. Bereaved clients reported significantly elevated depression-related symptoms (effect size=0.65) and increased suicidal ideation (odds ratio = 4.99). Current assessment batteries do not assess for complicated bereavement and counseling models used with torture survivors seldom address grief explicitly.

These results paint a picture of a highly diverse population of treatment-seeking torture survivors on the continent. They are a highly symptomatic group having often survived complex and repeated victimization, including violent bereavement. Many are struggling to survive in precarious circumstances or under active, ongoing threat. These factors impede access to services and undermine progress in rehabilitation. In the next section we examine what a sample of clients and their counselors describe as the most significant components of their therapeutic work.

Results of interviews with counselors and clients—most helpful therapeutic interventions

The qualitative analysis of incidents of therapeutic change narrated by clients and counsellors resulted in a set of interconnected themes which are summarized in Table 3 and elaborated below.

The theme mentioned by most respondents (both clients and counselors) was **trauma exposure work**, a theme that aligns well with existing EBP recommendations. The salience of this theme supports the position that a focus on past traumatic experiences is important in work with torture survivors in sub-Saharan Africa. While counselors emphasized the integration of traumatic memories and the empathic witnessing of gross human rights violations, clients were more likely to emphasize the cathartic benefits, describing the pain of telling and the relief that followed. A middle aged man who fled to South Africa after being tortured in Zimbabwe described his experience as follows:

> *In the beginning it is difficult to tell or retell the story. Because initially you just browse the story without going into, into details. And then you tell it the second and third. And then when you are now settled you actually tell the story as it is and with all the details. Whatever, actually telling the story with your heart and actually seeing, visualizing what has been happening. You can feel that there is an impact in you. … It had more meaning emotionally and then after that, with some sessions and retelling details, and doing some exercise, it no longer was, it was no longer necessary.*

The next two most commonly described themes were more rooted in current life challenges. That therapeutic work focused on **strengthening families** was important to both clients and counselors is not surprising given the proportion of clients who are married and caring for children, and the precariousness of their lives. Strain within families may result from direct traumatization, vicarious and transgenerational trauma, increased stressors due to forced migration, bereavement, and changing family roles. An older Kenyan man struggling with his wife's depression

Table 3: *Therapeutic interventions most frequently described by client and counselors as particularly helpful to torture survivors*

Theme	Description	Frequency
Trauma exposure work	Intentional, graduated retelling of trauma narratives combined with active affect and arousal regulation intended to integrate and habituate traumatic memories.	7 clients and 7 counselors from all 3 countries (14 incidents)
Strengthening families	Interventions intended to strengthen support within families and reduce vicarious and transgenerational trauma, including education around interpersonal effects of torture, parenting support, and conflict management.	5 clients and 5 counselors from Kenya and South Africa (15 incidents)
Problem solving	Collaborative problem solving intended to stabilize the client and increase agency and self-sufficiency in the face of persistent life challenges.	4 clients and 6 counselors from all 3 countries (15 incidents)

Theme	Description	Frequency
Psychoeducation	Explanations of underlying causes of distress in order to normalize reactions and encourage healthy coping. Explanations of counseling interventions to increase engagement with treatment.	4 clients and 6 counselors from all 3 countries (12 incidents)
Symptom management	Guidance and skills-building intended to reduce the frequency and severity of disruptive symptoms and improve global functioning.	4 clients and 6 counselors from all 3 countries (11 incidents)
Encouraging Spirituality	Supporting spiritual beliefs and encouraging participation in religious practices with the intention of sustaining hope and perseverance.	4 clients and 5 counselors from all 3 countries (11 incidents)
Disputing irrational beliefs	Exploring and testing evidence in relation to beliefs and thought patterns (particularly in relation to helplessness and isolation) with the aim of reducing distress and building support and agency.	1 client and 7 counselors from all 3 countries (11 incidents)
Sustaining hope	Holding a vision of an improved future in order to reduce hopelessness and increase agency in the face of persistent life challenges.	10 clients from all 3 countries (10 incidents)
Dignity and respect	Treating client with respect thereby upholding human dignity, establishing a therapeutic relationship and increasing engagement, and counteracting experiences of stigma and discrimination.	6 clients and 1 counselor from all 3 countries (7 incidents)
Encouraging activism and volunteer work	Encouraging advocacy and community work of importance to the client with the intention of increasing community connection, self-esteem and personal meaning.	2 clients and 4 counselors in Kenya and South Africa (6 incidents)
Case management	Identifying additional needs and referring client to other service providers with the intention of increasinges access to services and stabilizing the client.	6 clients in all three countries (6 incidents)
Grief counseling	Providing support for healthy grieving and encouraging community and private rituals of remembrance to reduce symptoms of complicated grief.	3 clients and 2 counselors in Kenya and South Africa (5 incidents)
Support for medications	Explaining purpose and proper dosage of medications to stabilize clients and reduce physical and emotional symptoms.	1 client and 4 counselors in all three countries (5 incidents)
Focus on strengths	Recognize and encourage use of personal strengths employed during and after traumatic experiences with the aim of improving coping and self-sufficiency.	1 client and 4 counselors in all three countries (f incidents)
Home practice	Agreement and monitoring of key activities to be practiced between sessions with the aim of stabilizing the client, improving coping, and building self-sufficiency.	2 counselors from Kenya and South Africa (4 incidents)

and suicidal thoughts after the couple were driven from their community described the help he received as follows:

> *We talked about my wife and how I am experiencing because still I was sick and, still I'm thinking how I cannot sleep well because I was thinking my wife can wake up and do something terrible. But [my counselor] explains … that the only thing she needs is care. Slowly with her I showed her I cared for her. I told her, "Okay, we can talk slowly, I never come with sharp word" or telling her anything she can be angry. And now I experience and I become okay with her.*

Therapeutic approaches that are too individualistic in focus may fail to address anxieties relating to family health, something that is inseparable from personal wellbeing to many people in sub-Saharan Africa.

Problem solving interventions were also often mentioned as being particularly helpful and are strongly connected to the challenges and threats in clients' daily lives. Therapeutic interventions focused solely on past trauma may be experienced as less helpful by clients who need assistance in dealing with immediate problems with important consequences for their survival. The Zimbabwean man quoted above had this to say,

> *I would prefer to talk about other people's problems. And, in a way, to me when I am talking other people's problems, and solving other people's problems, I would discover that I am also solving my own personal problems. They're the same.*

In these words we hear not only an increased sense of control but also solidarity with others who are suffering. Problem solving is most strongly linked with the seemingly overwhelming daily stressors that so many torture survivors, particularly people who have been displaced from their communities, are living with.

Understanding of the underlying causes of mental illness and the purpose of mental health services varies greatly in sub-Saharan Africa. For this reason, **psychoeducation** may be more important in this context than it is in others. A Kenyan counselor described how she uses metaphors and physical objects to help clients understand and label the underlying causes of their distress.

> *Simple ways of understanding in psychoeducation … finding practical ways of educating them to understand the root cause and how it's connected to their symptoms and the reactions that they are having. Because once they understand that, it makes sense to them. Then the treatment plan, that if they try this it could help relieve [their suffering].*

This counselor also links psychoeducation to the rationale for the treatment plan, implying that this is also important for client engagement in counseling.

Closely linked to psychoeducation is work on **symptom management**, which includes helping the client develop skills for arousal and affect regulation, as well as finding ways to cope with disruptive symptoms. A Kenyan client struggling with persistent and severe headaches described his counselor's intervention as follows:

> *I was coming here with headache. But [my counselor] told me there is something which I will be remembering … He shows me how I need to, to remove that kind of headache. I only start. Find somewhere comfortable, somewhere quiet. I sit myself there. I come to relax and he shows me how I can stay relaxed somewhere. And then I experienced that my headache become low. I found that was only stress … Yes, it goes away, yeah.*

Both psychoeducation and symptom management are often included (at least implicitly) in current EBP recommendations.

Many people in sub-Saharan Africa are devout Christians or Muslims with many

also honoring traditional African gods and ancestral spirits. A range of interventions that **encouraged spirituality** as a source of resilience were judged important by both clients and counselors. An older woman of strong Christian faith receiving treatment in Cameroon found it helpful that her counselor could work with her on a spiritual level too.

> *[I had] lost my hope. [My counselor] used to tell me that I don't have to lose my spirit. I have to continue with my faith in God. Even if the world is rejecting us, only Him, He change our situation … so I have understand that God was above us. That is why now I am stress free. I'm stress free and I continue to do my life.*

In this way the counselor is using a religious belief in divine care and protection to support the client's agency and sense of control in her life.

A related theme was that of **disputing unhealthy beliefs** and thought patterns, which was mentioned almost exclusively by counselors. A Kenyan counsellor describes working with a client who had lost her husband violently and whose grief had left her feeling marginalized and alone:

> *… to reframe "that everybody is against me, nobody wants me in this community" … So if people came and they quickly organized about how this body can be buried, they notified her parents, they built a house for her. And the visitors who came for the burial were taken care of and all that. That was some support! So although she thought everyone hated her, that wasn't strictly true.*

Serving a similar purpose were therapeutic interventions intended to **sustain hope.** Ten clients told us how their counselor instilled hope in them when they felt hopeless, and it is interesting to note that none of the counselors emphasizes this theme. In the words of a Kenyan woman:

> *From the time I was given counseling, that power I get from that time … because all things I struggle with will come in the end … the life is going different sometimes, sometimes it's okay. … [My counselor] told me this problem is to test my heart whether I'm strong enough to hold these problems and I have to be strong enough to … overpower my problems. He told me, "Never, never give up!"*

These themes of encouraging spirituality, disputing irrational beliefs and sustaining hope are all associated with building clients' capacity to persevere in the face of seemingly overwhelming challenges and threats to their present survival. The emphasis is powerfully on the present and not on past traumatic experiences.

Other important themes included case management and referral, as well as assistance with medications. All three centers were able to refer clients to a range of other services and did so routinely. Services offering emergency shelter and food were typically in high demand and over-subscribed. Referral for medical and psychiatric care was also available to all centers through either government or humanitarian agencies. Medical personnel are often limited in the time they have available to explain the purpose and dosage of medications and so counselors were often called upon to explain prescriptions and encourage adherence. In contexts where clients have less familiarity with "Western" health systems, the value placed on help in navigating these complex systems is significantly greater.

Also mentioned were more general principles of care including encouraging home practice, intentionally acting to protect the clients' human dignity, and recognizing the strengths that they displayed both during and after traumatic experiences.

Limitations of this study

This study has several limitations. Firstly, the findings are based on a narrow sample of cases drawn from only three of the multiplicity of sites across the continent at which torture survivors seek mental health and psychosocial services. Similarly, a review of 85 cases is unlikely to contain the full complexity of the challenges experienced by torture survivors in sub-Saharan Africa. Likewise, interviews with only 14 clients and 15 counselors cannot hope to be representative of the full range of experiences of rehabilitation in the field. Nevertheless, we hope these samples are diverse and large enough to identify key contextual challenges in the rehabilitation of torture survivors pertinent to the region.

Secondly, as with all key respondent data, the findings are dependent on the background, experience and training of the respondents. In this case and for ethical reasons, we interviewed only clients who had shown marked improvement during their time in counseling. The responses of clients who were less resilient or who had a negative experience of counselling might have been very different. Counselors' responses were also heavily influenced by their professional and subsequent training. Respondents are likely to favor interventions in which they have been trained and ignore others to which they have had limited exposure. Also, counselors' responses must be viewed within the frame of their relationships with the first author. However, it is important to remember that these are seasoned mental health and health professionals. The interview transcripts reflect informed, thoughtful and self-critical conversations about the work of torture rehabilitation in the region. With the exceptions of the emphasis on gradual exposure to traumatic memories and disputing irrational beliefs, the themes emerging from this analysis do not reflect the content of training material covered by the first author. Nevertheless, his influence as a capacity building consultant cannot be discounted. It is difficult to know how the results might have varied had a less trusted, but also less involved, person conducted the interviews.

Thirdly, the questions posed to counselors and clients were not identical and intentionally framed in broad terms. As a result, the responses include a mix of specific and non-specific factors. Specific factors, for example the recounting of traumatic memories and disputing of irrational beliefs, may be more directly relevant to debates around particular therapeutic approaches. Less specific factors, for example upholding clients' human dignity and case management, arguably apply to all competent forms of psychosocial intervention. Nevertheless, we feel they are relevant to discussions of how EBP is developed and implemented in sub-Saharan Africa.

Finally, the participating centers were able to conduct follow-up assessments on only a very few clients. Our analysis therefore offers no quantitative estimate of the effectiveness of the interventions discussed.

Conclusions

The strengths of this study lie in the intersection of our analysis of the profile and needs of a representative sample of the actual client population served by these clinics, with an in-depth analysis of the experience of the counseling work from the perspectives of both client and counselor. The findings emerge from the real-world of service provision, reflecting a wide range of case presentations, many of which are extremely complex, and drawing on the experience of actual counselors working in the region today.

The results suggest that counselors working in torture rehabilitation centers in sub-Saharan Africa incorporate key aspects of currently accepted EBP into their work. Foremost among these is the work of retelling narratives of past traumatic experiences with the intention of integrating traumatic memories. However, it seems that counselors also invest a great deal of counseling time into interventions intended to assist the client to survive and to hold their families together in the face of overwhelming current stressors and threats. These interventions involve problem-solving, instilling hope through spiritual and other means, and encouraging perseverance. Counselors also spend significant time helping their clients understand and manage their emotions, reactions and symptoms, and in navigating health and social welfare systems. Clients experienced value in virtually all these interventions.

These findings suggest a significant gap between those treatment approaches currently described as evidence-based, and the needs and experiences of torture survivors and their counselors in sub-Saharan Africa. These counselors would benefit greatly from training and supervision in clearly articulated treatment approaches that are less focused on individual recovery from past traumatic experiences, and instead recognize that most torture survivors have lost family, property, occupation, and community and are often struggling to survive in a dangerous world with little support. Such approaches need to be accessible and rooted in African understandings of mental health and healing. Counselors also need approaches that increase clients' resourcefulness and capacity for focused action and persistence in the face of adversity, as well as tools to strengthen families' capacity to protect and nurture their members. In this way the definition of treatment outcome may be expanded into something closer to the vision of rehabilitation expressed in UNCAT.

In torture rehabilitation, as in other aspects of mental health service delivery, evidence-based practice is insufficiently informed by counselor expertise and client preferences in particular contexts. It is our hope that methodologies such as the one we have utilized in this study will assist in more systematically integrating clinical and contextual knowledge in the ongoing discourse on therapeutic effectiveness. Our goal is that these findings will encourage innovations in the structure, content and process of therapeutic approaches to torture rehabilitation that are more effective in realizing torture survivors' right to rehabilitation in our region and around the world.

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Evaluation of the efficacy of a South African psychosocial framework for the rehabilitation of torture survivors

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Key issues box:

- When treating torture survivors in developing countries, it is essential to consider the inherent stressors and daily traumas in these environments.
- To assist with the psychosocial impacts due to torture, an evidence-based, contextually appropriate psychosocial rehabilitation framework has been developed by the Centre for the Study of Violence and Reconciliation.
- Following a 3-month intervention based on this psychosocial framework, torture survivors' anxiety and functioning improve, despite harsh contextual realities.
- However, ethical complexities and high levels of participant attrition during longer therapeutic intervention present challenges to experimental endeavours designed to test the efficacy of the rehabilitation framework.

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Abstract

Introduction: To address the consequences of past torture experiences as well as current traumas and daily stressors, the Centre for the Study of Violence and Reconciliation (CSVR) developed a contextually appropriate psychosocial framework for the rehabilitation of individuals who have been affected by torture. **Method:** To test the efficacy of this framework, a quasi-experimental study was conducted with torture survivor clients of the CSVR who met the 1985 United Nations Convention Against Torture (UNCAT) definition. A comparison group of clients (n=38) was initially included on a waiting list and thereafter received treatment, whilst the treatment group of clients (*n*=44) entered straight into treatment. **Results:** Baseline t-test comparisons conducted on 13 outcome indicators revealed significantly better initial psychological health and functioning of clients in the treatment group than those in the comparison group, with moderately large differences on PTSD, trauma and anxiety, and strong difference in depression scores. Three-month follow-up comparisons using the conservative Wilcoxon test revealed significantly greater improvement on the functioning and anxiety indicators of the treatment group relative to the waiting-list comparison group (odds ratios = 2.49 and 2.61 respectively). After a

further three months, when treatment was based on the CSVR framework for both groups, fewer than half the respondents remained in the study (n=20 in the treatment group; n=16 in the comparison group), and the Wilcoxon repeated measures test results on changes since baseline were counter-intuitive: for these remaining clients, there were now more significant outcome improvements for the comparison group than for the treatment group. However, the relative odds ratios for the groups were not significant for these indicators. Furthermore, the clients who dropped out from the treatment group had shown overall improvement in their psychological health and functioning in the initial three months of the study, whereas those who dropped out from the comparison group had shown improvements on fewer indicators. Thus, the research findings on the efficacy of the framework are inconclusive. **Discussion:** We suggest that this inconclusiveness can be explained by the severe challenges and ethical complexities of psychosocial research on vulnerable groups. The study highlights the serious problem of attrition of participants in the treatment programme which affected the overall study, and which may explain findings that at first appear counter-intuitive.

Introduction

Continuing traumas, daily stressors and trauma reactions from past traumas are characteristic of torture survivors in South Africa. Consequently, in 2013, the Centre for the Study of Violence and Reconciliation (CSVR) based in Johannesburg, designed a contextually appropriate, evidence-based psychosocial framework for guiding the long-term rehabilitation of individual survivors of torture (Bandeira et al., 2013). This paper presents this framework and describes a quantitative study designed to examine the effectiveness of its use for torture rehabilitation.[1]

Torture and its consequences

Torture is a gross human rights violation that distresses the individual, family, community and society at large. Despite a number of international conventions prohibiting torture and cruel, inhuman and degrading treatment (CIDT), torture is still practised in more than 140 countries internationally, and still widely practised in Africa where it has been criminalised in only 10 countries (Amnesty International, 2014). Sub-Saharan Africa hosts the largest number of refugees internationally, with South Africa receiving most of the asylum seekers in Africa (McColl et al., 2010; UNHCR, 2015). Many of these people are likely to have been tortured in their country of origin or in transit (McColl et al., 2010). Within South Africa, current victims of torture include youth in conflict with the law, non-nationals, and people who are in the wrong place at the wrong time (Bantjes, Langa, & Jensen, 2012; Langa, 2013).

The consequences of torture may be categorised broadly as physical, psychological and social. The physical consequences may be complicated by the psychological consequences (Quiroga & Jaranson, 2005). Similarly, torture-related mental health problems can cause physical and social problems which impact on both the personal and social functioning of survivors

[1] While the intervention was named a "model", due to the multi-modal nature of the document, it was felt to be more representative to call it a multi-modal framework for the rehabilitation of torture survivors.

(Baird, Williams, Hearn, & Amris, 2016). The physical sequelae of torture include pain - often chronic, disability and medical conditions (Harlacher, Nordin, & Polatin, 2016; Jørgensen, Auning-Hansen, & Elklit, 2017; Patel, Kellezi, & Williams, 2014).

The psychological consequences of torture are often viewed in terms of posttraumatic stress disorder (PTSD) and major depressive disorder (MDD) (Harlacher et al., 2016; Higson-Smith, 2013). Lesser acknowledged psychological consequences include cognitive impairment, decreased functioning, sleep disturbances, memory problems, attentional deficits and anger. Co-morbid psychiatric conditions include depression, suicide, psychosis and substance abuse (Bandeira, 2013; Quiroga, 2017; Quiroga & Jaranson, 2005).

The social consequences of torture impact on the social wellbeing of the survivor. These effects include the loss of "employment, status, family and identity" (Higson-Smith, 2013, p.165), separation from loved ones (Higson-Smith, 2013; Quiroga & Jaranson, 2005), the loss of functioning and safety, and loss of cultural and community connections (Higson-Smith, 2013).

Living in contexts of continuing threat and daily stress

Vulnerability to mental health challenges has been linked to pre-migratory exposure to war trauma and torture, the migration process itself, and the post-migratory stressors of host countries which include poverty and inadequate housing, and difficulties with asylum procedures (Bogic, Njoku, & Priebe, 2015; Buhmann, Mortensen, Nordentoft, Ryberg, & Ekstrøm, 2015; Jaranson & Quiroga, 2011; Jørgensen et al., 2017; Stammel et al., 2017).

Although the South African Constitution (Republic of South Africa, 1996) and the Refugee Act (Republic of South Africa, 1998) provide basic civil and political rights such as free basic healthcare, access to education and employment to refugees and asylum seekers regardless of nationality and legal status, in reality these constitutional rights may be denied (Bandeira, 2013; Higson-Smith, 2013; Langa, 2013; Patel et al., 2014; Quiroga & Jaranson, 2005). Refugees and asylum seekers experience high levels of crime and violence, xenophobia and exploitation (Bandeira, Higson-Smith, Bantjes, & Polatin, 2010; Higson-Smith, 2013; Langa, 2013; Mohamed, Dix-Peek, & Kater, 2016), and the South African asylum-seeking process has been associated with inconvenience, cost and distress (Higson-Smith & Bro, 2010; Langa, 2013). Continuing traumas threaten the survival of many refugees and asylum seekers through ongoing threats from the police, government officials and community members, and through domestic violence, sexual violence and xenophobia (Higson-Smith, 2013; Mohamed et al., 2016). Such traumas "may influence the way that survivors respond or adapt to their precarious circumstances, but it is the circumstances themselves that produce and maintain the client's psychological state" (Higson-Smith, 2013, p. 166). Fear, anger and distress, emotional collapse, helplessness and hopelessness (Bandeira, 2013; Kaminer & Eagle, 2010) are associated with daily stressors of documentation problems, concerns over the health and schooling of family members, accommodation problems, unemployment, poverty, loss of social and material support, ostracism and lack of security (Bandeira et al., 2010; Higson-Smith, Mulder, & Masitha, 2007; Miller & Rasmussen, 2010).

Research on treatment approaches for torture survivors

There are few scientific research studies on the treatment of torture survivors as clinicians are inclined to prioritise direct services to clients over research processes. Ethical concerns of differential treatment of clients in control trials (Jaranson & Quiroga, 2011; Stammel et al., 2017), the expense of scarce resources of rehabilitation programmes (Bandeira, 2013), and generalisability of study results (Pérez-sales, Witcombe, & Otero Oyague, 2017) are among the challenges of outcome studies.

The few experimental or quasi-experimental designs on torture survivors are usually affected by small sample sizes, the lack of control groups (Jaranson & Quiroga, 2011) and instruments with limited validity and reliability often focused only on improvement in PTSD and MDD (Jaranson & Quiroga, 2011). Meta-analyses of randomised control trials illustrate improvements of generally small effect sizes in PTSD and depression when using Cognitive Behavioural Therapy (CBT) and Narrative Exposure Therapy (NET), with moderate improvement on follow-up (Patel et al., 2014). However, exceptional experimental studies do exist, with substantial improvements found using the Common Elements Treatment Approach, compared to the less effective Cognitive Processing Therapy (Weiss et al., 2015). Quasi-experimental and outcome research on the rehabilitation of torture survivors provides further support for CBT (Halvorsen & Stenmark, 2010; Neuner et al., 2010) and NET (Dibaj, Overaas Halvorsen, Edward Ottesen Kennair, & Inge Stenmark, 2017; Hansen, Hansen-Nord, Smier, Engelkes-Heby, & Modvig, 2017), culturally tailored health promotion intervention (Berkson, Tor, Mollica, Lavelle, & Cosenza, 2014) and educational groups (Phaneth, Panha, Sopheap, Harlacher, & Polatin, 2014). Furthermore, the literature reviewed indicates a strong prevalence of European and North American studies on the rehabilitation of torture survivors, with few outcome studies based in Africa. There is clear need for scientific/ experimental research in this area of work in an African context.

The CSVR multi-modal framework for the psychosocial rehabilitation of individual survivors of torture

Given the dire contextual realities in which many torture survivors live, research on the effectiveness of treatment frameworks needs to include psychological and social health as consequences of torture (Patel, Kellezi, & Williams, 2014) in addition to the usual consequences of PTSD and MDD (Bandeira, 2013; Higson-Smith, 2013). Accordingly, the Centre for the Study of Violence and Reconciliation (CSVR) developed a multi-modal guiding framework for the rehabilitation of individual torture survivors that takes into account their lived realities of continuing traumas and ongoing daily stressors (Bandeira et al., 2013).

The development of the multi-modal CSVR model, hereafter referred to as the CSVR framework, was based on a literature search, analysis of intervention process notes of CSVR clinical staff, and a Delphi process for expert consensus on the most severe impacts of torture and the most appropriate methods of torture intervention in a South African context. There was consultation between the research and clinical teams on the categorisation of the impacts, their assessment and the most appropriate intervention approaches. As a result, the CSVR framework comprises the 18 most severe impacts of torture (14 after grouping the impacts) in contexts such as those found

in South Africa, and the most appropriate intervention strategies associated with each (Table A - 1, numbered alphabetically per area). Aspects of trauma-focused CBT (TFCBT), NET, dialectical behavioural therapy, supportive therapy, problem solving and solution-focused therapy underpin therapeutic interventions in the framework, with an emphasis on empowerment. As such, the framework is considered to be multi-modal and informed by mutiple theories.

Many centres adopt a multi-disciplinary, multi-modal, or "common-sense" approach to psychosocial interventions (Pérez-sales et al., 2017) in which the therapist chooses from different modalities according to the needs of the torture survivors. These approaches provide a more meaningful personalisation of the survivors' needs, which together with a clear therapeutic relationship and culturally tailored goals, may be more appropriate than a rigid "one-size-fits-all" therapeutic model. While there are several multi-modal treatment approaches for assisting torture survivors (Drozdek, 2015; Stammel et al., 2017), the CSVR framework offers clearly articulated therapeutic guidance relevant to South African and developing contexts. For example, it provides clear outlines for the role of clinicians in attending to the therapeutic needs of clients, and for the "core business" of the CSVR clinical team, both essential therapeutic elements for maintaining therapeutic boundaries, empowering clients and increasing their resilience. Although it is assumed that what the client brings to therapy will be the focus of the session, the CSVR framework provides guidelines on how to assist clients when certain needs arise, for example:

- Lack of safety, repeated victimisation and high levels of violence in a South African context:
  Given the reality of unsafe circumstances, it may be appropriate that clients' reactions include paranoia and hypervigilance. The clinical approach outlined in the framework uses reality testing, dealing with perceived threats, safety planning, skills development and symptom management to assist clients to reduce repeated victimisation and increase their skills to ensure their continued safety.
- Continuing traumas while dealing with past traumas and torture experiences:
  The framework provides guidelines on how clinicians may help clients understand their reactions to past traumas and how these reactions relate to their responses to the ongoing traumas that may affect them.
- Managing relationships with service providers, family members and community members:
  The framework provides guidelines on how clinicians may assist clients to deal with their emotional reactions to traumas, and to build the social capital necessary to maintain relationships and obtain services, for example, medical and legal assistance or documentation from the Department of Home Affairs.

Research design

The design of the current research is described as quasi-experimental. It comprises two groups of participants, both groups observed over six months but differentiated according to when their participants approached the Centre, when they commenced treatment with the CSVR framework, and the duration of treatment based on the CSVR framework (Figure 1). The 'treatment' group comprised clients who came for counselling between July 2014 and December 2015 and were treated based

on the CSVR framework for six months. The 'comparison' group comprised clients who came for counselling at the Centre between January and June 2014 and were placed on a 3-month 'Waiting list' condition before commencing three months of treatment based on the CSVR framework.

Psychological wellbeing and functioning were measured three times: participants in the treatment group were measured before the start of the CSVR intervention treatment (T1), three months after the start of CSVR framework treatment (T2), and after a further three months of the CSVR framework treatment (T3); participants in the comparison group were measured before the start of a 3-month waiting period (T1), at the end of the 3-month waiting period (T2), and then three months after the start of the CSVR framework treatment (T3) (see Figure 1).

Written informed consent was obtained from all participants. Ethical clearance was provided by an internal CSVR ethics committee as well as by external experts in the violence and/or torture field, including a lecturer at a Johannesburg-based university and two partners working at international NGOs providing services to survivors of torture. This approach to ethical clearance was necessary as there is no overarching national ethics body in South Africa, and CSVR is not affiliated with a university.

Hypotheses

As the treatment group received specialised counselling for the first three months and the comparison group received less specialised communication (as part of the waiting list protocol) for their first three months, it was hypothesised that there would be greater improvement in the psychological and functioning measurements from T1 to T2 for the treatment group than for the comparison group. Secondly, it was hypothesised that there would be greater improvement in the psychological and functioning measurements from T1 to T3 for the treatment group than for the comparison group, as the treatment group received treatment based on the CSVR framework for six months, while the comparison group received this treatment for three months only following the 3-month waiting list condition.

Methods

Procedure

The treatment group received treatment based on the CSVR framework for six months; the comparison group received an initial 3-month waiting condition before receiving treatment based on the CSVR framework for three months.

In the 3-month waiting condition, a clear waiting list management took place. A trained trauma professional phoned clients in the comparison group every two weeks to check that they still wanted to come for counselling, and to refer clients for medical, legal and humanitarian assistance if necessary. This condition compared with clients who went straight into treatment using the CSVR framework (see The CSVR multi-modal framework for the psychosocial rehabilitation of individual survivors of torture, on page 37). Emergency cases in both groups (clients experiencing psychosis, who were suicidal or other emergencies) were contained and referred for psychiatric assistance at a local hospital, or for medication from the consultant psychiatrist at the CSVR.

Baseline measures were carried out using the same instrument at the start of the CSVR treatment condition of the treatment group, and at the start of the waiting time condition of the comparison group (T1). A

second set of measures was carried out three months after commencement of the CSVR condition of the treatment group, and three months after the start of the waiting time condition of the comparison group (T2). A third set of measures was carried out three months after the second set of measures, i.e. six months after commencement of the CSVR condition of the treatment group, and three months after commencement of the CSVR condition of the comparison group (T3) - see Figure 1.

Every two weeks, clinicians participated in supervision sessions which focused

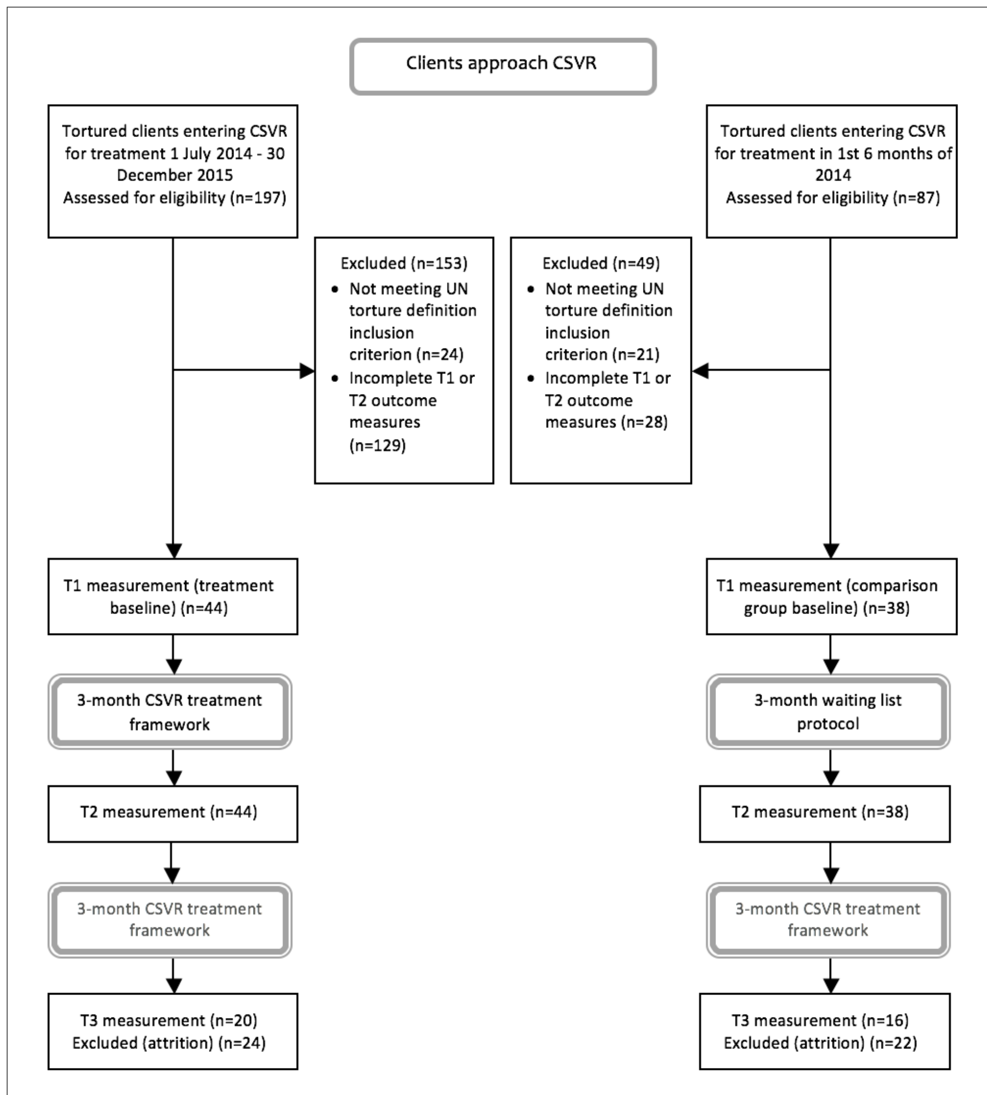

Figure 1: *Study procedure*

both on fidelity to the framework as well as guidance with therapeutic concerns. Supervisors ensured that clinicians followed the framework and concurrently documented which aspects of the framework were utilised using a fidelity checklist. Any difficulties with the implementation of the framework were discussed with the researchers and indicated in the fidelity checklist.

Participants
All participants were selected according to the 1985 UNCAT definition of torture (United Nations General Assembly, 1985) and were over 18 years old. No substantial historical events were noted for the 6-month period that separated the groups.

Participants in the treatment group: The participants in the treatment group were selected from clients who approached the CSVR between 1 July 2014 and 30 December 2015. Over this period, 197 clients were screened, and 24 clients excluded based on the UN torture definition, and a further 129 clients excluded due to incomplete T1 or T2 outcome measures. Thus 44 clients had completed both their baseline assessment and a three-month follow-up and were included in the treatment group. Of this group, 20 completed their six-month follow-up and were included in the follow-up study (Figure 1).

Participants in the comparison group: The participants in the comparison group were selected from clients who approached the CSVR from January to June 2014. Over this period, 87 clients were screened, 66 of whom met the inclusion criteria for the waiting list group, with 21 excluded as they had not experienced torture according to the UN torture definition. A further 28 clients were then excluded as they had not completed a follow-up assessment, leaving 38 clients as participants in the comparison group. These 38 clients had completed a comparison (waiting list) baseline (T1), were included in the waiting list group, and had also completed a treatment baseline (T2). At T3, 16 participants from this group remained, having completed the waiting list baseline, treatment baseline and 3-month follow-up assessment, and these 16 were included in the follow-up study (Figure 1).

Assessment measures: The assessment tools used for all clients at T1, T2 and T3 included the Harvard Trauma Questionnaire (HTQ) measuring posttraumatic stress disorder (PTSD), clients' self-perception of functioning and overall trauma (Harvard Program in Refugee Trauma, 1992), the Hospital Anxiety and Depression Scale (HADS) measuring anxiety and depression (Zigmond & Snaith, 1983), the De Jong Gierveld Loneliness Scale measuring clients' emotional loneliness and social loneliness (de Jong Gierveld & Van Tilburg, 2006), the number of areas of pain in the body,[2] and management of aspects of functioning.[3] Reliability measures are presented in Table A - 2.[4]

All assessments were administered by trained psychologists or social workers. Translation through interpretation was

2 The total number of areas of pain was based on the areas of pain in the body pointed out or indicated verbally.

3 For management of aspects of functioning, four Likert-type scaled questions were adapted from the International Classification of Pain and Disability (ICF) (WHO, 2001): Family-related stressors, External stressors (excluding family-related stressors), Managing situations that made the client angry, and Psychological or emotional functioning. Scale responses ranged from managing very poorly, to managing very well.

4 As Cronbach's coefficient α is correlated with the number of items in the scale, average inter-item correlations are also presented as their values are independent of scale length (Table A - 2).

provided to clients in the main languages of clients who come to the clinic. These include French, Swahili, Amharic, Somali and Lingala. All interpreters were trained on the assessment tools.

Analysis methods: Initially the baseline (T1) psychological and functioning measurement means of the treatment and comparison groups were compared using t tests and Cohen's d effect sizes, and categorical variables compared via the Chi square test. Thereafter the mean changes of the two groups were compared for the first three months (T1 to T2) and then for the six month period (T1 to T3) via mixed analysis of variance (ANOVA).[5] In both cases, the ANOVA interaction effects were examined for evidence of a significant differential pattern in the mean scores across the time periods depending on the group, and partial eta-squared effect sizes were used as measures of the strength of differences. Where necessary, the Scheffé *post hoc* test was used to locate significant differences between means. In view of the multiple violations of the assumptions of the mixed ANOVA analyses, the conservative non-parametric Wilcoxon signed-ranks test was used on the separate groups. In addition, the odds ratio was used to indicate effect sizes for the individual groups, and for assessing the odds of improvement in the treatment group relative to the comparison group.[6]

Finally, *post hoc* analyses were used to examine the effects of the higher than expected attrition rate of respondents of the two groups who dropped out of the study after T2, i.e. during the 3-month counselling period between T2 and T3. This comparison was deemed necessary to examine whether a systematic bias may have been added to the data at T3, should the participants who left the comparison group after T2 differ from the participants who left the treatment group after T2. Such a situation would bias the samples and the results of the T1-T3 comparison relevant to the second hypothesis. This analysis was a simple examination of the demographics, as well as of the direction of the mean differences for each scale from T1 to T2 for the participants in each group who dropped out after T2. No other *post hoc* analyses on the results are presented.

Results

Table 1 shows details of the participant characteristics for both groups. Approximately half of the participants were male, fewer than 10% were South Africans, and the dominant groups were from Congo (DRC), Ethiopia and Somalia. Over half were living with a partner, spouse, family member or friend, approximately 80% were either asylum seekers or refugees, and fewer than half of the participants of each group had experienced torture within the past year in each group (a third of the comparison versus 39% of the treatment group). Before the torture, 5% or fewer were unemployed whereas approximately three-quarters or more were unemployed at the start of the study. The ages of the participants ranged from 18 to 72 years, with mean age in the mid-thirties (*M*=36.20 years, *SD*=10.35 years for the treatment group, and *M*=34.82 years, *SD*=8.68 years for the comparison group). The treatment group had a higher

5 Ideally, mixed multivariate Analyses of Variance (MANOVA) would be computed on the components of the scales to detect multivariate response patterns, while controlling the family-wise Type 1 error rate with greater power to detect differences. However, the sample sizes were small, and in all instances, assumption violations of the multivariate analyses mitigated against the MANOVA tests.

6 This exploratory approach was undertaken whilst recognising that the family-wise Type 1 error increases with multiple statistical tests.

Table 1: *Demographics of treatment and comparison groups*

Demographics		Treatment group (n=44)		Comparison group (n=38)		
		n	%	n	%	p^
Gender	Female	22	50%	16	42%	0.47
	Male	22	50%	22	58%	
Nationality	Burundi	2	5%	1	3%	0.98
	Congolese (DRC)	15	34%	13	34%	
	Eritrean	0	0%	4	11%	
	Ethiopian	8	18%	13	34%	
	Somali	12	27%	3	8%	
	South African	1	2%	3	8%	
	Zimbabwean	2	5%	0	0%	
	Other *	4	9%	1	3%	
Marital status	Currently married	24	55%	8	21%	0.01
	Divorced/separated	3	7%	4	11%	
	Never married	13	30%	18	47%	
	Widowed	4	9%	7	18%	
	Missing	0	0%	1	3%	
Currently living	Living alone/strangers/shelter	14	32%	7	19%	0.14
	Living with family/ children	16	36%	5	13%	
	Living with friends	7	16%	10	26%	
	Living with spouse/ partner	4	9%	4	11%	
	Other	0	0%	4	11%	
	Missing	3	7%	8	21%	
Legal SA status	Asylum seeker/ refugee	37	84%	30	79%	0.78
	Citizen	2	5%	3	8%	
	Undocumented	4	9%	1	3%	
	Missing	1	2%	4	11%	
Pre-torture employment	Minor/ student	5	11%	5	13%	0.83
	Unskilled labour/ semi-skilled	22	50%	21	56%	
	Skilled/ professional	14	32%	10	26%	
	Unemployed	2	5%	1	3%	
	Missing	1	2%	1	3%	
Current employment	Minor/ student	0	0%	2	5%	0.39
	Unskilled labour/ semi-skilled	8	18%	3	8%	
	Skilled/ professional	3	7%	2	6%	
	Unemployed	32	73%	31	82%	
	Missing	1	2%	0	0%	

Demographics		Treatment group (n=44)		Comparison group (n=38)		
		n	%	n	%	p^
Education	No schooling	4	9%	1	3%	<.001
	Completed primary	10	23%	1	3%	
	Completed secondary	10	23%	25	66%	
	Tertiary/ postgraduate	14	32%	9	24%	
	Missing	6	14%	2	5%	
Time since torture	Less than a month	1	2%	3	8%	0.84
	2-6 months	6	14%	4	11%	
	7 months-1 year	10	23%	5	13%	
	2-5 years	13	30%	9	24%	
	6-10 years	7	16%	10	26%	
	More than 10 years	7	16%	0	0%	
	Missing	0	0%	7	18%	

^ categories were combined for Chi square calculation when expected frequencies < 5
* Angolan, Ugandan, Rwandan, Swazi, Zambian
Note that rounding error occurs where percentages do not sum to 100%

percentage of married participants than the comparison group (55% versus 21% respectively), and fewer of the treatment group had completed secondary or tertiary education (55% versus 90%).

In addition to the research selection criterion of torture experiences (United Nations General Assembly, 1985), the participants had experienced various other forms of trauma. On average, participants had experienced approximately five additional forms of trauma (M=4.96; SD=2.47), with most participants having witnessed trauma and experienced assault.[7] No significant difference in the number of forms of trauma experienced was observed between the groups (t(80)=1.75, p=.08, Cohen's d=0.39, M=4.52 and 5.47, SD=2.19 and 2.73 for the treatment and comparison and groups respectively). Similarly, the odds of experiencing any type of trauma in one group are in general not significantly greater than the odds in the other group, based on Fisher's Exact Probability test (the trauma type of mugging was the only exception, see Table 2). It is acknowledged that experiences of what is considered to be traumatic are subjective, and that cumulative trauma plays an important role in survivors' distress (Başoğlu, 2009).

The baseline (T1) scores of the two groups were examined prior to comparing the changes in the means of the psychological and functioning measures across the first three months (T1 to T2) for each group.[8] The t test results show

[7] The current study does not focus on multiples of any single type of traumatic event since this data is not collected. Thus, the cumulative traumas experienced is likely to be higher.

[8] Levene's test of the assumption of homogeneity of variances showed that 7 of the 13 t test

Table 2: *Trauma types experienced by respondents of the comparison and treatment groups*

	Treatment group (n=44)		Comparison group (n=38)		Odds ratio: Treatment/ Comparison	
					OR	Fisher exact test (p)
	n	%	n	%		
Torture/ CIDT	44	100%	38	100%	-	-
Witness to trauma	31	70%	30	79%	0.64	0.27
Assault	25	57%	28	74%	0.47	0.09
Bereavement/ traumatic bereavement	16	36%	21	55%	0.46	0.07
Armed robbery	18	41%	18	47%	0.77	0.36
Xenophobia	12	27%	17	45%	0.46	0.08
Mugging	5	11%	13	34%	0.25	0.02
War	15	34%	13	34%	0.99	0.59
Hostage/ kidnapping/ abduction	9	20%	8	21%	0.96	0.58
Rape/ attempted rape/ sodomy	14	32%	6	16%	2.49	0.08
Motor vehicle accident	2	5%	5	13%	0.31	0.16
Hijacking	5	11%	5	13%	0.85	0.53
Relationship/ domestic violence	2	5%	5	13%	0.31	0.16

that three of the four initial coping or managing scores of the treatment group are significantly better than those of the comparison group, and the PTSD, trauma, anxiety and depression scores are lower (α=.05). The effect sizes of these differences are moderately large (Cohen's *d* with magnitude at least .5), with the exception of the strong difference in depression scores of the two groups ($t(79)=3.36$, $p<.001$, M=1.54 and 1.97, SD=0.62 and 0.52 for the treatment and comparison groups respectively). Thus, the initial psychological health and functioning of the treatment group appears somewhat better than that of the comparison group.

comparisons were adjusted to accommodate heterogeneous variances (the three loneliness scales, external stressors, PTSD, the anxiety and depression scales).

Comparison of the changes in the psychological and functioning measures across the first three months (T1 to T2) for each group: Based on the direction of the differences between each of the T1-T2 pairwise means for the treatment and the comparison groups considered separately, all 13 of the pairwise differences of the treatment group are in the ideal direction of improved psychological health and functioning, compared to 10 of the pairwise differences of the comparison group (the exceptions being the indicators of social and total loneliness, and the HTQ scale of functioning). These T1-T2 effects do not differ significantly between the groups as none of the interaction effects of mixed ANOVA comparisons are significant (α=.05). For both groups, the results of the T1-T2 effects are moderately strong for anxiety, depression and the number of areas of pain, with other effect sizes weak (partial eta squared values of .05 or lower). However, as Levene's test shows homogeneity of variance

assumption violations for the T1 or T2 scores of 7 of the 13 ANOVA comparisons, the T1-T2 comparisons of the separate groups were re-examined using the conservative non-parametric Wilcoxon signed-ranks test with Z score conversion for large sample sizes and asymptotic significance, and the odds ratio (OR) used to indicate effect size (Table 3).

The Wilcoxon results of the treatment group show seven significance changes (emotional and total loneliness, external stressors, functioning, trauma, anxiety and areas of pain), all with odds ratios greater than 1 (Table 3). By contrast, there are two significant T1-T2 differences (depression and areas of pain) in the comparison group. For the treatment group, the odds of improvement relative to non-improvement are greater (odds > 1) for 9 of the indicators of psychological health and functioning, compared to 5 indicators for the comparison group. Furthermore, ratios of the odds for the treatment group relative to the comparison group computed per indicator variable show OR values greater than 1 for most indicators (emotional and total loneliness, the coping indicators of external stressors and psychological difficulties, the HTQ scales of PTSD, functioning and trauma, the HADS anxiety scale, and areas of pain - Table 3). Thus, for these indicators, members in the treatment group improved their psychological health and functioning from T1-T2 more than members in the comparison group did. However, based on the Fisher Exact Probability test (1-tailed, α=.05), the odds ratios are only significant for the HTQ functioning scale and for the HADS anxiety scale. The OR value of 2.49 for functioning means that the clients in the treatment group improved their functioning 2.49 times more than the clients in the comparison group did; the OR value of 2.61 for anxiety means that the clients in the treatment group reduced their anxiety 2.61 times more than the clients in the comparison group did.

There thus appears to be partial support for the expectation of greater improvement in psychological health and functioning from T1 to T2 for the treatment group relative to the comparison group. We therefore conclude, conservatively, that there is insufficient statistical evidence for overall support of the first hypothesis of the research and we instead discuss the significant T1-T2 differences on the individual indicators, specifically differences on the indicators of functioning and anxiety.

Comparison of the changes in the psychological and functioning measures across the three time periods (T1-T3) for each group: The comparisons from T1 to T3 are based on substantially reduced sample sizes owing to attrition of participants in the two groups after the second set of measures. Under half the respondents remained after T2 (45% or 20 of the 44 participants in the treatment group, and 42% or 16 of the 38 participants in the comparison group).

Based on the mixed ANOVA tests, there is no evidence of significant interaction effects that would show a difference in the changes of scores over time depending on the group, and the magnitude of all effect sizes, as measured by partial eta squared values, are negligible to weak. However, significant main effects across time, in the direction of increased psychological health and functioning, were found for coping with anger, the HTQ, the HADS, as well as for number of areas of pain. In particular, based on *post hoc* Scheff**é** comparisons, measures of self-perception of functioning, depression and number of areas of pain improved significantly from one time to the next. As for the T1-T2 comparisons, the

Table 3: *Wilcoxon signed-rank test and odds ratio effect sizes for T1-T2 repeated measures for treatment and comparison groups*

Indicators		Treatment group (n=44)				Comparison group (n=38)				Odds ratio: Treatment/ Comparison	
		Z	p ^		Odds ^^	Z	p ^		Odds ^^	OR	Fisher exact test (p)
Connection to others	Emotional loneliness	2.06	0.04	*	1.32	0.10	0.92		1.06	1.25	0.40
	Social loneliness	0.98	0.33		1.16	0.13	0.89		1.24	0.94	0.53
	Total loneliness	2.11	0.03	*	1.29	0.03	0.98		1.09	1.18	0.44
Coping or managing	Angry situation	1.43	0.15		0.83	0.49	0.63		0.84	0.98	0.58
	Family related stressors	0.59	0.56		0.67	1.59	0.11		0.87	0.77	0.38
	External stressors	2.06	0.04	*	1.06	0.07	0.94		0.69	1.54	0.23
	Psychological difficulties	1.34	0.18		0.97	0.58	0.56		0.79	1.23	0.42
Harvard trauma questionnaire	PTSD	1.70	0.09		1.21	0.27	0.79		1.10	1.10	0.52
	Functioning	2.57	0.01	*	1.71	0.39	0.69		0.68	2.49	0.04 *
	Trauma	2.28	0.02	*	1.56	0.02	0.99		0.79	1.97	0.10
Hospital anxiety and depression scale	Anxiety	2.83	0.01	**	1.56	0.48	0.63		0.60	2.61	0.04 *
	Depression	0.99	0.32		0.87	3.17	0.01	**	1.79	0.49	0.10
Pain	Number of areas of pain	2.44	0.01	*	1.23	2.26	0.02	*	0.94	1.31	0.36

* $p < .05$; ** $p < .01$
^ denotes the asymptotic significance value (2-tailed) for Wilcoxon Z for large samples
^^ tied changes were randomly distributed in equal proportions to positive and negative changes, rendering the odds ratio more conservative than the Z score

T1-T3 comparisons were re-examined using the conservative non-parametric Wilcoxon signed-ranks test on the separate groups, owing to violations of ANOVA assumptions.

For both groups, most of the outcome means changed in the direction of improved psychological health and functioning, exceptions being social loneliness and coping with external stressors. However, counter-intuitively, the results of the Wilcoxon signed-ranks tests on the T1-T3 comparisons computed on the separate

groups revealed more significant T1-T3 improvements for the comparison group than for the treatment group. For the comparison group, 7 of the 13 outcome measures improved significantly from T1 to T3 (α=.05), (coping with anger, the HTQ measures of PTSD, functioning and trauma, the HADS measures of anxiety and depression, and areas of pain), compared to only 1 of the 13 outcome measures (areas of pain) for the treatment group. Nevertheless, none of the odds ratios computed via the ratio of odds for the treatment and comparison groups per indicator variable are significant based on the Fisher Exact Probability test (α=.05). Thus, although there are more significant T1-T3 improvements in the comparison group than in the treatment group, the magnitude of these improvements is not sufficient to render the odds of the improvements in the comparison group significantly greater than the odds of the improvements in the treatment group.

However, the counter-intuitive Wilcoxon test results on the T1-T3 comparisons, whatever their magnitude, need to be addressed. A possible explanation is presented in a *post hoc* set of comparisons using a basic analysis of attrition after T2.

Comparison of participants in each group who dropped out after T2: Based on the Chi square test for between-group comparisons, there is no evidence of significant differences in the demographic characteristics of participants who dropped out of the treatment group after T2 versus those who dropped out of the comparison group after T2. However, comparison of the T1-T2 changes in the psychological health and functioning measures of these two groups suggests that there may be a differential pattern of attrition between the groups.

In Table 4, the means for each scale are presented for those members of the treatment group and the comparison group who left the programme after the second set of measures.[9] The outcome measures with T1-T2 changes in the direction of improved psychological health and functioning are indicated with a tick ( ).[10]

The members of the treatment group who left the programme after T2 had improved their mean scores on all 13 measures at T2. By contrast, the members of the comparison group who left the programme after T2 had improved their mean scores on fewer than half (6 out of 13) of the measures (social and total loneliness, family related stressors, psychological difficulties, depression and areas of pain), a significant difference in percentages (p=.002). Thus, participants in the treatment group who left the programme at T2 had improved their overall psychological health and functioning, whereas the participants in the comparison group who left the programme at T2 had not shown this overall level of improvement. After T2, the treatment group appears to have been weakened by the loss of members who had improved health after three months, while the comparison group had not lost overall improvers. This differential pattern of attrition between the groups may explain the counter-intuitive findings of greater improvement from T1-T3 of the remaining members of the comparison group compared to the remaining members of the treatment group.

9 As tests of significance are reserved for a future in-depth article on attrition, this analysis does not indicate significance or effect size.

10 In each comparison, the direction of the means is based on the difference in the pairwise means of individuals.

Table 4: *Mean scores from T1-T2 of participants who left the comparison and treatment groups after T2*

			Participants who left after T2:			
			those who left from the treatment group (n=24)		those who left from the comparison group (n=22)	
Indicators			Mean	T1-T2	Mean	T1-T2
Connection to others	Emotional loneliness	T1	2.83	ü	2.48	
		T2	2.52		2.50	
	Social loneliness	T1	2.87	ü	2.52	ü
		T2	2.75		2.32	
	Total loneliness	T1	5.70	ü	5.00	ü
		T2	5.17		4.82	
Coping or managing	Angry situation	T1	2.61	ü	2.14	
		T2	2.67		2.00	
	Family related stressors	T1	2.23	ü	1.60	ü
		T2	2.43		2.21	
	External stressors	T1	1.87	ü	1.90	
		T2	2.33		1.86	
	Psychological difficulties	T1	2.35	ü	2.10	ü
		T2	2.74		2.24	
Harvard trauma questionnaire	PTSD	T1	2.54	ü	2.76	
		T2	2.33		2.91	
	Functioning	T1	2.48	ü	2.60	
		T2	2.25		2.82	
	Trauma	T1	2.50	ü	2.67	
		T2	2.28		2.83	
Hospital anxiety and depression scale	Anxiety	T1	1.71	ü	1.86	
		T2	1.31		1.89	
	Depression	T1	1.57	ü	1.89	ü
		T2	1.28		1.63	
Pain	Areas of pain	T1	1.96	ü	3.23	ü
		T2	1.83		2.32	

Discussion

The research was designed to test the efficacy of the CSVR psychosocial intervention framework using a sample of torture survivors, almost all of whom were asylum seekers, refugees and undocumented persons in a South African environment filled with daily stressors and continuing traumas. These individuals were found to have clinical baseline scores on PTSD, depression, anxiety and low levels of functioning, which may be explained, at least in part, by their history of torture which severely impacts psychological and psychiatric wellbeing (Bandeira et al., 2010; Higson-Smith, 2013; McColl et al., 2010; Patel et al., 2014; Quiroga & Jaranson, 2005). The CSVR framework is designed to address the complexity of the past traumas exacerbated by contextual realities of a hostile South African environment (Bandeira, 2013; Bandeira et al., 2013).

Efficacy of the CSVR framework

The assessment of the efficacy of the CSVR framework was based on the expectation of a long-term differential effect when an initial three-month waiting list condition was included, compared to when clients entered straight into treatment. The findings of the research did not provide clear support for the hypotheses of greater improvement in the psychological health and coping indicators of the CSVR treatment group than the waiting list comparison group. However, the results are complex and less than clear.

The data gathered reflect the challenges of attempting rigorous quasi-experimental quantitative research in the context of torture, using established measurement scales that were found to have lower than desirable reliability for our sample, and data that do not meet all the stringent assumptions required for parametric statistical analyses. Attrition created a further problematic effect in our study as the treatment group clients who dropped out of the study after T2 showed greater overall improvement in their psychological health and coping from T1 to T2 than the comparison group clients who dropped out of the study after T2. This differential attrition effect may have biased the longer-term comparison of the mean scores from T1 to T3 (the second hypothesis of the study), creating paradoxical results. Thus, our main finding pertaining to the hypotheses on the efficacy of the CSVR framework is that we have not found sufficient evidence to warrant the efficacy of the framework, owing mainly to several severe challenges inherent in research of this nature. It may be fairer to conclude that the research results on the efficacy of the framework are inconclusive.

However, there are several interesting results in the research. Firstly, improvement in the psychological wellbeing and functioning of the clients of both groups from T1 to T3 occurred despite the context of the lack of safety and continuing daily traumas of the torture survivor clients. This result is consistent with the CSVR framework's prioritisation of empowerment, problem solving and trauma-related therapy. Secondly, after three months of treatment under the CSVR framework, there are indications of clients' improved connection to others. This result is encouraging within the inherent mistrust, isolation and fear as consequences of torture (Quiroga & Jaranson, 2005). Building trusting relationships after a torture experience should be viewed as a long-term therapeutic goal (as per the approach of the CSVR), as torture often results in the annihilation of interpersonal trust (Bandeira, 2013;

Bandeira et al., 2013). Further research is warranted on the prioritisation of a family and group model or framework in the South African context to mitigate the isolation felt by the torture survivor, and the best way to reintegrate the torture survivor into trusting familial, group and community relationships. Thirdly, after three months in therapy, clients appear to deal better with their past traumas and torture experiences in the context of unsafe situations, specifically in terms of increased functioning and reduced anxiety levels.

We move now to discuss the main challenges of scientific research on trauma, based on the lessons of this study.

Challenges of research on trauma rehabilitation

It is essential to conduct thorough research on the outcomes of torture rehabilitation programmes that could improve the quality of the services and care to torture survivors, contribute to professional development in the field, and empower torture survivors (Jaranson & Quiroga, 2011). Although quantitative studies involving the principles of randomised experimental design, sound sampling techniques, objective measures and rigid statistical analysis are scientific ideals, such criteria are, in reality, unattainable in the complex and challenging world of torture rehabilitation with its thorny ethical considerations and limitations. Ethical compliance precludes randomised control group designs; instead, researchers of torture attempting scientific studies are restricted to quasi-experimental or outcome designs with compromised internal validity.

We present the consequences of these research design restrictions in our research. Although there was no apparent reason for the groups to differ at baseline, and no outstanding historical events occurring in the time interval between the start of the CSVR treatment framework for the two groups, we found that the psychological health and functioning of members of the treatment group was somewhat better than that of the comparison group at baseline testing. The groups also differed on marital status and education levels.

In addition to these baseline differences between the groups, the nature of the comparison group condition, i.e. the waiting list protocol, was not a true placebo comparison as it offered a level of support to clients in the comparison group. The comparison group clients received support in telephone calls every second week, referrals offered for legal, medical or humanitarian aid, and assistance offered if they were psychotic, suicidal or required other emergency assistance. After three months of receiving this level of support, these waiting list clients may well have felt somewhat better on a psychological and functioning level than they had at baseline. Indeed, the results of the comparison group clients showed significant improvement in their depression scores. However, despite the possible confounding effect of the waiting list condition, it is an ethical necessity in the context of the vulnerability of torture survivors.

High levels of overall attrition are expected in this population due to the transient nature of tortured refugees in South Africa who often need to move to find employment or accommodation, or due to safety concerns. Furthermore, many refugees and asylum seekers use the CSVR for introduction to legal, medical or humanitarian aid, and then terminate contact with the centre. Although previous CSVR reports indicate an attrition rate of 21-44% of clients annually (Dix-Peek, 2012a, 2012b), the current research indicates a much higher rate (75% or 129 of 173 clients in the treatment group, and 42% or 28 of

66 clients in the comparison group).[11] The high rate of attrition from screening to T1, referred to here as overall attrition, for both groups, but particularly for the treatment group, is a clear limitation of the current research. Contextual challenges of staffing changes within CSVR may have contributed to clients not completing their baseline T1 or follow-up T2 assessments and the consequent stark overall attrition for the treatment group. CSVR has attempted to mitigate the high overall attrition through ensuring that clients receive transport money to and from the office, conducting drop-out reports for a better understanding of why clients stop coming for counselling, providing ongoing training with CSVR clinicians and monitoring and evaluation staff, and ensuring adherence to the monitoring and evaluation system.

The high rate of attrition of clients after the initial three months of the programme is also of great concern for the CSVR rehabilitation endeavours as over half of the clients left the study after T2 (55% of the treatment group members and 58% of the comparison group members). A rudimentary *post hoc* attrition analysis of the means of the outcome measures suggests that different patterns of attrition in the comparison and treatment groups may explain the counter-intuitive results from T1-T3. The comparison group clients who left the programme at T2 showed limited improvement in their psychological health and functioning, while the treatment group clients who left the programme at T2 showed improvement on all indicators. While attrition of participants was not planned, losing participants from the treatment group who improved their health may be evidence of the preliminary success of the CSVR framework, although the sustainability of the improvement is unknown.

The topic of attrition is planned as part of a future journal article.

Conclusion

The CSVR psychosocial framework for the rehabilitation of torture survivors provides a set of therapeutic guidelines in the context of daily stressors, continuing traumas, past torture and trauma events. It is also a framework designed for developing country settings where survivors live with lack of safety and extreme socio-economic concerns. Thus evidence-based research on the efficacy of this framework is essential as a first step towards investigating its legitimacy as "best practice" for torture survivors in developing countries. However, conducting such research is often not prioritised due to scarce financial and human resources, practitioners who may not recognise the need to prioritise outcome research over the "core" therapeutic and psychosocial work (Bandeira, 2013; Montgomery & Patel, 2011), attrition and small samples sizes, limited academic and research expertise, and ethical concerns (Jaranson & Quiroga, 2011). Our study has aimed to contribute to a detailed understanding of the intricacies and challenges of undertaking psychosocial research in the torture field. It highlights the serious problem of attrition and offers several lessons for future studies.

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[11] These numbers exclude clients who were excluded as they were not tortured according to the UNCAT definition of torture.

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Appendix 1

Table A - 1: *Impacts and intervention strategies used in the CSVR framework*

Area	Impact	Intervention approaches
Current stressors	1. Accommodation difficulties	• Referral • Building assertiveness • Increasing internal locus of control
	2. Concern for employment opportunities	• Referral • Building assertiveness • Increasing internal locus of control
	3. Difficulties with service providers	• Prepare client for possible difficulties • Explore a negative experience • Problem solve • Prepare client for next interaction
	4. Economic difficulties	• Referral • Building assertiveness • Increasing internal locus of control
	5. Loss of status, recognition, position in society	• Psycho-education • Building self-esteem • Addressing guilt • Meaning making and reframing
	6. Pain	• Referral and accessing medication • Skills development • Psycho-education
	7. Repeated victimisation	• Referral • Safety planning — dealing with real threats • Psycho-education • Skills development and symptom management • Reality testing • Dealing with perceived threat
	8. Safety concerns	• Referral • Safety planning — dealing with real threats • Psycho-education • Skills development and symptom management • Reality testing • Dealing with perceived threat

Area	Impact	Intervention approaches
Social / interpersonal difficulties	9. Family breakdown	• Assisting the client with family tracing • Skills development • Psycho-education
	10. Family-related stressors	• Psycho-education • Skills development • Problem solving • Referral • Crisis management
	11. Isolation	• Explore causes and impact of isolation • Develop client's skills in relation to reducing their isolation • Prepare client for possible negative experiences
Psychological responses	12. Anger	• Skills development • Psycho-education • Exploring underlying emotions • Boundary setting
	13. Bereavement	• Emotional expression and dealing with unresolved issues • Meaning making • Integrating rituals / cultural and religious healing practices • Psycho-education
	14. Coping difficulties and stress	• Increasing coping • Problem solving • Skills development • Referral
	15. Distress	• Contain the client and explore cause(s) of distress • Problem solve in a direct and quick solution-focussed way • Skills development • Referral
	16. Intrusions	• Symptom management • Exposure • Psycho-education • Meaning-making
	17. Mood disturbances	• Assessing for suicide • Cognitive behavioural interventions • Psycho-education • Referral for psychiatric assessment and medication
	18. Traumatic responses	• Symptom management • Exposure • Psycho-education • Meaning-making

For the full framework, see Bandeira et al., (2013): http://www.csvr.org.za/images/docs/Other/developing_african_rehabilitation_model_part2_engagment_clinical_team.pdf.

Table A - 2: *Reliability measures for scales based on the literature and the current study*

Scale[12]	Coefficient α from literature	Number of items	Coefficient α from current study	Average inter-item correlations	n
The De Jong Gierveld Loneliness Scale					
Emotional loneliness	.81 - .91	3	.45	.21	79
Social loneliness	.80 - .94	3	.77	.54	78
Total loneliness		6	.69	.29	78
Functioning		4	.69	.37	76
Harvard Trauma Questionnaire PTSD	.96	16	.82	.23	79
Harvard Trauma Questionnaire Self Perception of functioning		24	.89	.26	78
Harvard Total trauma score	.93 - .98				
Hospital anxiety and depression scale: Anxiety	.92	7	.70	.25	80
Hospital anxiety and depression scale: Depression	.88	7	.74	.29	80
Overall	.94				
Pain		8	.75	.27	81

Most scales were found to have acceptable coefficient α reliability, although the reliability of the emotional loneliness scale is inadequate, and the average inter-item correlations of most scales fall short of the required minimum value. As poor reliability reduces the power of statistical tests and generally attenuates effect sizes below their true (population) values, the low to moderate reliabilities of the scales may well have impacted negatively on the results of the study (Kline, 1998).

[12] For a more extensive outline of the De Jong Gierveld Loneliness scale (de Jong Gierveld & Van Tilburg, 2006), Harvard Trauma Questionnaire, and Hospital Anxiety and Depression Scale, contact the authors.

The Chronic Traumatic Stress Framework: A conceptual model to guide empirical investigation of comprehensive treatments for refugees and survivors of torture

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Key points of interest:

- A biopsychosocial framework outlining the physical and psychological impact of traumatic war events, post-migration living stress, and daily hassles in refugees and survivors of torture is proposed.
- We discuss the importance of measurement when implementing biopsychosocial multimodal interventions including the following domains: 1) supportive (community or group connection); 2) psychoeducation and symptom reduction; 3) addressing the trauma narrative; and/or 4) attention to physical health.
- The Chronic Traumatic Stress (CTS) Framework introduced in this article serves as a guide for empirical investigation of outcomes of interdisciplinary treatments beyond a focus on pathology such as that outlined in post-traumatic stress disorder (PTSD).

Abstract

An increasing number of refugees and survivors of torture resettled in the United States are presenting to clinics for treatment related to trauma and post-migration difficulties. Although clinicians experienced in treating trauma with diverse populations may recognize the limitations of a PTSD diagnosis, one of the primary diagnoses received by refugees and survivors of torture remains post-traumatic stress disorder (PTSD). A variety of interventions exist (e.g., supportive, trauma specific, interdisciplinary including physical, social and psychological) for survivors of torture and trauma that move beyond this diagnosis, however, a unifying conceptual model is needed to guide treatment and further the empirical investigation and evidence base in this growing field. In this paper, we propose a broader biopsychosocial framework of the impact of traumatic war events including the measurement of stress related to post migration living difficulties, and daily hassles while highlighting the importance of protective and risk factors. Intervention outcomes emphasize resilience, physical well-being, and mental well-being, along with traumatic stress symptoms. We describe Chronic Traumatic Stress (CTS) as an integrated and unifying framework which provides guidance for the growing number of providers conducting assessment and

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intervention with refugees and survivors of torture. We also highlight that this model is specifically designed for empirical testing.

Keywords: torture, refugees, PTSD, trauma

An overwhelming 65.6 million individuals have been displaced due to war conflict, persecution, and/or unstable political infrastructure contributing to record numbers worldwide (UNHCR, 2018). These refugees, asylum seekers and internally displaced persons often endure severe hardships including torture and other traumatic events (Campbell, 2007); (Porter & Haslam, 2005). Many refugees experience chronic traumatic stressors throughout war, during flight and the resettlement process. Additionally, post migration living difficulties and daily stress have been shown to exacerbate the impact of war related trauma (Miller & Rasmussen, 2010). The complex physical and mental health needs of the growing numbers of resettled refugees often challenge the professional bounds of clinicians and mental health providers. Mental and physical health concerns can be far reaching, affecting extended families and communities within which these individuals are attempting to rebuild their lives. While one of the most commonly studied Western diagnoses is post-traumatic stress disorder (PTSD) (Fazel, Wheeler, & Danesh, 2005; Steel et al., 2009; Weiss et al., 2016), the applicability of assigning traditional, western diagnoses to refugees and survivors of trauma and torture continues to be vigorously debated (Campbell, 2007; Johnson & Thompson, 2008; Marsella, Friedman, & Spain, 1992; Nickerson, Bryant, Silove, & Steel, 2011). Many clinicians providing individual and group interventions recognize these limitations and move beyond the characteristics of the PTSD diagnosis when conducting treatment (Bunn, Goesel, Kinet, & Ray, 2015). Indeed, Miller and Rassmussen (Miller & Rasmussen, 2010) suggest that daily stressors and post migration living difficulties (e.g., lack of housing, poverty, language barriers, discrimination) should be prioritized as the initial focus of mental health treatment for refugees. Furthermore, a recent review of existing interventions for survivors of torture identified three overlapping categories of refugee group mental health intervention currently utilized including: 1) supportive (community or group connection); 2) stage one (psychoeducation and symptom reduction); and 3) stage two (trauma narrative) (Bunn et al., 2015). Similarly, in a rigorous review of psychological treatments of PTSD in adult refugees, Nickerson and colleagues (Nickerson et al., 2011) refer to two contrasting approaches; trauma-focused therapy and multimodal interventions (Nickerson et al., 2011). Another recent review of 88 studies of interventions for survivors of torture and systematic violence concluded that although Cognitive Behavior Therapy, including exposure techniques, has the strongest evidence for reducing mental health symptoms associated with PTSD, Depression and Anxiety, they strongly recommended further research and randomized control trials of other promising interventions including multidisciplinary therapies (Weiss et al., 2016). Collectively, these review articles emphasize the need for greater research addressing varying multimodal treatments. Many broader interventions not only address symptoms related to PTSD and trauma, but also attend to post-migration difficulties, daily stressors, bio-psychosocial factors, acculturation, and human rights atrocities (e.g., (Bunn et al., 2015) and (Nickerson et al., 2011); (Weiss

et al., 2016). A unifying conceptualization for refugee service provision is important when considering scientific investigation of the impact of various interventions on differing outcomes.

As the specialty field of treatment services for refugees and survivors of torture further develops, it is clear that a broad variety of interventions will continue to be provided by clinical communities. Given the complexities of the refugee experience and extensive range of responses, we propose a unifying conceptualization acknowledging the importance of varying clinical interventions. Moreover, the proposed model is intended to foster empirical testing regarding outcomes associated with different treatment modalities. The conceptualization (see Figure 1) is intended to be non-pathologizing, respecting a range of cultural responses (including strengths and resilience), while also acknowledging the ongoing impact of war. The model includes ongoing Chronic Traumatic Stress (CTS) related to war and political conflict and migration, in addition to post migration challenges, and daily stressors. As witnessed by many clinicians, protective and risk factors may moderate the impact of traumatic experiences on the individual embedded in his/her family, community, and culture (Bronfenbrenner, 1992). Outcomes of these traumatic and stressful events include resilience and wellness, along with mental health and physical problems, and trauma specific symptoms. While the established PTSD diagnosis guides treatment for reducing a specific set of symptoms, the proposed conceptualization expands the understanding of sequelae beyond post-traumatic stress symptoms. In this paper, we first present the utility and limitations of the PTSD diagnosis for refugees and survivors of torture. Next, we present the CTS model outlining the psychological and physical sequelae associated with the broader refugee experience. Finally, utilizing the CTS framework, we highlight the existence of multidisciplinary interventions currently incorporated by practitioners and highlight the need for further research.

Utility and limitations of PTSD emphasis

The establishment of Post Traumatic Stress Disorder (PTSD) as a clinical diagnosis provided the mental health community with a platform from which clinicians and researchers could collectively develop empirical frameworks for assessment, intervention and prevention. Heretofore, soldiers, victims of rape and survivors of accidents did not have adequate diagnostic or treatment options. The field of traumatic stress flourished with efficacious treatments (e.g., Prolonged Exposure [PE], Cognitive Processing Therapy [CPT], and Trauma Focused Cognitive Behavioral Therapy [TF-CBT] and provided a framework for mental health services (Cohen, Mannarino, & Deblinger, 2006; Foa & Rothbaum, 2001; Resick, Monson, & Chard, 2016; Resick & Schnicke, 1993). However, the heterogeneity of post-traumatic stress reactions emphasize the problems with assigning a single PTSD diagnosis for the range of responses to trauma (Galatzer-Levy & Bryant, 2013; Herman, 1992). The conceptualizations of Complex-PTSD, Complex Developmental Trauma, and Disorders of Extreme Stress not otherwise specified (DESNOS), collectively attempted to move beyond PTSD as it is delineated by the Diagnostic and Statistical Manual of Mental Disorders (DSM III, DSM IV). These affiliated conceptualizations give

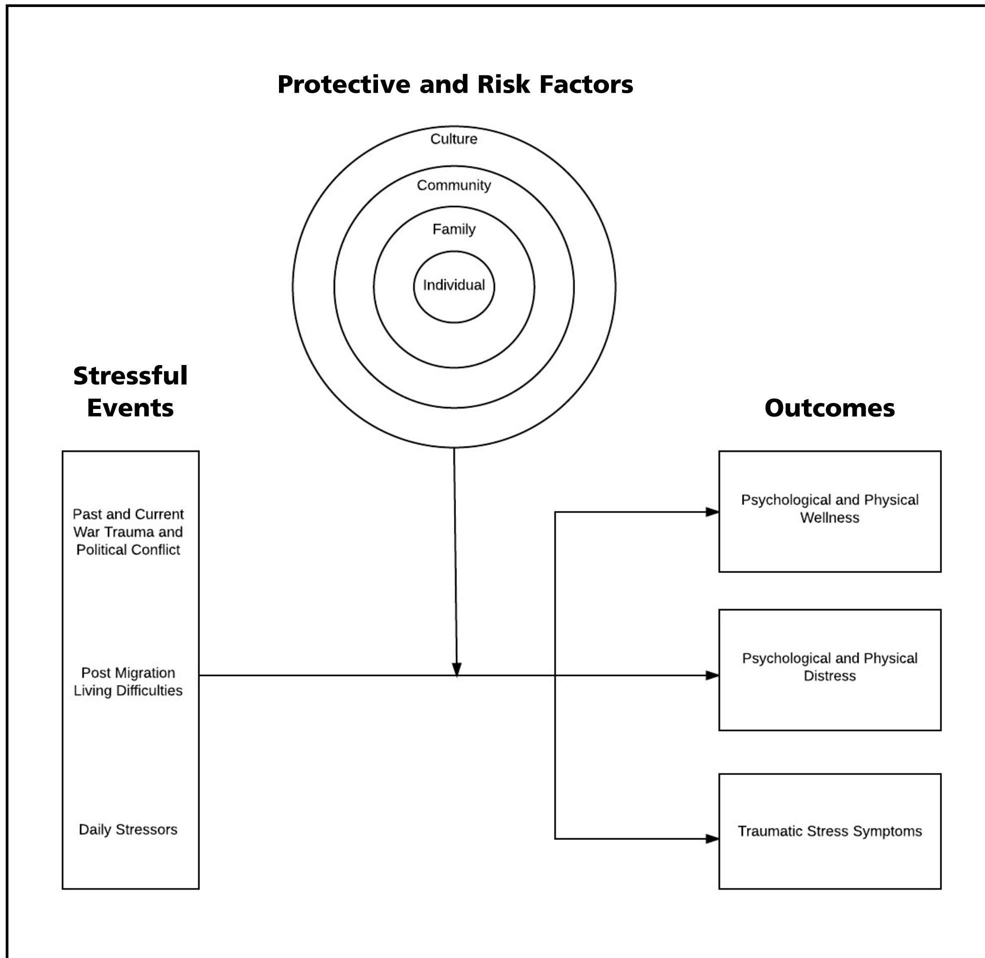
broader recognition to the complexities involved in diagnosing traumatic stress, however, refugees and survivors of torture present unique experiential and cross cultural considerations not fully accounted for by any of these diagnoses (McFarlane & Kaplan, 2012). Additionally, while the DSM 5 PTSD diagnosis requires that an external event(s), such as combat or rape has been experienced, an emphasis is placed on the *reactions* by individuals to these event(s) (Association, 2013). Labeling the human response to war trauma as disordered is problematic, as it shifts blame to the individual and takes the attention off the event(s). This emphasis on pathology implies that there is a correct response and duration of responses to these horrific traumatic events. Moreover, individuals from other cultures may internalize this diagnosis and believe that there is something inherently wrong with them as a result of their experienced trauma.

It has been empirically demonstrated that many refugees and survivors of torture who present with PTSD symptomatology (e.g., flashbacks, intrusive thinking, dissociation), and symptoms associated with depression and anxiety, may sufficiently be treated with trauma focused cognitive behavior therapy treatments with an emphasis on exposure techniques (Nickerson et al., 2011; Weiss et al., 2016). However, as described by a number of authors (Bunn et al., 2015; McFarlane & Kaplan, 2012; Nickerson et al., 2011; Weiss et al., 2016), further research is needed as refugee mental and physical health needs are complex and include concerns far beyond trauma related symptomatology. As such, clinicians are implementing interventions that incorporate functionality, social support, psychoeducation, and behavioral activation in conjunction with trauma specific techniques and attendance to post migration and daily stressors (Bunn et al., 2015). Unfortunately, many of these interventions are not rigorously empirically tested. However, pre-post testing often shows promising results for many of these comprehensive or interdisciplinary programs (Bunn et al., 2015; Weiss et al., 2016). Based on their recent review, Weiss and colleagues (Weiss et al., 2016) concluded that regardless of the intervention provided, it is critical for clinicians and researchers to collaborate and show that outcomes are moving in the expected direction with either pre-post testing at a minimum or randomized controlled trials, if possible.

Introduction to the Chronic Traumatic Stress (CTS) model

Although the CTS model is conceptual, it is designed for clinical purposes and has the added benefit of providing guidance for empirical investigation. When studying the effects of traumatic war events and stress on individuals, families and communities, different cultures may have varied psychological and physical outcomes. These refugee population differences need to be taken into account when interpreting symptoms and deciding which outcomes to measure and at what frequency. In the overview presented, events and stressors are described as precipitants, and physical and psychological strengths and challenges are described as outcomes (see Figure 1). Moderating risk and protective factors are exhibited at the individual, family, community, and cultural levels. It is important to note that studies reviewed in the following sections are not comprehensive but rather offered as examples of precipitants, outcomes, and moderators which can be measured using the CTS framework.

Figure 1: *Chronic Traumatic Stress (CTS) Framework*



Traumatic and stressful events - precipitants

As shown in the CTS Framework, refugees and survivors of torture experience a range of traumatic and stressful events, including past and current events. These include Chronic Traumatic Stress (CTS) related to war and political conflict, post migration living difficulties, and daily hassles. These constructs are intentionally separated in the CTS model in order to retain the ability to empirically investigate their unique and shared contribution to outcomes.

Chronic Traumatic Stress (CTS)

It is well established that refugees experience traumatic stress associated with war and political conflict including physical injury, sexual assault, rape, the witnessing of violence, loss of family members, and torture (Mollica, McDonald, Massagli, & Silove, 2004; Peel, 2004). In addition to specific

traumatic events, refugees and survivors of torture may face stressors related to safety, lack of food and shelter, and appropriate medical care while attempting to escape persecution (Fazel et al., 2005). In the CTS model, these war related experiences are characterized as traumatic stress related to "past and current war trauma and political conflict." Due to the ongoing nature of many wars and political conflict, refugees may experience chronic traumatic stress even after they have been resettled (e.g., on-going war or unstable political climate in country of origin).

Post migration living difficulties

During post migration and resettlement, accompanying stressors may exacerbate the impact of initial traumatic experiences (Miller & Rasmussen, 2010). The empirical literature indicates that the most prominent post migration stressors among refugee populations include language barriers (Goodkind et al., 2014; Schweitzer, Brough, Vromans, & Asic-Kobe, 2011), inadequate social support (Goodkind et al., 2014; Teodorescu, Heir, Hauff, Wentzel-Larsen, & Lien, 2012), and worries about family members who reside in other countries (Schweitzer et al., 2011). Other frequently cited post migration living difficulties are unemployment, poverty, lack of housing, discrimination, acculturation struggles, family problems, and transportation difficulties (Schweitzer et al., 2011). Financial challenges can be particularly stressful as monetary assistance during resettlement is often extremely time limited. Further, discrimination related to varying cultural backgrounds and religious affiliations can exacerbate stress (Perera et al., 2013). Indeed, a number of studies have shown the negative impact of post migration living difficulties on psychological and physical outcomes in refugees (Schweitzer et al., 2011; Silove, Steel, McGorry, & Mohan, 1998). Including this construct when measuring stress associated with the refugee experience is critical as these stressors may impact treatment outcomes and are sometimes necessary targets of treatment. For example, lack of housing may exacerbate sleep problems which may enhance trauma symptoms. Addressing this challenge may dramatically impact treatment outcomes.

Daily stressors

Although the terms "daily stressors" and "post migration living difficulties" are often used interchangeably in the literature on refugee stress (Miller & Rasmussen, 2010), we purposefully separate these constructs in our model. Support for separating these constructs is demonstrated by research with immigrants in which findings showed separate contributions of acculturation specific and acculturation non-specific daily hassles on psychological distress (Lay & Nguyen, 1998). As previously described, we define post migration difficulties as those challenges typically related to the refugee experience after resettlement in a host country. Alternatively, daily stressors may be independent of the refugee struggle and include hassles commonly experienced by the broader population of refugees and non-refugees. Events such as managing financial obligations, difficulty finding childcare, or unexpected car troubles are considered daily hassles (Safdar & Lay, 2003). In our model, these constructs can be measured together or independently to assess the differential impact on well-being and distress.

Protective and risk factors - moderating variables

Traumatic and stressful life events often impact refugees or survivors of torture at

the individual level. However, it is well recognized that the impact of trauma and stressful events permeates relationships, families, communities, as well as societies (Nickerson et al., 2011). The ecological model underscores the interaction between individual, family, community, and cultural levels to help describe individual functioning (Bronfenbrenner, 1992). In the CTS framework, the interplay between individuals and surrounding environments is central to understanding the impact of war, post-migration living difficulties and concomitant daily stress. Specifically, protective and risk factors at each level may moderate the effect of stressful and traumatic life events. Risk factors interact with stressful events to increase the likelihood of negative physical and psychological outcomes whereas protective factors mitigate negative outcomes and increase resilience. Empirical investigation of protective and risk factors can assist with the testing and development of effective multimodal interventions.

While resilience is defined differently by various authors (Barber & Doty, 2013; Hoge, Austin, & Pollack, 2007), we refer to this construct as positive adaptation in the context of severe adverse circumstances (Luthar, Cicchetti, & Becker, 2000; Hooberman, Rosenfeld, Rasmussen, & Keller, 2010). Research has demonstrated that protective factors increasing resilience such as adaptive coping styles, social support, and community engagement may mitigate the negative effects of trauma and reduce psychological impairment (Başoğlu, Paker, Özmen, Taşdemir, & Şahin, 1994; Bonanno, 2004; Hooberman et al., 2010). Individual protective factors may include genetic predisposition, age, sex, coping style, and emotion regulation skills (Hoge et al., 2007). Protective factors increasing resilience may also be noted in families (e.g., family cohesiveness, family support, economic status), communities (e.g., community resources, community support) and cultures (e.g., spirituality, cultural identity, cultural traditions). Studies addressing the negative impact of risk factors on the functioning of refugees and torture survivors have focused on all levels, including individual risk factors (e.g., substance abuse, suicidal thoughts), familial factors (e.g., domestic violence), community factors (e.g., community violence) and cultural factors (e.g., acculturation difficulties, discrimination, historical loss) (see Fleming & Ledogar, 2008). The moderating effect of risk and protective factors on the impact of stress across all levels can be empirically measured and may enhance our understanding of the impact of multimodal interventions for refugees.

Outcomes

The vast majority of studies assessing outcomes associated with refugee trauma focus on the negative impacts including psychological disorders, physical ailments, and trauma symptoms. Within the CTS framework, while negative consequences of traumatic events are highlighted, an emphasis is also placed on understanding psychological and physical well-being in the face of war trauma.

Psychological and physical well-being

The construct of psychological well-being has been described in various ways throughout the literature (e.g., Berry, 1997; Lazarus & Folkman, 1984; Ryan, Dooley, & Benson, 2008). While psychological well-being within the CTS Framework includes the lack of significant symptoms of anxiety, depression and PTSD, it also includes the utilization of psychological resources (e.g.,

coping mechanisms, distress tolerance techniques, acceptance strategies) and accessing social and community supports (e.g., making decisions according to one's identified values, cultivating a sense of meaning). Additionally, psychological well-being includes acceptance and management of symptoms associated with anxiety, depression, and post-traumatic stress. The construct of physical well-being may include healthy sleep patterns, exercise, nutrition, abstaining from substance abuse and management of medical conditions, along with the lack of significant physical ailments. Service providers often witness the amazing psychological and physical strengths of refugees and survivors of torture, however these constructs are rarely measured as outcome variables in treatment studies. The empirical investigation of treatment outcomes associated with increased well-being may be an important emphasis for promising multimodal treatments that focus on enhancing strength-based factors.

General psychological distress and physical problems

Disentangling psychological and physical sequelae of war trauma can be challenging, if not impossible, as conditions within these domains frequently overlap. Nevertheless, the literature is replete with support for the deleterious psychological and physical outcomes of war. Specifically, post-traumatic stress, anxiety and depression are among the most frequently cited psychological symptoms experienced by refugees and survivors of torture (Schubert & Punamäki, 2011). Sleep disturbances (e.g., insomnia and nightmares) and somatic complaints (e.g., gastrointestinal problems, headaches, dizziness, and chronic pain) have all been empirically demonstrated to be associated with war trauma (Hinton, Hinton, Eng, & Choung, 2012; Hinton, Hinton, Pich, Loeum, & Pollack, 2009; Kirmayer, Groleau, Looper, & Dao, 2004). Rates of traditionally defined physical ailments such as hypertension, diabetes, and obesity have also been shown to be higher in refugee populations as compared to non-refugees (Bhatta, Shakya, Assad, & Zullo, 2015). Moreover, although not often empirically tested as outcome variables for intervention, traumatic brain injuries and chronic pain are also common (Weiss et al., 2016). Including physical problems and general psychological distress measures (beyond trauma responses) may broaden our understanding of the impact of the multimodal interventions for refugees.

Traumatic stress symptoms

Symptoms of PTSD delineated by the DSM 5 include intrusive symptoms (e.g., recurrent memories, flashbacks, nightmares); avoidance of trauma related stimuli; negative alterations in cognitions and mood (e.g., persistent negative beliefs about the world); and alterations in arousal and reactivity (e.g., hypervigilance, exaggerated startle response) (American Psychiatric Association, 2013). Trauma specific outcomes in refugees may be commensurate with symptoms included in the DSM 5 but may also include somatic complaints such as headaches and gastrointestinal problems (Hinton & Lewis-Fernández, 2011). The traditional symptoms of PTSD as outlined in the western diagnostic system often co-occur with the previously mentioned symptoms of general distress. Additionally, cultural perceptions of mental illness and health may impact interpretation and endorsement of trauma related symptoms. For example, in the Bhutanese population, anxiety driven by fear of distressed ancestors may exacerbate symptoms and add to traumatic stress

symptoms. Regardless of the intervention provided, it is important that empirical investigation of treatment outcomes for refugees include a measure of traumatic stress symptoms along with general physical and psychological well-being and distress as delineated in the comprehensive CTS model.

Summary

Treatment modalities and intervention planning depends on theoretical perspectives regarding the etiology and maintenance of impairment. Existing treatments to address trauma symptoms experienced by refugees and survivors of torture are documented in the literature and utilized globally (e.g., Prolonged Exposure (PE) (Foa & Rothbaum, 2001); Cognitive Processing Therapy (CPT) (Resick & Schnicke, 1993; Schulz, Resick, Huber, & Griffin, 2006); Narrative Exposure Therapy (NET) (Schauer, Neuner, & Elbert, 2005); Culturally Adapted-Cognitive Behavioral Therapy (CA-CBT) (Hinton, Rivera, Hofmann, Barlow, & Otto, 2012). Additionally, cultural adaptations to existing empirically based interventions have been developed and utilized e.g., (Bunn et al., 2015). Finally, novel, multimodal, interdisciplinary, and comprehensive treatments are utilized in clinics and treatment centers around the world, however, these treatments rarely receive empirical investigation. Together, these interventions address individual symptoms related to PTSD and trauma, and stressors associated with post-migration difficulties and daily hassles, in addition to attending to family, community, and cultural factors. Our proposed conceptualization attempts to provide guidance for interdisciplinary treatments, including medical, social, and psychological treatments (e.g, supportive, coping technique-based, and exposure-based treatments) (Bunn et al., 2015). Additionally, empirical testing can be conducted regarding outcomes associated with existing interdisciplinary treatments.

CTA Framework guides empirical investigation

The CTS Framework guides empirical investigation beyond a focus on PTSD and associated symptoms by providing a comprehensive, strength based model. Throughout this article, we emphasize the significance of all modalities of biopsychosocial treatment; 1) supportive (community or group connection); 2) psychoeducation and symptom reduction; 3) addressing the trauma narrative; (Bunn et al., 2015) and 4) attention to physical health. While intervention focused solely on PTSD assesses the occurrence of a past event (or events), the CTS model highlights chronic stress including ongoing traumatic stress events related to war, post migration stress, and daily hassles in order to assess the unique and combined impact of these events. Also, the CTS moderating variables at all ecological levels emphasize the need to investigate risk and protective factors that can be addressed during intervention and may have a unique impact on outcomes. Finally, the outcome section of the model exhibits the importance of assessing well-being, resilience, and strengths, along with physical and psychological sequelae. PTSD interventions typically target the reduction of trauma symptoms as the sole outcome measure.

Further empirical testing in the form of randomized control trials would benefit the field regarding the assessment of comprehensive treatments for refugees and survivors of torture. Unfortunately, conducting randomized control trials can be costly, requiring grant funding and advanced

statistical support. While randomized control trials represent the gold standard, this may not be feasible for many or most programs in which this cost may be prohibitive. While practitioners are devoted and believe strongly in the effectiveness of their services, without measurement of program success, these methods remain understudied. We suggest that measurement conducted before, during, and after treatment may be feasible for programs and important to understanding the impact of interdisciplinary intervention (Weiss et al., 2016).

Measurement-based care for interdisciplinary interventions

Assessment conducted prior to, during, and after, interdisciplinary intervention is often not conducted by practitioners. For those programs that do collect data for clinical or program evaluation purposes, results are rarely published or widely disseminated. Measurement can provide knowledge regarding overall program success, useful program modifications, and may enhance future funding opportunities. In this paper, we provide a model that can be used as guidance for measurement of treatment variables and clinical outcomes. We suggest that regardless of the combination of treatment domains (e.g., social, physical, psychological), it is beneficial to include a comprehensive stress profile as explicated in the CTS model (e.g., past and current war trauma and political conflict, post migration living difficulties and daily stress). Such measurement provides information regarding the separate and additive impact of stress upon the participants prior to, during, and post intervention. Moreover, when assessing the impact of the intervention, adding an analysis of potential moderating variables to the empirical investigation such as protective factors (e.g., family and/or community support, economic status, and spirituality) may shed further light on important variables related to change. For example, a program may enhance healthy psychological well-being through community engagement and behavioral activation while not necessarily impacting the experience of sadness associated with the loss of family members or anxiety associated with fear of being deported. Finally, adding outcome measures that go beyond the intended focus of the intervention may demonstrate the broader impact of interdisciplinary treatments. For example, trauma specific measures can be used as outcomes for interventions aimed at reducing social stress (e.g., poverty, unemployment). Although not commonly measured when social work interventions are employed, it is possible that traumatic stress symptoms (e.g., flashbacks, hypervigilance, avoidance) may decrease after an intervention targeting outcomes such as secure housing or gainful employment is conducted. Similarly, measures regarding chronic pain or other physical health variables (e.g., hypertension) could be added as outcome measures for treatment intended to target trauma symptoms. The possibility that one treatment domain (e.g., physical, psychological, or social) may impact another domain is central to outcome measurement as delineated in the CTS model. Finally, collaborative efforts, such as those demonstrated by the National Consortium of Torture Treatment Programs (NCTTP), to disseminate cumulative data collected across multiple programs would be beneficial to the broader community of service providers by increasing dissemination of novel evidence-based approaches.

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An ethical and aesthetic challenge: symbolic reparation and the construction of memory

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Key points of interest:

- *Clínicas do Testemunho* is a psychological reparation pilot project, which is of an experimental character and the first of its type to be subsidized by the Brazilian state.
- Testimony of survivors of torture experienced at the hands of the Brazilian state during and after the dictatorship in Brazil from 1964 to 1985 produces repercussions in the wider social context.
- From the point of view of the individual, testimony is not only a clinical tool for healing but also the construction of memory.
- From the point of view of society, testimony is an important part of the reparation process and forms an important role in the construction of collective memory and the foundation of democracy.
- It is recommended that similar projects are initiatied in other settings and countries.

Abstract

This article concerns the *Clínicas do Testemunho,* a pilot project carried out in Rio de Janeiro, which was supported by the Amnesty Commission of the Brazilian Ministry of Justice and was carried out between 2013 and 2015. It highlights how giving testimony can be a vehicle for psychological reparation and can help in the process of constructing individual and collective memory, as well as resistance. The article begins with a narrative about the dictatorship and the struggle for Memory, Truth, Justice and Reparation that followed, showing how psychological reparation emerged as one of the components of this process. Through the clinical experience, it highlights the effects of persecution and torture on subjectivity, and the use of clinical strategies and devices that produce changes in subjectification. It also highlights testimony as an important part of the reparation process and its role in the construction of memory and democracy.

Keywords: torture, testimony, reparation, transitional justice, disappearance, amnesty, memory

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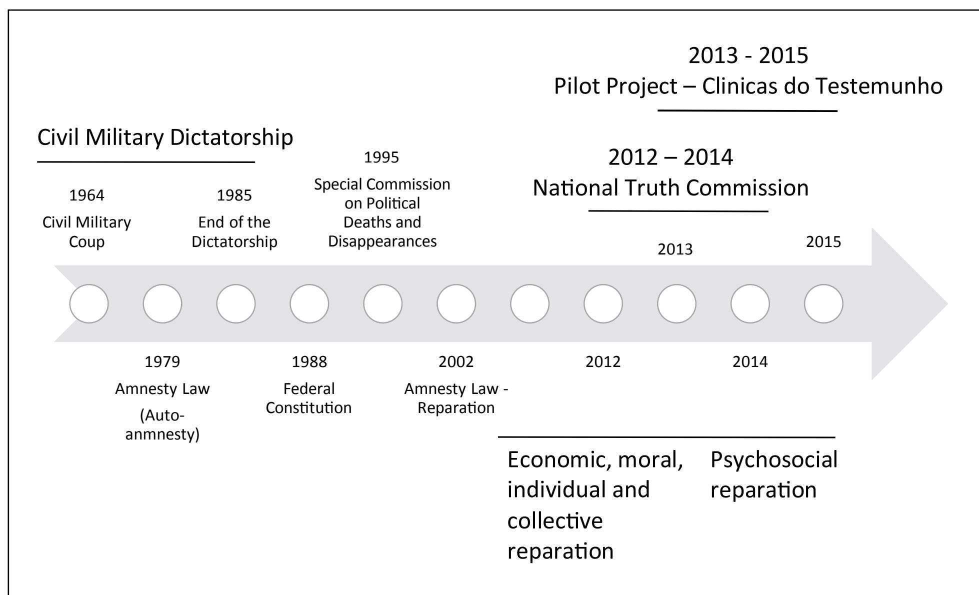

Introduction

> *"… I felt that the people who were present at the public hearing, those looking at me attentively and who heard my testimony, were talking to me, that they believed in me."*

The words above express surprise and emotion. They refer to a scene that had been experienced a few days before by a torture survivor at a public hearing organized by the State Truth Commission of Rio de Janeiro. These words had also been heard by a clinical psychological group, the *Grupo de Construção de Testemunhos* (Construction of Testimonies Group), one of the *Clínica do Testemunho*'s activities. Breaking the silence of a violent past that occurred 40 years ago, F. spoke publicly about what had happened shortly before she turned 18 years old. While imprisoned and tortured, her two brothers were killed by the brutality of the agents of repression.

When the narrative's author reveals what she has repressed for so many years, the sphere of subjectivities is impacted. Therefore this act of testimony produces repercussions in the wider social context. Those who listen to the testimony see themselves entangled in the fabric of the story being told. Through the act of testimony, the story of an individual's life, which is simultaneously a part of and produced by the universe of barbarity, radiates to the common sphere. Through this process, the memory of dark times can be recuperated and shared. This is the symbolic value of words, how what is spoken is transferred to the collective and affects those who listen.

Clínicas do Testemunho is a psychological reparation pilot project, which is of an experimental character and the first of its type to be subsidized by the state. It is intended to help us to critically analyze the production of subjectivities; what it has meant for each individual. In order to do this, it is fundamental to examine, briefly at least, how the authoritarian state affects subjectivity with respect to the bodies of the regime's opponents and their relatives, as well as society as a whole. It is necessary,

therefore, to present a retrospective on the struggle for human rights in order to situate the issue of symbolic reparation and the potential of the collective in this process (See Appendix for a timeline of key events).

Politics of reparation in Brazil

> *"Se podes olhar, vê. Se podes ver, repara."* [If you are able to see, look. If you can look, take note.]

In political regimes that are organized in a vertical, dogmatic and authoritarian manner, maintaining themselves through strong repressive control, dominant forms of subjectivity tend to be reproduced. Beyond the force of authoritarianism, during the Brazilian dictatorship, these forms of subjectivization were solidified through social relations, guaranteeing that the damage caused endured. Throughout the long period of dictatorship spanning 21 years and in the years that followed, silence, amnesia and denial were fostered. Even directly after the dictatorship, the reasoning that predominated was not to look back; it was assumed that forgetting human rights violations and arbitrary action by the state would guarantee a promising future. This was a strategic message spread by political speeches and contemporary cultural expression through the media, to stifle silence imposed during the authoritarian regime and to create the space to forget.

Although some progress was achieved during the brief democratic regimes, basic principles of human rights were and are still not guaranteed. Challenged by that which was left behind, Brazil has not addressed all the measures which Transitional Justice shows to be necessary (Abrão & Torelly, 2011; Gomez, 2014). It is undeniable that the scars left by institutionalized violence at the hands of the state are still apparent. Even the marks of the colonization of this continent remain visible. The brutal violence that the indigenous people of Latin America and the slaves brought from Africa were subjected to appears today through assassinations and/or is demonstrated by the miserable conditions of Brazilian prisons. As with the living remnants of the open wounds of slavery, the country is riddled with racism, a social trauma that until recently was denied and continues to produce new victims daily. The political, social and economic practices that were rooted in authoritarianism, social relations are tainted with discrimination, intolerance, prejudice, and profound inequality. These scars illustrate the weaknesses in our democracy, highlighting the need to make substantial strides to guarantee civil rights.

The Brazilian state belatedly recognized its responsibility for crimes against humanity carried out during that dictatorial period. Civil society's struggle to expose state violence and to bring to justice those who were responsible has only recently gained public attention but dates back many years. The demands of civil society organizations, especially relatives of those who were killed or disappeared and the survivors of those who were persecuted, opened the way for the affirmation of human rights specifically in the field of civil rights in Latin America, and later, the public recognition of the violations carried out by the authoritarian state.[1] The pilgrimages of relatives to the barracks and prisons in search of information about their loved-ones had already begun during the authoritarian

[1] We can highlight here the work of the movements *Grupos Tortura Nunca Mais, Associações de Familiares de Mortos e Desaparecidos*, and the support of the *Comissão de Justiça e Paz*, and the National Press and National Bar Association (ABI and OAB).

regime. With the parties that were directly affected by the terror of the state as protagonists, these movements and other Latin American movements triggered the beginning of a process which has denounced gross violations perpetrated by state agents and called for the recognition of human rights. Consequently, in the last few decades, with the process of democratization, the assurance of human rights has broadened in several areas. The strength of this pressure, of sections of society crying out for justice, resulted in sowing the seed of change in public policy. Public policy changes were necessary to address violence in ethnic-racial relations and discrimination, as well as intolerance regarding gender and police violence towards the most vulnerable groups of Brazilian society. This process, however, was slow-moving. Prior to the introduction of the new Federal Constitution in 1988, the response to the recognition of the violations suffered by victims was complete denial.

The creation of the Special Commission on Political Deaths and Disappearances[2] formed in 1995, 10 years following the return to constitutional rule, was the first measure taken by the state to recognize crimes committed during the dictatorship. The Commission, based in the Presidential Secretary of Human Rights [Secretaria de Direitos Humanos da Presidência da República], has been responsible for the investigation of crimes against humanity, in particular political deaths and enforced disappearances, its mandate being to search for documentation, shed light on the truth and construct the collective memory on the violence perpetrated by the authoritarian regime.

Only years later, reparation policies became more extensive and driven by the *Comissão de Anistia* [Amnesty Commission] of the *Ministério de Justiça* (Ministry of Justice) decreed by Law no. 10.559/2002. The Commission recognizes violations that occurred between 1946 and 1988, such as torture, imprisonment, exile, arbitrary dismissal, political disenfranchisement, among others, invoking political amnesty for victims of these acts.

It is worth noting that the *Lei da Anistia* [Amnesty Law][3] decreed during the dictatorship period was at the time (1979) met with a wide campaign that occupied public spaces all over the country demanding "ample, universal and unrestricted Amnesty." There are, two "Amnesty" laws that incorporate different content, exposing the ambivalence with which the Brazilian state

[2] Created by the Law 9.140/45 that implemented the *Comissão Especial* [Special Commission], the Brazilian state recognized political deaths and enforced disappearances during the military dictatorship. In the 2017 publication "*Direito à Verdade e à Memória*" [The Right to Truth and Memory] produced by the National State Secretary of Human Rights, 136 political deaths and enforced disappearances were identified. In the Final Report of the National Truth Commission published in 2014 (which can be found here: http://cnv.memoriasreveladas.gov.br/index.php?option=com_content&view=article&id=571), 434 political deaths and enforced disappearances were identified. Although the number of victims of the genocide of the indigenous population is not included in the final report, the Commission recognized but did not quantify this statistic.

[3] The *Lei da Anistia* [Amnesty Law] 6.683/79, instead of embracing civil society demands, only gave partial amnesty to those who opposed the *coup d'état*. It allowed the return of exiles, freed some political prisoners while keeping some imprisoned (those accused of committing so called "blood crimes"), and protected those who ordered and carried out crimes against humanity.

dealt and deals with its past. In the 1979 law, the concept of amnesty is that of "amnesia"; a state pardon for the crimes committed by those who opposed the oppressive regime of the civil-military dictatorship. Those responsible for the crimes against humanity perpetrated during the dictatorship were granted protection under this law as a strategy to conceal and deny crimes committed by state agents. The second amnesty law, approved in 2002, reverses the logic of the 1979 law, addressing reparation for victims of state violence. The 2002 law recognizes the right to resist a totalitarian state and exclusively grants protection for those that faced material, physical or psychological suffering due to state violence. The comprehensive reparation process is comprised of three types of reparation: (i) economic reparation,[4] (ii) moral reparation,[5] and (iii) individual and collective reparation through the construction of memory.

Reparation means that the state is recognized as a promoter of crime and persecution and is a complex concept. Connected to the survivor's suffering, it is a process comprised of several dimensions: judicial, political, economic, moral, symbolic and clinical. It is insufficient to consider separately, as solely a judicial or administrative initiative, or even merely an individual deed. The symbolic dimension is particularly valuable as it allows the emersion of new perceptions of victims' suffering, much of which has been frozen in time, and acknowledges society's collective experience in living through this terror.

Between 2007 and 2015,[6] the *Comissão da Anistia* [the Amnesty Commission] created strategies to disseminate its work and further the construction of memory. One of the mechanisms the Amnesty Commission used was called the "*Caravanas da Anistia*" [Amnesty Caravans]. Beginning in 2008, this project toured several cities where violations were committed, hosting public sessions assessing claims by those petitioning for political amnesty. Another project, "*Marcas da Memória*" [Memory Marks], subsidized the creation of films, documentaries, plays, exhibitions, and publications utilizing artistic resources to depict the dimensions of the authoritarian period. These cultural exercises fortified the construction of collective memory, making amends through interrogating the present by exposing open wounds of the past. The Amnesty Commission considered psychological damage as an issue, accepting the task of amplifying reparatory measures, because it acknowledged the damaging effects of state violence on subjectivity and the lack of public policy on psychological reparation that could help those affected.

In 2012, a public bid was launched for a pilot project to provide clinical attention to victims and their families. The project, named "*Clínicas do Testemunho*", worked to create conditions to establish public policy on the psychological element of reparation. The project consisted of three key action points:

(i) the provision of clinical care for those granted amnesty and their families;
(ii) the provision of professional training to psychologists; and,
(iii) the production of information for the creation of future public policy.

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4 Economic reparation refers to monetary compensation for the interruption of life plans.

5 Moral reparation refers to the issuance of an apology by the relevant authorities.

6 The *Comissão de Anistia* activities became more limited in 2016 following the juridical-parliamentary-media *coup d'état* that removed then President Dilma Rouseff.

Various clinical teams from around the country applied to participate in the project. The selection process considered regional diversity and the teams' expertise. The Amnesty Commission hoped to utilise the public selection process to mobilise civil society around the subject of psychological reparation and to consolidate partnerships with qualified teams. Four applicants[7] were chosen, including the *Equipe Clínico Política*[8] of Rio de Janeiro.

The team from Rio de Janeiro has 20 years of experience in providing clinical care to those affected by state violence and in providing training to mental health professionals. Their application was developed with the non-governmental organization *Grupo Tortura Nunca Mais* of Rio de Janeiro, whose projects were subsidized by international cooperation agencies. In 1999, the "*Red Latinoamericana y del Caribe de Instituciones contra la Tortura, la impunidad y otras violaciones de los Derechos Humanos*" [The Latin American and Caribbean Network of Institutions against Torture, impunity and other human rights violations] was created, and has also been supported by the International Rehabilitation Council for Victims of Torture. The clinical team's experiences in providing care for trauma victims informed the integration of specific points into the pilot project. These points included issues such as:

- The complexity of state terror and violence and the use of a trans-disciplinary perspective of the clinical approach examined under an ethical-political perspective.
- The relevance of the historical, social and political dimensions, as a constitutive part of subjectivity of each individual, emphasizing the production of subjectivities in permanent circulation of the *socius* (Guattari & Rolnik, 1996).
- The team's clinical approach opposed the focus on the psyche as an entity isolated from social and political aspects and/or that which considers the family dynamic fundamental.

Moreover, for the clinical team it was clear that only the State could amend the damage because it was the agent of the violence. In addition, the team recognized the limits that a clinical instrument has without state support for memory, truth and justice. The first project in symbolic reparation was created for ex-political prisoners who had received amnesty, those who were in the amnesty process and relatives of those who were killed or disappeared during the dictatorship.[9] It began in 2013 and went on until 2015.

To the benefit of the project, public debate on corresponding themes gained momentum with the launch of the first

7 In addition to the Instituto Projetos Terapêuticos RJ project in Rio de Janeiro, Instituto Projetos Terapêuticos and Sedes Sapientiae from São Paulo, as well as the Associação Sigmund Freud from Porto Alegre were also chosen.

8 The Clinical Team in Rio de Janeiro was made up of seven professionals: four psychotherapists, one psychoanalyst, one psychiatrist, and one body therapist.

9 In its constitutional mandate the *Comissão de Anistia* received reparation claims of those persecuted between 1946 and 1988. These claims were examined by the board, through the documents presented, who decided whether or not they were "anistiados politicos." The people attended to by the project were those who had already received amnesty and those who were still waiting for the board's decision. Up until 2012 more than 70,000 political amnesty requests were presented as the majority were granted and others were in the process of being evaluated.

National Truth Commission and the 2014 commemoration of the 50-year anniversary of the civil-military coup. Although the public remained wary of the state's intentions in regards to the reparation initiative, the opportunity to break the silence on the suffering experienced was triggered. In this context, beyond documentation, the role of testimony became increasingly valuable in the investigations carried out by the National Truth Commission. Many individuals that were persecuted, former political prisoners and their relatives felt encouraged to testify. The sentiment spread throughout the country. Local committees and collectives comprised of former political prisoners and young, militant human rights activists were created to monitor the Commissions. The opportunity to break the silence unlocked the ability to verbalize victims' lived experiences. The psychological scars, illustrated through the clinical and public testimonies, that were produced by the totalitarian state remained visible even 50 years after the military *coup d'état* that instated the dictatorial regime.

In 2013, the *Clínica do Testemunho* of Rio de Janeiro developed various different types of services: individual clinical sessions, psychiatric sessions, groups, family sessions, physical therapy[10] and accompaniment for those that testified in the National Truth Commission. The clinical team also organized a number of relevant activities, such as:

(i) trainings for mental health professionals in Rio de Janeiro and other Brazilian states[11];

(ii) "*Conversas Públicas*" (Public Discussions), an extended listening device to present and promote the psychological reparation proposal[12]; and,

(iii) produced information that could serve as reference for the creation of future public policy, specifically the production of a publication titled "*Uma perspectiva Clínico Politica na reparação simbólica: a experiência da Clínica do Testemunho do Rio de Janeiro*" [A Clinical-Political Perspective in symbolic reparation: an experience of the *Clinica do Testemunho* in Rio de Janeiro].

In April 2013, the proposal was presented in a public discussion, which attracted approximately 100 participants, among them ex-political prisoners, relatives, civil society organizations, political parties, as well as mental health professionals interested in joining the team. Even after the first discussion, the manifestation of testimonies impacted attendees' perceptions about individuals' experiences under authoritarian rule.

Testimony and symbolic reparation

How can we take away the pain of those families whose relatives disappeared or were killed by the civil military dictatorship? How can we "give back" the time of those that faced imprisonment in abject conditions and/or were subjected to torture? How do we heal the scars of torture, the trauma of violence committed by agents of the state after so many years of silence? Is it possible to rectify atrocities that are certainly not capable of being rectified, such as death?

Memory, the construction of the present

[10] In total 135 participants were seen, 97 in group sessions and 38 individually.

[11] 6 workshops, in total 12 hours, carried out in Minas Gerais, Rio Grande do Sul, Rio de Janeiro, in two stages, being 24 hours in each locality, involving 57 professionals.

[12] In total 8 "Conversas Públicas", two in Belo Horizonte, three in Rio de Janeiro, one in Vitoria, and two in Porto Alegre, in total 381 people.

through the happenings of the past, as well as the act of testifying, are part of clinical practices. In the clinical context, the psychotherapist receives the "extended testimony", the experience of one who listens to the testimony and to the suffering of the subject. Jean Marie Gagnebin (2006) affirms that the function of the "extended testimony" is that:

> *"They can hear the unbearable narration of another, not because of guilt or compassion, but because only by symbolic transmission, acknowledged despite and because of the unspeakable suffering, only by going back to the past in a reflexive way can we help not to repeat it forever, to venture to draft another story, to invent the present."* (p.57)

Those who experience violence first-hand become witnesses of their time. The figure of the witness became relevant for the first time during the Nuremberg Trials and later, due to the revelation of the horrors experienced and the oppressive and barbarous mechanisms in place, in Latin America. The testimonial narrative was key in giving visibility to the crimes against humanity, exposing what had been hidden and denied by repressors, and contributing to clarifying what happened. This narrative was also key in returning the witnesses' condition of being human and to once again feel part of humanity. A way to root out the injected evil of the limited experience of the concentration camps and prisons. The action of testifying opened the possibility of symbolic reparation, restoring the ability to feel, returning dignity to those that went through extreme conditions, through torture and cruel treatment in the position of objects, as disposable beings.

Effects of torture

In clinical work with survivors of torture and state violence, many varied subjective effects may be identified. Experiencing trauma and torture produces an isolating effect, in which silence overcomes the victim. In all its forms and with all its consequences, the amount of impact on an individual's psychological and physical being, as well as their social connections must be highlighted. Torture ruptures the bonds that connect the individual to the external world, affecting relationships between siblings, families, between peers, resulting in a painful process.

Perpetrators not only seek to force the subject to provide information, confess their actions, and/or to betray their networks, but also to dominate the victim, quash their individualism and overpower the individual. The aftereffect of torture is silence (Sironi, 2011). Under the mandate of terror, the isolating experience of torture was produced. When victims remember the terror they experienced, they often remain silent, dreading the panic attacks that frequently occur when recalling the trauma they experienced. The fear of not being able to transmit, of not being understood by those that listen to them, of hurting others by expressing the horrors they experienced, results in the silence and isolation of the individual with their family members and their social groups. Families, marked by the incommunicability of what happened, live the pain and the angst of the trauma, which transmits to subsequent generations (Cardoso & Mourão, 2015; Herrera, 2015; Kolker, 2009; Vital-Brasil, 2009). Torture survivors, however, can break the legacy of isolation through testimony. The act of providing testimony may allow for a new direction in a victim's life, that before was confined to the individual and that thwarted social bonds. Given the complexity of the process of testifying, how can society feasibly break the silence following so many years of denial, without actively listening to victims' experiences? How can memory be

reconstructed about a period of time that has been suppressed through silence and collective amnesia?

As we are dealing with actions of men, who historically are inserted in politics by groups, that use the production of what is evil to politically dominate others, an ethical political instrument is necessary in this process of access to the memory of these dark times. Showing the importance of a "professional" listener, whether it be a mental health professional or the public authorities responsible for psychological reparation. Testimony refers to truth and this is what gives it consistency. This exposed truth isn't what was actually lived; it is what was left of the experience that happened (Deleuze, 1974); of what was left in the memory as a fragmented recollection of the facts.

Fabiana Rousseaux, a psychoanalyst who has accompanied those who have testified in cases about crimes against humanity in Argentina, claims that a testimony is a production "of fiction and of writing" (Rousseaux, 2015, p.107). It is precisely through this psychological endeavor to construct the truth that the witness is able to produce new meanings for what happened, find new expressions and directions. Providing testimony is not the repetition of what is remembered, but an eruption of a memory, of something that resided there, where the paradoxical form wasn't accessed or verbalized (Rousseaux, 2015).

> "*On being arrested I received a passport to hell and this hell has never ended.*"

This statement was expressed by a torture survivor after they began clinical therapy with the *Clínica do Testemunho* Project in Rio de Janeiro. The patient referred to the continuation of their suffering and the memories of the past that have accompanied them throughout their life. Throughout the treatment, this statement and others began to gain validity. Months later, having found an outlet for their pain, an internet-based initiative titled "*Cartas ao Vento*" was created. The initiative, created by those involved in the *Clínica do Testemunho* project, consisted of anonymous letters to the general public penned by torture survivors, narrating their traumatic experiences.

To expose traumatic experiences, it is necessary to create politically-sound clinical strategies that take into account elements and conditions that can facilitate expressions of suffering. In the *Clínica do Testemunho* Project of Rio de Janeiro, we sought to create strategies that supported the construction of narratives and other expressions for the lived events, helping to transform the position of victim to that of witness by bringing together a psychological dynamic which is usually suppressed or blocked by trauma. In addition to the variety of group treatment methods used,[13] other mechanisms were created to permit the interaction with the diverse collectives involved in memory and truth issues.

One of this project's objectives was to find methodological approaches to create public policy on the basis of clinical findings, a strategy used in the introduction of experimental mechanisms. Guidelines included: the promotion of broad participation; the creation of innovative devices that help to free words and/or expression about traumatic experiences; the introduction of activities that increase exchange; the promotion of more communicability about what had been confined to the private environment.

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[13] Reception Group, the Construction of Testimonies Group, the Therapeutic Group, Special Groups, Body Therapy Group, the Women's' Groups

These guidelines were put in place in favor of the production of meaning and the reconstruction of a social fabric.

Conversas Públicas or Public Conversations: Accordingly, mechanisms, such as "*Conversas Públicas*", were developed to allow for the dissemination of the project. This activity mobilized individuals to share their experiences during the authoritarian period. Participants included former political prisoners, relatives, human rights activists, members of political parties and psychologists. Inspired by the name of the project, participants began to provide public testimonies. Rodrigo Blum claims that in the "*Conversas Públicas*", "the boundaries between what is public, what is clinical, and what is conversation become so close that they become the same territory" (Blum, 2015, p.36). The spoken word crossed the different universes of experiences, facilitating the construction of a collective memory.

Collective testimony mechanisms: The project also created collective testimony mechanisms exclusively for those enrolled in the project. These mechanisms were created with the intention of promoting inter-generational integration project participants, facilitating the space for victims to explore the motives of their relative's silence in regards to what occurred during the period of terror, for example. Is was shown through the project's impact assessment that people who had never been together were united through the activity's meetings, including retired and persecuted military personnel and former political prisoners, as well as their children and grandchildren. Their interaction enabled these individuals to discover, through different struggles and acts of resistance, the effects that violence had had on the course of people's lives and on their physical bodies.

Participants and therapists also participated in public hearings, seminars, plenaries and public activities, so that listening to testimonies would be a shared experience, transmitted to the socio-political sphere; a shared sphere of citizenship.

Communication network: A new communication network and a new form of agency emerged. A new form of social and political 'protaganism' was created through the act of giving testimony (becoming protagonists of their own stories). The experience of both listening and of being heard mobilized the creative methods of providing testimony. The use of poems, drawings, texts, photographic exhibitions and dramatizations was born out of this experience. Revealing what a pencil line or a gesture can say beyond that of the written or spoken word, various forms of expressions were built on the aesthetic power of what words alone cannot express.

Furthermore, new collectives were born out of the *Clínica do Testemunho* project beyond the clinical meetings comprised of persecuted low-rank soldiers, survivors of the Army's Central Hospital, as well as the children and grandchildren of survivors, the killed and disappeared during the dictatorship. The acceptance and recognition of their pain through state-mandated psychological reparation in the form of psychological treatment cut across these groups of primary and secondary victims. This permitted the transition of relatives from their supportive position to those affected and further into becoming a formalized collective, the "*Grupo de Filhos e Netos por Memória Verdade Justiça*" (Group of Children and Grandchildren for Memory of Truth and Justice). Through this process they are able to reclaim their own narratives on the effects of violence, an issue no longer

exclusive to their parents or grandparents, allowing them to become protagonists in the larger struggle.[14]

In total 44 people who signed up to the project, accompanied by therapists, gave testimony in various public hearings of the National and State Truth Commissions. They were heard by both the public and by the authorities under state mandate.

After clinicians from the project accompanied those who testified for the Commissions, as was set out in the original project proposal, a partnership with Rio Janeiro's State Truth Commission[15] was consolidated. This led to other people becoming involved, such as the members of the Commission themselves. Their team, due to the impact of the witness accounts, was shaken by the intensity of the violence, and asked for support from the clinical team to ensure a qualified listening process.

Conclusion

> *"A testimony, as it confronts humanity with its heinous parts and draws attention to the ethical position that consists of transmitting the unspeakable, became the privileged method to narrate an experience of what is not transferable precisely by those who have tried to convey it."* (Koltai, 2015, p. 149)

Due to its methods, crimes against humanity affect both the individual and society at large, revealing the effects of human cruelty that reverberate through society. Torture simultaneously destroys the dignity of both the tortured and the torturer.

Torture interrupts victims' life plans, altering a victim's destiny. Through testimony, victims expose their wounds to everyone.

The reparation process does not give back the time that was lost in torture chambers or reinstate the lives of those who were killed or disappeared. It is possible and necessary, however, as a legacy for following generations, to reclaim the narrative of those whose lives were uprooted by the hand of state violence. Through the intermediary of testimony, we can experience the struggles of historical moments and understand what this meant for each individual during this period in order to reconstruct the fabric of collective memory.

In the clinical context, a testimony is a driver of new subjectivities for the testifier, and simultaneously, a driver in the construction of a collective memory that is imprinted on the common realm. Through the testimony, the link between those affected by state violence, individually and collectively, can be reconstructed.

Being listened to is fundamental to those giving their testimony, the individual who risks narrating in words their tragic experience. Through this process, they can reconnect the threads of an interrupted life and reintegrate into the community and rebuild relationships. The action of listening, in which the effects unfold between those who are touched by the testimonial narrative can be moved from otherness, empowered by the ethical commitment to Memory, Truth and Justice.

During the *Clínica do Testemunho* project in Rio de Janeiro, patients and clinical staff appreciated the role of the project in pioneering the ability to re-position themselves in relation to their past and open themselves up to the present in order to become protagonists of resistance struggles

[14] About the diversity of the aesthetic productions and the political actions see the publication: "*Uma experiência Clínico-Política na reparação simbólica: a Clínica do Testemunho do Rio de Janeiro*." Available at: http://www.justica.gov.br/central-de-conteudo/anistia/anexos/livro-on-line-2.pdf.

[15] Rio de Janeiro's Truth Commission mandate was from March 2013 to November 2015. More information available at: http://www.cev-rio.org.br/.

against arbitrary policies. The clinical team provided a range of tools and mechanisms in which words gained different forms of impact. The recognition of witnesses' words in the mandate of the Truth Commissions can be understood on two levels: to recognize and to be recognized. In their final reports, the Truth Commissions expressed the importance of psycho-social reparation for the damaged caused by state violence. Clinical teams in various states asked the *Comissão da Anistia* for an expansion of the project. The Brazilian state maintained its commitment in the development and consolidation of a symbolic reparation policy, creating a new public call in 2015 in which additional clinical teams were incorporated into psychological reparation initiatives.

In recent years, the Brazilian state has made important steps in strengthening democracy through the development of human rights, memory, truth and reparation policies. The work of the Truth Commissions launched a larger conversation on violations during the dictatorial regime, the extent of which society previously knew little about. Their final reports included recommendations for the Brazilian state, suggesting a number of measures, such as the creation of institutional policy; suggestions which require action.

Today, the Brazilian justice system continues to provide amnesty to torturers and facilitates impunity for the current police forces. The country still lives under the protection of the 1979 interpretation of the Amnesty Law, despite recommendations having been made by the Truth Commissions and by Inter-American Court.[16] The lack of reinterpretation of this law indicates the conservative political bias that has prevailed in the judicial field, establishing a serious limitation for necessary changes within the democratic process. Moreover, the lack of recognition for the crimes and violations committed in the past by the Armed Forces and the police have led to a pattern of violence and killing within the most vulnerable societal groups, primarily those who live in the slums, black people, the indigenous populations and the imprisoned.

Today, the world is confronted by a conservative and regressive movement. Brazil is not immune to this trend. Brazil's fragile democracy, in 2016, suffered a judicial-political-parliamentary *coup d'état* with the decisive support of the media that removed the president without her having committed any crime; a regression on rights that had been conquered after years of struggle. The implementation of the so-called "economic adjustment policies" has seen a significant increase in the levels of unemployment and social economic inequality. Police violence has also increased, primarily toward the most vulnerable groups of society. Intolerance is exposed through culture, where fundamentalism dominates. Fascism is manifesting itself all over the country, even those who have parliamentary mandates praise torture and revere notorious torturers. Public authorities break with constitutional principles shamelessly or with no qualms of possible sanctions. The Amnesty Commission, a state organ, responsible for reparation, is currently at risk of extinction. The attack on these principles and conventions, to which the Brazilian state is signatory to, speaks to the core of Brazilian democracy's fragility.

[16] Gomes Lund case, November 2010, which determined that crimes against humanity should be investigated and the perpetrators should be held responsible by the Brazilian state.

We can infer that if the state had invested more earlier on and with more effort in the construction of human rights, enabling an advance in Transitional Justice measures, current levels of violence would not be so high. With more established ethical principles and with a stronger sense of citizenship, society's capacity to respond to this setback could have been halted as would the tendencies to reverse the social and political conquests of the last decades. Democracy and human rights are inseparable. They coincide to create a historical context where the level of "democracy" is variable, depending on the respect and the guarantees provided by the state's public administration. Reyes Mate affirms, above all, that, "there is no justice without the memory of injustice," and that, "the philosophical response to the irreversible injustice caused to the victims is to keep it alive in the memory of humanity, we cannot say it has been dealt with until the past has been accounted for" (Mate, 2009, p.22).

Injustices should be remembered so that they are not repeated. Although memory can be considered a necessary political condition, it is insufficient to stop human barbarity from happening again. Keeping the memory about injustices of the past alive, however, is an enormous contribution to the construction of an ethical dimension that has a critical edge. It is an important contribution for those that gave testimony to find new places of belonging, to construct ethical benchmarks for future generations, as well as for the development of a common agenda in the pursuit of justice.

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Cultural logics of emotion: Implications for understanding torture and its sequelae

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Key points of interest:

- Moral emotions, like shame, guilt, or humiliation reflect cultural systems of meaning that are used to inflict damage in torture and that must be renegotiated in the process of recovery.
- Emotions involve bodily and social processes that are based on cultural models, social scripts and scenarios; much of this knowledge is tacit or implicit and emerges in response to specific cultural affordances that depend on social context.
- Exploring the cultural meaning of emotions for survivors of torture in both their original and current social contexts can contribute to clinical assessment and the design and delivery of interventions.

Abstract

This paper explores the significance of cultural variations in emotion for the meaning and impact of torture, focusing on the dynamics of shame, humiliation, and powerlessness. Forms of physical and psychological pain and suffering share some common neurobiological pathways and regulatory systems that are influenced by social and cultural factors. All forms of torture follow an affective logic rooted both in human biology and in local social and cultural meanings of experience. Understanding the impact of specific forms of torture on individuals requires knowledge of their learning histories, and of the personal and cultural meanings of specific kinds of violence. Exploring cultural meanings requires attention to over-arching discourse, embodied practices, and everyday engagements with an ecosocial environment. Restitution, treatment and recovery can then be guided by knowledge of cultural meanings, dynamics, and strategies for coping with catastrophic threats, injury, humiliation, helplessness and loss.

Keywords: torture, shame, humiliation, cultural variations in emotion, treatment, recovery

Introduction

In this paper, we explore the significance of cultural variations in emotion for our understanding the nature of torture. Our aim is to show how a contemporary ecosocial approach to cultural

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neurophenomenology can inform theory and practice (Kirmayer, 2015). In particular, we draw from recent work in embodied and enactive cognitive science, which suggests new ways of thinking about the interactions of culture and biology in experience (Kirmayer & Ramstead, 2017). We do not focus on specific cultural examples because of the risk of creating misleading stereotypes. Instead, we illustrate a general approach to cultural meaning through discussion of the role of moral emotions, particularly shame, in the dynamics of torture. We want to argue for the utility of an approach to cultural variations in emotional experience that can both help to explain the mechanisms of suffering in torture and point the way toward new strategies of assessment and intervention that foreground social context.

The term "culture", in this discussion, stands for all of the humanly constructed and transmitted knowledge, institutions, and practices that constitute a way of life. Culture shapes experience developmentally, laying down learned associations, habits, skills, and automatic patterns of perception and dispositions to respond. Across the lifespan, cultural influences continue to organize experience both from the top down, through discursive practices that provide narratives for experience and, from the bottom up, through body practices that shape how we carry ourselves and respond to the physical presence of others and the environment. Culture is transmitted not only through explicit talk about mind, self and person, moral codes and the meaning of actions, experiences and events, but also through social and environmental affordances—cues and possibilities for perception and action present in particular life worlds and social niches. A major part of culture is learning how to attend to, interpret and act on these humanly constructed contexts (Ramstead et al., 2016). Much of this involves regimes of shared attention that allow cooperative action. Hence, we approach culture as situated meaning and practice.

Torture manipulates, attacks and deconstructs the familiar cultural contexts of everyday life, substituting one that is chaotic and unpredictable. In so doing, it acts to dismantle the individual's sense of self, coherence, and community, which is based on ongoing participation in a shared and predictable social world (Breyer, 2017). Yet, before, during, and after the experiential ruptures of torture, individuals use all the resources of culture to make sense of suffering and reconstruct their lives. A cultural perspective that emphasizes the social embedding and meaning of emotions, trauma and suffering can thus explicate crucial dimensions of the phenomenon of torture. Indeed, recognizing these dimensions may be essential to engage clients in treatment and address the full range of their concerns.

Torture and the nature of suffering

Torture occurs in very different social contexts, is directed against people from diverse backgrounds, and varies in ways that reflect cultural differences in values, coping strategies, sense of self and personhood. While some theories portray the response to torture as biologically fixed and determined (whether as the response to intense pain, conditioned fear, or loss of control), a cultural perspective insists that structures of meaning and social practices reach down into the body to shape experience from its inception. Although pain and fear are universal responses to injury and the threat of injury, their relationship to suffering is complex and mediated by meaning and context (Kirmayer, 2008). Forms of physical and psychological pain and suffering share

some common neurobiological pathways and regulatory systems (Eisenberger, 2015), but these are influenced by cultural factors both developmentally and through current social contexts. Thus, both the experience of pain and fear during torture and their long-term effects are shaped by culture (Kirmayer, Kienzler, Afana, & Pedersen, 2010).

Trauma-related distress covers a broad domain of symptoms and suffering, but much clinical research on torture has emphasized the diagnostic construct of post-traumatic stress disorder (PTSD). The construct of PTSD reflects universal patterns of responding to trauma but joins together multiple components in ways that have been determined by a history of social and cultural practices as well as political and economic considerations (Kirmayer, Lemelson & Barad, 2007; Young, 1995). DSM-5 describes the behavioral symptoms of PTSD in terms of four clusters: re-experiencing; avoidance; negative cognitions and mood; and arousal (American Psychiatric Association, 2013). Considerable cultural variability can be found in each of these clusters along with specific symptoms of trauma-related stress (Hinton & Lewis-Fernandez, 2011).

The appeal of PTSD has been both its fit with common patterns of experience and its link to a large body of research on conditioned fear responses in animals and humans (Kirmayer, Lemelson & Barad, 2007). However, the picture of trauma response in PTSD, and the focus on fear do not capture the full range of impacts of torture, which commonly occur in settings of social disruption and massive human rights abuses (Bolton, et. al., 2012; McGregor et al., 2016; Tay et al. 2015, 2016; Sales, 2016) and a broader view of trauma-related distress is needed (Kagee & Naidoo, 2004). Exposure to torture and massive violence can have consequences that go beyond fear-related responses to include persistent distress associated with shame and guilt, as well as depression—all of which may contribute to disability and dysfunction (Lee, Scragg, & Turner, 2001; Somasundaram, 2008; Steel et al., 2009; Tol et al., 2007; van Ommerren et al., 2001; Wilson, Droždek & Turkovic, 2006).

Based on clinical observations and field research, Silove provided a broader picture of the potential consequences of torture and massive human rights violations in terms of five biosocial adaptive systems, involving: attachment and social bonds; safety or security; social identity or role; justice and human rights; and existential meaning (Table 1) (Silove, 1999, 2007; Kirmayer et al., 2010); Tay et al., 2015). These systems span individual psychological and social processes so that the framework may be thought of as ecosocial as well as biobehavioral. Each of these adaptive systems is associated with particular emotions which are exacerbated by the torture experience and which unfold in specific social and cultural contexts.

Attachment and social bonds. Torture may deliberately target social bonds, making the individual feel an intense sense of isolation, loss, and abandonment. We depend on stable attachments to others for emotional sustenance and self-regulation not only early in development but across the lifespan. Social support and solidarity through interpersonal processes have a complex relationship to trauma response and recovery (Maerker & Horn, 2013). However, there is evidence that social support can mitigate risk for post-traumatic depression and other trauma-related symptoms (Brewin, Andrews & Valentine, 2000; Johansen et al, 2007; Johnson & Thompson, 2008; Ozer et al., 2003; Porter & Haslam, 2005; Shalev, 2007).

Table 1: *Adaptive systems affected by torture*

Adaptive System	Threats	Emotional Reactions	Psychopathology	Interventions
Attachment	Separation from significant others, and culture	Anxiety Grief Home sick-ness Nos-talgia	Anxiety Depression Complicated grief	Re-connection with loved ones Mourning Creation of new bonds Membership in social groups Recreating community systems
Security	Uncertainty Loss of control	Anxiety Insecurity Hypervigi-lance	Anxiety PTSD	Re-assert control over self and environment
Identity/Role	Loss of social and occupational roles and status Misrecognition, identity	Powerless-ness, shame and humili-ation	Suicidality Role confusion	Recognition of status and identity Opportunities for mean-ingful action Family interventions Community membership Human right protection Social security
Justice	Sense of injustice, arbitrary violence Impunity	Anger, Hos-tility Lack of trust Resentment Bitterness	Traumatic anger Paranoia	Engagement Trust redevelopment Family trust redevelop-ment Truth and reconciliation Human rights protection
Existential Meaning	Loss of sense of coherence, purpose, and hope for future	Search for meaning	Alienation Disengagement Crisis of faith Transgenerational transmission	Testimonial approach, telling one's story Re-engagement in life projects Linking with culture, community and religious traditions Political activism

Adapted from Silove (1999, 2007), Ekblad & Jaranson (2004), and Kirmayer, Rousseau & Measham (2010)

Safety and security. Torture exposes individuals to inescapable threat, fear, pain and injury in ways that are designed to make the victim feel intensely vulnerable and powerless. Survivors may endure continuing threats to their own physical safety or that of their families due to economic stress, material deprivation, or proximity to their torturers, who may continue to hold power and have impunity from prosecution. The lack of safety in refugee camps and other transitional settings can contribute to torture survivors' distress and impaired functioning (Miller

& Rasmussen, 2010). Asylum seekers may experience detention under harsh conditions and prolonged uncertainty about their future—all of which compound the disruption of security from torture (Silove, Austin & Steel, 2007).

*Identity and Social Role***.** Torture often involves systematic attacks on the identity of the person and their social and moral status within the community, undermining a sense of purpose, value and esteem. Many forms of torture, like rape, explicitly aim to damage or destroy the person's social standing or "face." Shame and humiliation are key emotional mediators of this process of abjection, which are shaped by cultural norms of honor, recognition, and respect. In effect, the stigma attached with the experience of torture, rape and denigration of identity undermines survivors' control over their own social identity and self-presentation.

Justice and human rights. The arbitrary or capricious way that torture is meted out may contribute to intense and persistent feelings of anger at injustice, but this is mediated by the meanings ascribed to the situation (Batson, Chou & Givens, 2009; Wemmers & Manirabona, 2014; Tay et al., 2015). There are universal expectations for a just world and forms of restorative justice aim at re-establishing this moral order for individuals and communities (Mendeloff, 2009). However, notions of justice and fairness vary with different social, moral and political systems (Avruch, 2010; Hatfield & Rapson, 2005). Cultures that accept specific types of hierarchy and gender roles may differ in what they consider unjust for specific classes or categories of people and may sanction violence as a way to restore honor and social equity (Fiske & Rai, 2015; Ignatieff, 1998). In international arenas, human rights discourse and legislation provide ways to assert and argue for forms of justice that transcend local systems of honor, discrimination or political expediency (Donnelly, 2013). Human rights are framed in terms of common human needs for dignity, realization of capabilities, and flourishing but, again, the details of how this is to be achieved for people with specific social roles and positions may vary across societies (Appiah, 2011; Kateb, 2011; Kirmayer, 2012).

Existential meaning. Torture aims to isolate the individual from their usual frames of reference and make core values and commitments seem pointless or absurd. The loss of a stable community and cultural frame of reference can create a state of bewilderment and uncertainty, undermining the sense that one's life and actions have meaning and value. Commitment to the social cause or ideology of the threatened or oppressed group may mitigate the impacts of stress and torture (Barber et al., 2014; Başoğlu et al., 1997a,b; Willis, Chou & Hunt, 2015). However, by insisting on the individual's powerlessness, torture may be deliberately organized to be maximally disruptive to the person's sense of agency, order, coherence and the possibility of meaningful action.

This list is not exhaustive but serves to enlarge our ways of thinking about the impact of torture and encourages us to look at the role of several different affective systems. Torture exerts its damaging effects through loss of sense of control, disruptions in interpersonal functioning, and the denigration and destruction of individual and group identity (Nickerson, Bryant, Rosebrook & Litz, 2014). Intense emotions of fear, anger, shame, and disgust can all contribute to the suffering caused by torture. Undermining a sense of justice, meaning in life, and a valued social identity all serve

to impair survivors' ability to exert control over their world. At the same time, others' awareness of the history of torture may have corrosive effects on the way they view the survivor and on the functioning of family and community. The broader meanings of torture can be elucidated by exploring the implications of the violence for the survivor, for their family, and for others in the community (Rousseau, 1995).

Torture survivors are often reluctant or unwilling to tell their stories of trauma before basic needs are met and trust is developed (Jaranson et al, 2001). They also may be unwilling to talk about their trauma experiences due to lack of confidence in health care staff, feelings of shame, fear of increasing their symptoms, or a lack of knowledge about available help (Jaranson, et al. 2001). Understanding the broad dimensions of experience that are attacked by torture and the intense emotions associated with these kinds of attacks on the person can guide practitioners in rebuilding survivors' sense of trust, self-efficacy, and control over their lives (Mollica, 2004; 2008).

Emotions in cultural context

Emotions reflect both putatively universal human systems of adaptation and culture-specific scripts rooted in particular forms of social life. There are universals of emotion rooted in biological, psychological, social and existential realities. At the biological level, for example, anger and fear reflect basic adaptive responses of fight or flight built into the nervous systems of animals that are predators and prey. Such basic emotions are shared with other animals and reflect biobehavioral patterns that organize motivated, adaptive behavior (Panksepp & Biven, 2012). However, emotions also involve cognitive appraisal processes that determine what counts as danger, what future consequences are to be feared or expected, and how to respond behaviorally, beyond the initial physiological arousal. These attributions and interpretations reflect cognitive maps, models or schemas of situations. This process of appraisal and interpretation is crucial for more complex emotions, which reflect social scenarios and predicaments that follow particular cultural scripts (Oatley, Keltner, & Jenkins, 2006). Such emotions can only be understood by appreciating the history, current context and future consequences embedded in that script. To the extent these scenarios describe a local social world or situation that depends on particular cultural institutions, identities, roles, and practices, the emotions they give rise to may be culturally distinctive.

As a result, emotions are grounded in meaning systems that shape the interpretation of experience. Because such interpretive systems depend on culture (Markus & Kitayama, 1991), cognitive theories suggest that people learn to interpret their physiological signals, bodily sensations, and environmental contexts in different ways across cultures (Kitayama, Mesquita, & Karasawa, 2001). Emotional response then is not directly determined by a situation or event but rather by the individual's *appraisal* of what the event means and by the responses of others. Thus, the learning theory of trauma, for example, builds on earlier work on stress and appraisal (Lazarus & Folkman, 1984) to posit that individuals appraise potential threats to psychological well-being to determine whether such threats are controllable or not (Başoğlu, M., & Salcioğlu, 2011; Başoğlu, 2017). Such appraisal influences subsequent emotional and behavioral responses.

How individuals appraise a particular situation depends on how they interpret

its significance in terms of their personal history and cultural meaning systems. As a result, there may be significant differences in how people view even apparently similar events across cultures (Moors et al., 2013). Moreover, emotions differ across cultures to the extent that emotions reference particular kinds of social situations, scenarios or predicaments that depend on specific cultural notions of person, family and community (Lutz & White, 1986). Culture-specific emotions may be built on the foundation of basic emotions but extend them through social scripts that give emotions new meaning, experiential contours and social consequences. In effect, emotions are embodied and embedded in specific social and cultural contexts that involve sequences of interpersonal actions and reactions (Boiger & Mesquita, 2012). These interactions are part of social affordances that elicit and elaborate emotional responses (Ramstead, Veissière & Kirmayer, 2016). Getting a clear picture of emotions requires thus learning more about their social contexts—including their developmental history, current configurations, and future consequences—which determine the experiential quality and temporal unfolding of the emotion (Prinz, 2014). These cultural dynamics of emotion will influence how the processes that mediate the suffering and sequelae of torture unfold over time in terms of emotional experience, symptoms, and functioning.

One way that appraisals vary cross-culturally is connected with how people think about the relationship between self and others. For example, there is an extensive literature showing that certain cultures can be characterized as more relational or collectivistic, while others are more individualistic in orientation (Markus & Kitayama, 1991). This is reflected in the ways that people respond to measures of basic emotions (Özkarar-Gradwohl et al., 2014). People from cultures that emphasize interdependence tend to think of themselves in relationship to others, while those from cultures that more highly value independence tend to think of themselves as interpersonally disengaged (Mesquita, & Ellsworth, 2006). These preferred modes of self-construal influence the ways people respond to social situations, including those that involve moral transgressions (Dean & Fles, 2015).

The ways in which societies exert social control may also be influenced by the perceived relationship between self and other. In cultural psychology and psychological anthropology, this has been framed in terms of cultural differences in the relative emphasis on shame or guilt for social control (Wong & Tsai, 2007). In more relational cultures, a primary device for maintaining social order may be the inculcation of shame, with the concomitant threat of social exclusion. In more individualistic cultures, social control may be maintained more often by creating and reinforcing feelings of guilt for engaging in prohibited behaviors. Whereas shame is experienced in response to perceived moral violations in the eyes of the other, guilt is experienced when individuals violate their own internalized moral standards. It is important to note, however, that this contrast is framed from an individualistic perspective that downplays the extent to which all self-experience, evaluation and direction are grounded in social models, norms, and the expectations of others. To the extent that individuals' sense of self incorporates the gaze of the other, the distinction between shame and guilt breaks down and more complex accounts are needed to capture multiple facets of the self

and their influence on cultural variations in emotion (Kirmayer 2007b).

Björkqvist (2017) discusses how shame serves social regulatory functions and how social shaming and exclusion can cause intense pain, which may be mediated by attachment systems. The self-conscious emotions of shame and guilt have been termed "moral emotions" because they are linked to perceived violations of a moral code (Morgan, 2011; Williams, 2008). In a sense, though, any emotion linked to particular social events and outcomes may function as a moral emotion (Frijda, 2004). Moral emotions locate socially valued (or prohibited) behaviors within a larger cultural matrix of desirable and appropriate (or harmful and transgressive) values, goals and behaviors. Research by Shweder and colleagues (2003) emphasizes that people in different parts of the world tend to use different kinds of moral codes to guide their moral judgements and distinguish three kinds of moral codes or "ethics": 1) *Ethics of autonomy*, in which morality is viewed in terms of individual freedoms and rights violations; 2) *Ethics of community,* where morality is conceived in terms of the duties individuals have to perform in accordance with their role in the community; and 3) *Ethics of divinity,* in which morality revolves around concerns about purity or sanctity and the perceived "natural order" of things. Rozin and colleagues (1999) found that violation of each of these codes produced specific moral emotions: Violations of the ethic of autonomy tend to provoke anger; when the ethic of community is violated it leads to contempt toward to the violator; and violations of the ethic of divinity evoke disgust. When the violator is victim, made to violate as part of the regime of torture, the negative emotions may be self-directed. These codes are not arbitrary or abstract systems but are based on cultural systems of meaning and grounded in social practices. The experience of specific moral emotions gives cultural systems of meaning and value their cogency and bodily-felt immediacy.

Moral emotions and the logic of torture

These considerations on cultural variations in emotion have implications for how we think about torture. Moral emotions play a central role in the logic of torture. The ethical or moral codes that are transgressed in specific acts of torture may give rise to particular emotions. In general, any context of torture will involve transgression of multiple codes. For example, rape may be seen as a violation of personal autonomy, social bonds and identity, and purity. This would be expected to differentially elicit feelings of anger, shame, and disgust, respectively. In most instances, all of these emotions will be evoked but with varying intensities and implications that depend on cultural meaning and explanations.

Through knowledge of what constitutes a moral violation or transgression, the torturer seeks to cause maximal suffering, loss of control, shame and humiliation to destroy the dignity of the individual and nullify their social standing, sense of self-efficacy and self-respect. The particular ways that torturers do this draw from psychological universals but also employ knowledge of cultural systems of meaning and social contexts, especially those situations that tap into moral emotions. Başoğlu (2017) cites evidence suggesting that the traumatic impact of humiliating treatments or attacks on personal integrity, cultural values, morals, or religious beliefs is mediated in part by helplessness arising from inability to act on anger and hostility generated by such aversive treatment. Guilt, shame and humiliation may have other

corrosive effects related to the individual's loss of valued social identity and position. Identifying the pathways by which torture exerts its immediate and long-term effects therefore requires knowledge of the cultural meanings of the torture in relation to the communities from which survivors come and those to which they return.

Any noxious sensation or emotion that is sufficiently intense and uncontrollable can lead to profound feelings of demoralization and powerlessness. Intense feelings of anger, shame, and disgust all can play a role in causing emotional injury. For example, intense shame can disorganize thinking and impair coping and interpersonal interactions; intense anger can be equally disorganizing. These noxious emotions can also be conditioned to trauma-related cues and persist or recur despite individuals' efforts at mastery and recovery. Because such conditioned emotional responses can be intense, derailing, and difficult to suppress, emotions like fear, shame, disgust not only may be inherently distressing in terms of their experiential quality (Levinas, 2003) but also signal loss of control through cognitive, emotional and bodily responses (e.g. trembling, urination; fainting; retching) in ways that add to the person's experience of shame and helplessness.

Beyond causing immediate distress, the experience of intense negative emotions can reorganize behavior through processes of memory, conditioned learning and coping responses in ways that leads to continued suffering and disability. Emotions like shame serve to organize salient memories, and rumination on shameful experiences can be intensely preoccupying, impairing social functioning and contributing to anxiety and depression (Matos, Pino-Gouvela & Duarte, 2012). In addition to these cognitive influences on memory, conditioned emotional responses can exert profound effects on aspects of bodily and psychological functioning in ways that occur outside of an individual's conscious cognition. Thus, just as cues associated with pain can evoke fear in anticipation of future pain, so too can cues associated with nausea come to evoke feelings of queasiness and disgust. In fact, we are biologically prepared to learn to associate nausea and disgust with salient stimuli. The capacity for disgust is hardwired and likely served evolutionary functions of avoiding potentially toxic, infectious or parasitic disease (Curtis, 2013). Thus, responses of disgust in response to bodily transgression can occur rapidly, without much cognitive mediation, and be extremely difficult to suppress (Russell & Giner-Sorolla, 2013). But this basic bodily response can be readily linked to other symbolic stimuli. What counts as disgusting, then, reflects a personal and cultural history of exposures. Thus, a person who observes Muslim dietary rules of *halal* might develop intense feelings of nausea and disgust when forced to eat pork. Moreover, in every culture disgust is elaborated and becomes linked to more complex social cues associated with symbolic notions of impurity and moral transgression. Symbolic acts that violate cultural norms of purity can then be used to evoke intense disgust and even nausea, which—when sufficiently intense, uncontrollable and persistent—may lead to enduring feelings of helplessness. Koenig (2017) provides clear examples of how violation of cultural norms was used to induce shame and helplessness in Guantanamo detainees. Deliberate transgression of religious symbols of the sacred has been used to deliver faith-based torture (Khan, 2010).

Shame and humiliation play major roles in most forms of torture. Budden (2009) has argued that shame is an important mediator of the effects of trauma both in the acute stage

and in later coping. Moreover, shame is central to the social consequences of trauma. Two broad sources of shame can be distinguished: 1) failure to conform to social norms and expectations; and 2) loss of social status or experience of one's inferior status (Fessler, 1999, 2007). These forms of shame may serve to maintain social order through conformity and hierarchy, respectively, and may be closely coupled, when failure to perform according to norms leads to loss of social status or when diminished social status impedes the individual's capacity to maintain appropriate behavior. However, cultures vary in the extent to which they distinguish between the two forms. To take the examples offered by Fessler (2004), in North American English, the word "shame" tends to be applied mainly to feelings in situations of failure to conform to social norms and expectations. In Bengali and some other Indian languages, *lajja* refers primarily to a sense of shame associated with status inferiority (Sinha & Chouhan, 2013). In Indonesia, *malu* refers to both status inferiority and failure to conform (Röttger-Rössler et al., 2013). This conjunction may reflect the fact that maintaining the status hierarchy is a key social norm and that reminders of one's lower status serve a social regulatory function.

In torture, intense feelings of status inferiority are created by acts of domination that cause acute subjugation. This results in a loss of agency and control, which when persistent and profound leads to feelings of helplessness. In ordinary social life, we exert control not only through our own actions but by eliciting cooperative responses from others. The whole context of torture violates social norms and expectations for recognition, cooperation, care, reciprocity and respect from others. Victims experience powerlessness not only because of their personal loss of control over circumstances and behavior but also because of the abrogation of basic social expectations for predictable responses and cooperation from others. Moreover, in torture individuals may lose control over both bodily functions and the social presentation of self as a consequence of violence and deprivation or may be forced to explicitly violate social norms by their own actions under coercion leading to a loss of moral integrity and rupture of social identity. While these forms of violence rely on universal logics of emotion and psychophysiological mechanisms that make them just as intense as processes that involve physical pain or terror, their initial impact and long term consequences also depend on specific cultural frameworks that confer meaning and provide modes of explanation.

People have implicit causal theories they invoke to explain both actions and afflictions. These theories draw from cultural systems of practical and moral reasoning (Tilly, 2006). The psychological and social consequences of specific explanations depend on larger systems of meaning that are embedded in particular ways of life and that reference cultural ontologies that identify what kinds of entities or processes can act as causal agent. Explanations of complex events often use concepts drawn from multiple frameworks and a range of ontologies can be invoked in response to torture based on the context in which it occurs. In the case of torture in the context of war, socio-political explanations may be relevant. Understanding torture as a risk related to one's political commitments may help individuals to prepare to endure it, confer a level of control over the experience since it is framed as a consequence of political choices or resistance, and help to make sense of suffering (Başoğlu et al., 1997a,b; Punamäki et al., 2008). However, given that torture often involves the transgression of moral codes, moral explanations are

commonly used. In addition to anger directed toward the torturer, survivors of torture may perceive themselves as having transgressed moral boundaries. In part, this may reflect a general tendency to understand misfortune in terms of one's own actions or to consider that one might have done something to avoid adverse outcomes. This attribution may serve to maintain an illusion of control in situations of helplessness or reframe the torture in ways that maintain a sense of moral order. However, in many instances, the torturer aims to make the survivor feel responsible for all that has befallen him or her as part of the attack on social personhood or on the larger community. This may include blaming the victim bringing suffering and loss to their own loved ones. To the extent that this attribution succeeds, victims may see themselves as the architects of their own suffering. Finally, the arbitrariness and lack of correlation or proportion between action and response in the delivery of violence that is part of the deliberate design of torture may have a corrosive effect on the survivor's sense of justice and coherence.

Learned helplessness and loss of control

Torture renders the individual helpless and defenseless both physically and psychologically. Indeed, the structure of torture, with repeated experiences of loss of control, works to dismantle the individual's sense of self-efficacy and moral worth in ways that may persist after their release and engagement with new social situations. The experience of being forcibly confined and cut-off from ordinary social interaction, relationships and supports destabilizes the person's sense of identity and control (Gallagher, 2014), which are ordinarily maintained by cooperative and reciprocal relationships with others. Normal strategies to deflect, reject and resist abuse are no longer possible. This confinement, domination and violence force the person to endure unbearable suffering, to comply with his tormentor and to agree to actions utterly inconsistent with his values and identity. This coercion aims to destroy personal integrity. Breaking down individuals' resistance and forcing them to perform transgressive acts "voluntarily" leads to a loss of agency and dignity. The shame and humiliation that follow from such subjugation contribute to feelings of utter helplessness that come from being forced into passivity and "acted upon" as a dehumanized object.

Many of the effects of torture, including the impact of shame and humiliation, can been understood in terms of the theory of learned helplessness (Abramson, Seligman, & Teasdale, 1978; Başoğlu, 1992; Başoğlu & Salcioğlu, 2011). Aspects of everyday life that are commonly understood as being normally or potentially under the individual's personal control include bodily functions, choices of action, and self-presentation. Torture works to undermine these domains of control and self-mastery, not only in the moment but into the future. It accomplishes this by repetitive attacks, coercion, pervasive uncertainty, and direct undermining of efforts to re-establish control.

The domains where individuals expect controllability also depend on cultural ontologies and explanations. Not every kind of event is viewed as (potentially) controllable. Explaining events in terms of forces or agencies like fate or "God's will" that lie beyond anyone's control may help some individuals to endure but they may also lead to ineffective coping strategies that impair functioning. On the other hand, traditions that emphasize coping by controlling one's own mind may help individuals endure experiences of loss of behavioral control and the same attitudes

may help with subsequent adaptation (Agger, 2015; Elsass, Carlsson, Jesperson, & Phuntsok, 2008; Elssass & Phuntsok, 2009; Kohrt & Hruschka, 2010). Forcing individuals to transgress cultural and religious norms and values then constitutes multiple forms of violence, causing direct injury, blocking efforts to give meaning to suffering, and damaging their social identity in ways that may lead to persistent feelings of estrangement from others (Khan, 2010; Kirmayer, 2015).

Conclusion

Torture involves many forms of violence, targeting multiple systems involved in the response to intense fear, physical and emotional pain, threat or injury to loved ones, loss of social bonds, hopelessness, helplessness, and humiliation. The impact of torture involves not only its physical and psychological effects on the sufferer but its social meaning to all involved. These meanings are interpreted and understood through systems of cultural knowledge and practice, which contribute to the social and psychological dynamics of emotion.

To more fully grasp patients' experience, clinicians need to map the social spaces, body practices, scripts, and contexts that give moral emotions their meaning and consequences. This map includes the tacit dimensions of experience which individuals may not be able to describe but only show. Important aspects of cultural meaning may remain unsaid because of suppression, avoidance, or dissociation or unsayable because they are hypocognized and embedded in external affordances. Eliciting this information may require discussion with others as well as family, home, or community visits. This mapping can include: the pre-torture context, where it can elucidate structures of meaning that are associated with vulnerability and resilience; the context of torture, where it can help explain the impact of specific forms of violence; and current contexts of adaptation, where it shapes the dynamics of hope and recovery.

Discussions of culture in mental health often focus on traits or characteristics of designated others (usually 'non-Western' peoples) who are depicted as different in relation to the tacit or explicit norms of Western societies. Becoming aware of and "sensitive" to these differences is supposed to improve care (Kirmayer et al., 2016). However, in practice, this sometimes results in crude stereotypes that may impede clinical understanding and rapport. Moreover, this approach hides what is most central to culture, namely the taken-for-granted assumptions of the observer. From this perspective, the cultures that are most important in clinical practice include those of the receiving society, the practitioner, and of the profession itself, which provide the background knowledge and implicit norms that are used to judge what is unusual, interesting, or clinically relevant about others.

Lack of understanding of others' cultural worlds leads to inhumane responses to their predicaments. This failure of empathy and imagination is seen both in public policy and in the microcosm of clinical care. In recent years, many countries have begun to renege on their commitments to receiving refugees, and those who make it to the shores of a safe country may face systemic discrimination, as well as skepticism and disbelief when they recount their experiences (Kirmayer, 2007a). Mapping the social and emotional meanings and consequences of torture can foster better understanding and more appropriate social, political and clinical responses.

Taking local meanings of emotion seriously has implications for how we measure

outcomes in research, clinical assessments, or human rights advocacy. We need to look not only at physical and psychological symptoms but also to broader adaptive functioning in terms of individuals' ability to feel confidence in their own capacities, in the predictability of the world, and the trustworthiness of the human community (Campbell, 2007; Jaranson & Popkin, 1998; Kirmayer, Rousseau & Measham, 2010). Torture has consequences not just for individuals' physical health, cognitive-emotional functioning, and psychological well-being but also for their relationships with others (Maercker & Horn, 2013; Nickerson et al., 2014). Of course, the quality of interpersonal relationships and social interactions is closely related to individual's psychological functioning. Hence, when psychological treatment improves individual functioning, relationships with others may also improve. But the causal process works the other way as well: forms of political violence directed to families and communities that disrupt trust and social bonds, increase the risk of trauma-related disorders among everyone and may be stronger predictors of PTSD among torture survivors than the torture experience itself (Başoğlu et al., 2005). This has wider ramifications for families and communities. Beyond individual impacts, then, we need to consider the ways in which the impact of torture disrupts families and communities and contributes over to time to cycles of violence. Understanding the cultural contexts of torture and its aftermath is essential both for effective treatment of survivors and for the prevention of torture.

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Factor interaction in prevention of torture Reflections based on Carver and Handley's research

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Key issues box:

- Preventive means should be seen as a complex of factors that interact in synergy and, together, they impact on practices in detention where torture is committed.
- Ranking the importance of factors can be problematic since it draws the focus of prevention to components that may only work fully in synergy with other components.
- The merging of many different observations concerning preventive actions of diverse quality may blur outstanding results. When designing prevention programmes inspiration should, inter alia, come from identified best practices. High quality work pays off.
- Assessing accurately the "burden" of torture (torture vs. severe torture) is difficult and the distinction is problematic from both a legal, strategic/political and practical/research point of view.
- The exclusion of intentional ill-treatment during interrogations in research on torture is problematic, given the blurred border to torture and given the frequent manipulation of definition or misclassification of torture by authorities.

Summary

"Does torture prevention work?" is a very comprehensive book based on commendably profound research in 16 countries. It contains a wealth of very important results concerning the relationship between a multitude of factors in the prevention and occurrence of torture. However, the results described may be interpreted in a manner different to how it was done in the book. The intention of this paper is to draw attention to some challenges in the research design and to give a broader view of the complexity of torture prevention.
The book: The authors have identified a host of preventive factors, organised them in clusters (detention law and practice; prosecution (of torturers) law and practice; complaint law and practice; and, monitoring law and practice), and scored them according to whether they fulfil international standards. A torture score comprising frequency, geographical spread and severity of torture was constructed (CHATS). Ill-treatment was excluded. Correlations between preventive factors, clusters and CHATS were calculated. However, the interrelationship between various factors and clusters was not analysed. The main findings included that detention practice had the strongest (negative) correlation to torture and that the torture scoring, pooled

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for all countries, declined during the study period (1985-2014). **Comment:** For several reasons, distinguishing 'more severe torture' from 'torture' is problematic. Excluding ill-treatment in the research is also problematic because the border between the two may be blurred and difficult to interpret and it may be manipulated by authorities, leading to falsely low torture incidence. The pooling of data of diverse quality may hide outstanding prevention results. Identification and implementation of best practices is recommended. Preventive means implemented with low quality may give legitimacy to practices in torturing detentions. The quality of preventive actions is key to efficiency. Factors and clusters of preventive means interact in synergy making each other fully effective. A new model for torture prevention is proposed, which emphasises that all preventive means interact together with transparency, lack of corruption and reprisals, forming the practices in detention where torture takes place. The political will to prevent torture is a key factor.

Keywords: Torture, ill-treatment, prevention, factors of prevention, interaction, quality, best practice, new model, political will

Introduction

Richard Carver and Lisa Handley have written a great and commendable book on prevention of torture based on original research undertaken in 16 countries covering the period 1985 - 2014,

"Does Torture Prevention Work" (Liverpool University Press 2016; 662 pages). It is a book definitely worth reading for its wealth of information relevant for torture prevention. It also invites reflection on how research on this subject should be designed and how results can be interpreted.

The amount of work invested in the research work is obviously immense. Apart from Carver and Handley (in addition to auxiliary staff, including statisticians), there must have been researchers employed full-time in each country studied for up to two years, amounting to an estimate of at least 30 years of research. It is practically unthinkable that other researchers could find such time and money to do something similar. Therefore, this book will represent a key source of knowledge in the field of torture prevention and be a valued handbook on torture prevention for many years to come.

Given this inarguable status of the book, it is important that it is analysed thoroughly with respect to the design of the study as well as the interpretation of the results presented. The intention of this paper is therefore not to give a comprehensive overview of existing literature on prevention of torture, but to analyse and comment on the book on its own premise with the eyes of a practitioner. The overall goal is to encourage discussion among practitioners and academics on how torture prevention works and how its effectiveness can be improved. This paper will therefore give an overview of the findings and conclusions in the study, raise some questions regarding methodological approaches, and discuss the findings as well as the implications that may be drawn from this comprehensive study.

The present paper consists of four sections:

(1) a section describing the content of the book (assuming that only a few professionals dealing with torture prevention have found time to read the whole book[1]) emphasising some key issues concerning study design, results presented and the authors' interpretation of the findings;

(2) comments on issues mentioned in (1);

(3) propose a model for the way factors important for torture prevention interact (Figure 2 and 3 of the original book).

[1] A summary of the book can be found at: http://www.apt.ch/content/files_res/apt-briefing-paper_yes-torture-prevention-works.pdf

(4) a summary of conclusions and main considerations.

The content of the book

The design of the study

The study consists of:

- A section on quantitative analysis of the relationship between preventive measures and the incidence of torture for each year in the period 1985-2014 in the countries studied: The UK, Norway, Chile, Hungary, Indonesia, Israel, Peru, South Africa, Georgia, Tunisia, Turkey, Ethiopia, India, Kyrgyzstan, The Philippines and Argentina (approximately 100 pages).
- Qualitative descriptions of factors of importance for A from the 14 countries where torture was found. In Norway, torture did not exist and Argentina was excluded; nevertheless, some qualitative information from Argentina appears in the book.

The authors argue that qualitative studies succeed in describing complexity, but fail to convince that observations can be generalised; and that quantitative studies often have been unconvincing because they have relied on flawed measures, including failing to recognize that legal obligations must be translated into practice to have effect. They therefore combined quantitative and qualitative measures. They further identified multiple elements of prevention, separated legal obligations—*law*—, from their implementation—*practice*—, and developed a new measure of torture incidence.

Measures in torture prevention, the independent variables

The authors present a model to illustrate the relationship between various important factors in relation to torture prevention. According to this model (Figure 1), the political environment, in interaction with law and training of relevant actors, determine the practice (implementation) of preventive means. This again determines the degree to which torture is practiced or prevented.

The authors have identified a number of means of prevention and organised them into clusters. The clusters of preventive measures are divided into two groups, one for relevant legislative measures, 'law' and one for the corresponding 'practices'. The eight clusters are: 'Detention law and practice', e.g. existence of unofficial /secret detention centres; 'Prosecution (of torturers) law and practice', e.g. whether independent investigations were done; 'Complaint law and practice', e.g. whether cases were referred to investigating / prosecutorial authorities; 'Monitoring law and practice', e.g. conducting interviews with detainees. For more details, cf. below.

All elements of the clusters were scored from 0-2. The highest score of 2 was given if legal requirements or practice were in accordance with international standards. The sum of scorings of elements made up the index of the cluster. Higher scores indicate more complete fulfilment of international standards in law and practice.

All indices increased in value with time. Monitoring indices increased much more than the other indices and their values were by far greater than the values of all other clusters by the end of the study, i.e. by the end of the study, monitoring fulfilled international standards much better than the other groups of preventive means (clusters).

The authors found that law clusters scored better than practice clusters, i.e. law was more often in agreement with international standards than practice. In four graphs, the law and practice scorings are visualized over the study period. The gap between law and practice was greatest for the prosecution indices.

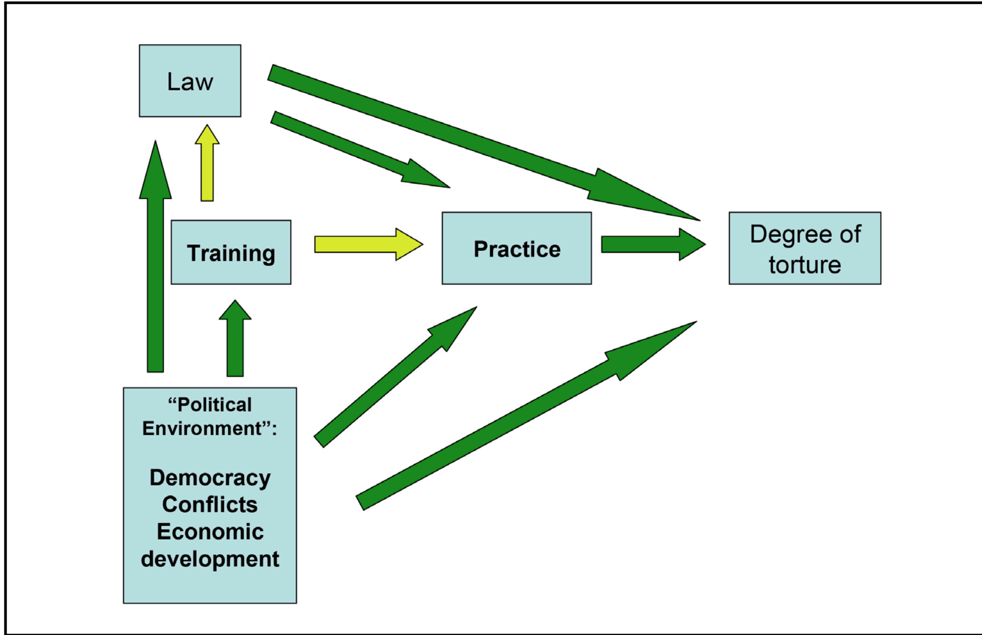

Figure 1: *Various important factors in relation to torture prevention (p49)*

In the multivariate analysis, four control variables—democracy, national conflicts, economic development and population size—were included. Level of democracy was measured using the Polity IV database; conflicts assessed using the Major Episodes of Political violence index; and for economic development Gross Domestic Product (GDP) was chosen.

Incidence of torture, the dependent variable
The authors assessed a number of existing torture scales and found *inter alia* that, based on one of these scales, torture is much more prevalent in the UK than in Ethiopia! Amnesty International (AI) reports, together with reports from the US State Department, formed the basis for these assessments. The authors emphasise that AI's reports are about known cases and not about incidence, hence not apt for comparison over time or between countries. Countries with few cases and easy access to information (an aspect of democracy) may ring the torture bell more often than a country with many cases and difficult access to information and /or high risk of reprisals for reporting torture—the "human rights information paradox" (HRI paradox).

Torture was distinguished from other forms of ill-treatment where suffering is not inflicted deliberately (a criterion of torture in the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment and Punishment (UNCAT)). The authors acknowledge that ill-treatment caused by poor conditions in prisons may have an impact on the general respect of detainees' rights, including freedom from torture, and forms a part of the mandate of monitoring mechanisms. However, the authors choose to investigate the impact of prevention on the incidence of torture and not on the incidence of ill-treatment. The severity criterion of the UNCAT was employed.

When assessing the incidence of torture, the authors used information from contemporaneous annual reports as a starting point and verified that information using other sources, i.e., reports from international and domestic human rights organisations, official and unofficial statistics and interviews with primary sources. All scores of torture produced by the country researcher were peer reviewed paying particular attention to years of changes.

The authors designed their own score for measuring torture, CHATS (the Carver-Handley Torture Score). Three measures are included in this:

(1) *Frequency:* on a score 0-3, from absent to routine and pervasive.
(2) *Geographical spread:* 1 for occurrence in particular regions or areas, 2 for the whole jurisdiction.
(3) *Severity:* 1 for treatment sufficiently severe to qualify as torture, and 2 for more severe torture. The distinction is based on torture methods used, duration and repetition, and combination of methods.

A value was calculated for each country.

If torture exists (frequency score > 0) the geographical factor was only added to the scoring if torture was observed in the whole jurisdiction and then only with one point. Likewise, the severity factor only added one point to the score if the observed torture was severe.

The authors state that the distinction between torture and severe torture was included because prevention not always eliminates torture, but sometimes prompts changes of methods. This became apparent when dealing with Turkey where changes to less severe methods of torture preceded a decline in frequency of torture. The reason for introducing the distinction was to capture the intent of the state agents who commit torture.

The CHATS values, based on the mean values for all countries taken together, decreased in the course of the study period. Turkey was mentioned as a success case.

Correlations between clusters of preventive measures and CHATS values

The scoring values of the eight cluster indices (detention law and practice; prosecution (of torturers) law and practice; complaint law and practice; monitoring law and practice), as well as the scoring values of elements of the clusters were correlated to CHATS values; results are given in tables provided in the book. The impact that a cluster or an element could have on other clusters or elements was not dealt with in the book.

The cluster detention practice came out as the best predictor (strongest negative correlation with CHATS) followed by prosecution practice. Correlations between the four law indices and CHATS were weak.

In the bivariate analysis, all eight clusters came out as significantly negatively correlated to CHATS (the better the law and practice, the less torture). Detention practice was by far the strongest predictor, followed by prosecution practice and monitoring practice. The remaining clusters only correlated weakly.

When the four control variables (democracy, national conflicts, economic development and population size) were included in multivariate analyses, detention practice was the only cluster that (nearly consistently) came out as significantly correlated negatively to CHATS.

Correlations between elements of preventive measures and CHATS

Correlations between elements of preventive measures and CHATS are, in the following, listed for each cluster according to strength of negative correlation.

Detention law: ‘Recording of interrogations’, ‘family notification’ and ‘unlawfulness of unofficial detention’ came out as significantly negatively correlated to CHATS.

Detention practice: 'Unofficial detention not practiced', 'family notification of detainee's whereabouts', 'detainee informed of right to lawyer', 'exercise right to lawyer', 'medical examination performed', 'lower reliance on confession', 'recordings of interrogations', 'prompt presentation before judge', 'video monitors used and available', 'training of police and custodial personnel' were all correlated negatively and significantly to CHATS. All practice elements scored better than law elements.
Prosecution law: 'Independent investigation' was much stronger (negatively) correlated with CHATS than 'existence of substantial penalties' and 'no statute of limitation' and 'criminalisation of torture'.

Nearly all the negative correlation between 'prosecution practice' elements and torture were far more convincing, 'torture complaints lodged' being the strongest, followed by 'conviction rates', 'no amnesty for torturers', 'complaints investigated' and 'suspension of suspected torturers'.

Complaint law and practice: most issues are to a low or moderate degree negatively correlated with CHATS. That law 'permits complaint mechanism to compel evidence' and the practice to 'refer cases to prosecution' have the strongest correlations followed by 'training of complaints personnel', 'effective investigation conducted and reports of activities published'.
Monitoring law: The best law measure was found to be the 'power to conduct unannounced visits', 'power to conduct interviews', and 'requirements to produce reports'.
Monitoring practice: Best of all monitoring elements was that 'monitors were not sanctioned' for their monitoring activities followed by 'conducting interviews', 'training of monitors' and 'publishing reports'.

Both international and national monitoring have a moderate and comparable negative correlation with torture.

Implementation and impact of recommendations based on monitoring were not analysed.

Immunity for inmates for communicating with monitors is mentioned as a very important factor for effective monitoring. Fear of reprisals is mentioned as a major obstacle to effective monitoring, but the issue of reprisals is not systematically analysed.

Law measures were (almost) consistently found to be more weakly correlated to CHATS than practice measures. This was not seen as if anti-torture laws were unimportant; but practice came out as a better *predictor* for occurrence of torture. Laws were seen as a necessary fundament for good practices and not as isolated measures. In this line there was a (weak) negative correlation between ratification of the UNCAT and its Optional Protocol and CHATS.

Training of personnel involved in arrests, interrogations and custody; prosecutors and judges; complaint personnel; police and prison facility monitors were significantly (but not strongly) correlated negatively to CHATS. Training of professional skills of police investigators and doctors was more effective than mere human rights training. The authors refer to anecdotes indicating that sometimes human rights training was regarded as a required ritual that had little bearing in the real world. When Soviet police investigators left Georgia and Kyrgyzstan after the collapse of the Soviet Union, the incidence of torture increased. The new police investigators were not capable of resolving crimes and resorted to torture.

Environmental /control factors: Democracy is supposed to be more prone to offer procedural guarantees, more likely to adhere to rule of law and hold perpetrators accountable. The observations from Georgia and Kyrgyzstan (cf. above) are noteworthy. India is a parliamentary democracy where the incidence of torture has been high during the whole study period.

It was found that democracy and existence of conflicts were (in some of the statistical models) correlated to CHATS in the expected manner, while Gross Domestic Product was not.

The book has a section on transitional justice. The main impression was that is does not work well, partly because of a great delay, but also because the public is "able to simultaneously believe that torture of middle class political activists (the minority of all cases) is heinous while torture of marginalised and allegedly criminal youth is unfortunately necessary" (p88) (e.g. Argentina).

Merging observations from different countries: The authors state that the record on monitoring and complaint is uneven in many of the countries studied, making it difficult to draw firm general conclusions on efficiency (when pooling very different results).

Comments and reflections

In the following I will present comments and reflections based on my reading of the study, and in particular, the points raised above.

Exclusion of ill-treatment from the analysis

The authors restricted their analysis to the concept of torture and excluded ill-treatment. Ill-treatment, in relation to torture and detention, may mean different things:

(a) Deplorable conditions in cells, i.e., non-intentional suffering most often caused by lack of resources, which the authors excluded. This may be regarded as an aggravated form of "pain or suffering arising from, inherent in or incidental to lawful sanctions" (UNCAT § 1), which the Convention does not include under the definition of torture.

(b) Beatings, threats, humiliations, deprivation and exhaustion procedures during interrogations and detention not reaching a level that qualifies it as torture, i.e., *intentional* infliction of suffering by officials, for a purpose, but not meeting the severity criterion. This form of ill-treatment has similarities with torture; its infliction of pain and suffering is intentional, purposeful and committed by a public official.

The UN Convention against Torture *and Other Cruel, Inhuman or Degrading Treatment and Punishment*, deals with ill-treatment as well as torture. As an example, the fact that its §16 expresses that provisions in §§10-13 apply for other cruel, inhuman or degrading treatment and punishment as well as torture. Although only torture is mentioned explicitly in those articles, the connection between torture and ill-treatment is underlined.

A frequent and serious problem in the fight against torture in countries where torture is widespread is that the states do not acknowledge its existence. The threshold of suffering between ill-treatment and torture is set very high by authorities with the consequence that many cases that should have been classified as torture are only labelled as minor offences, e.g., abuse of power, or excessive use of force, or enhanced interrogation techniques. This problem is related to (c) below.

(c) In countries with a certain level of access to information, torture consists of methods that do not leave physical marks e.g., suffocation with a plastic bag or with water; a combination of repetitive non-violent beatings, threats, sleep deprivation, physical and psychological exhaustion and confusion procedures (Spain). These are far more difficult to document than bruises and fractured bones. Nevertheless, these acts should be classified as torture.

It is not quite clear how the authors tackle these challenges, i.e., the manipulation of terminology by authorities and interpretation

of those cases on the border between torture and intentional ill-treatment. Moreover, in the chapter on Hungary, it appears that statistics on ill-treatment exist and that ill-treatment (supposedly in the intentional form related to detention and interrogation) apparently contributed to determine the CHATS value for Hungary.

If the intentional ill-treatment (above (b)) is excluded from the discourse it will, particularly in combination with (c), give states where torture is used in the fight against terrorism and crime, an incentive to shift from "classical" physical torture methods that leave marks and chronic physical conditions to more sophisticated methods that are easier to conceal, much more difficult to document and probably much more difficult to raise public awareness about; but equally effective for achieving the purpose (e.g., obtaining confession or information whether true or false, breaking up groups of "terrorists" or felons, or intimidating the general population) and detrimental for the long term psychological health of the victim—and of course still a serious crime. It could be feared that the success of torture prevention in Turkey found by the authors is a result of such a shift from classical very violent torture to more refined methods now labelled ill-treatment—or at best "less severe torture"; and labelled that way it does not add points to the CHATS value (cf. below). It is not clear how the criteria for distinguishing torture from ill-treatment and less severe from severe torture worked in practice. Is e.g. water boarding torture or severe torture? And how is the scoring of all three CHATS elements done if the two types of torture coexist?

A related problem is that the interpretation of the definition of torture may shift as mentioned in the book. British authorities used the "five techniques" (deprivation, exhaustion and confusing procedures) against Irish Republican prisoners, which in 1978 was classified as "inhuman and degrading treatment" by the European Court of Human Rights (ECHR). However, in the 2000 case of *Selmouni v. France*,—the ECHR regarded a significantly less severe treatment as torture. This could make comparisons over time difficult and it underlines the difficulty that arises when only torture, and not ill-treatment, is considered in the analysis.

It could be argued that particularly because the distinction between torture and ill-treatment is blurred and often subject to manipulation, ill-treatment must be included in measurements of abuses in detention. Moreover, authorities who resort to ill-treatment described under (b) above can be expected to cross the ill-treatment/torture border if they find it necessary for their purpose.

The distinction between less severe and severe torture and the CHATS

The authors argue in favour of the distinction between less severe and severe torture by referring to observations that a shift towards less severe torture often precedes a decline in the incidence of torture and that they wanted to capture the intent of state agents who commit torture.

An alternative interpretation is that such a shift to less severe torture made it easier for authorities to misclassify cases of torture as e.g. abuse of power, hence achieving a better CHATS scoring. It could be that the intent of officers was to conceal the practice of torture using methods that are harder to detect, which can hardly be seen as a great success of prevention, particularly if such practice is accepted by superiors, politicians and the public as less controversial and thereby used more generally against more suspects.

CHATS is a measure of incidence (frequency and geographical spread) and

severity of torture. How observations on frequency were translated into scorings does not appear clearly with an example.

It appears that the way CHATS works—only severe torture adding points to the score—means that, for example, a few cases (1 point) of severe torture (1 point) spread over the whole country (1 point) will score as much as routine (3 points) less severe torture (0 point) in half of the country (0 point). A scenario that may occur in countries with internal conflict (Turkey?). Or: a country that shifts from more to less severe torture and at the same time spreads its practice from one province to the whole country will have an unchanged score. At first glance, this does not seem a fair picture of the practice of torture in the country. It would have facilitated the understanding of the appropriateness of the CHATS if the book had given examples of how the CHATS had been applied on observations from the individual countries.

A further consideration could be that subdividing torture into less severe ("soft" or "clean") torture and severe (mainly physically mutilating?) could jeopardise the fundamental concept that *all* torture is extremely cruel and that it has severe consequences for the majority of victims—in its less severe form maybe "only" psychological and social. A country that shifts from severe to less severe torture will—all things being equal—be seen as having made progress, which is hardly in line with the spirit of the pertinent international conventions.

The case of Argentina illustrates another problem: (registered) incidence of torture fell when democracy was restored; but it persisted. It could be speculated that the initial fall in incidence was limited to political cases of high visibility and awareness, while torture of ordinary criminal suspects remained constant, and that (at least part of) a subsequent raise in incidence was due to the HRI paradox: with more democracy, more cases of torture of ordinary criminal suspects (the majority of cases) became known due to more transparency in the administration of justice.

Environmental control factors included in the multivariate analysis

As the measure of economic development, GDP was chosen and it was found not to be related to CHATS. Some sort of average national economic potential could be thought to impact on incidence of torture, e.g. via availability of technical resources for police investigation and training of all relevant staffs. However, it could be argued that the level of inequality would be a much more relevant measure since inequality is correlated to political instability and crime, and torture could be a means to maintain power and wealth for the privileged, who feel a need to be tough on crime.

Correlations of preventive factors with CHATS

Components included in the clusters

(a) 'Unofficial detention not practised' was found to have the "highest impact on the incidence of torture" (p68). This way of wording may be problematic since a cause-effect relationship is not fully documented. In the following the phrase 'negative correlation to CHATS' is used. However, the finding is not surprising since there is no outside scrutiny to protect the detainee's rights. Unofficial detention has been practiced in countries in conflicts like Argentina in the seventies and later by the US as "extraordinary rendition." In these cases it can be assumed authorities at the highest level were aware of this form of detention and used it deliberately as a means to, inter alia, extract information under torture. After unofficial or secret detention, many victims disappeared.

On the other hand, a ban on unofficial or secret detention may be seen as an indicator for governments' willingness to abolish or limit torture. If so, one could suppose that the government at the same time would introduce other measures against the use of torture, indicating that it may be problematic to look at clusters and elements separately because connections between components and clusters exist. However, unofficial detention could also be seen as an indicator that government has little control over this and potentially also other activities of the police. Again, this indicates that there are strong connections between various factors.

(b) 'Training' of all relevant actors comes out as significantly (but not strongly) correlated negatively to CHATS. It could be supposed that the way training is organised and its quality is very important for its impact, i.e. implementation of changes of institutional practices. After two to three days of training a police officer may return to untrained colleagues, who may not be willing to listen to the wisdom learned, and a change of institutional culture cannot be expected. A huge number of training workshops carried out by a state may look impressive, but the impact may swiftly vanish if the management of the institution and colleagues are not prepared to implement changes. To be effective, training must be organised in a way that facilitates a change of the culture of the whole institution. The quality of the preventive means can be supposed to be key to impact.

(c) The existence of 'medical examinations' is found to be among the elements that had the strongest negative correlation to CHATS, which is a little surprising. In many countries, a medical examination is only built on an encounter between doctor and detainee of a few minutes (e.g. some places in Mexico). The examination can be regarded as a formality without practical significance and is sometimes conducted in the presence of the police. In some countries (e.g. Spain), police officers are often within hearing distance. Such factors will discourage many victims from relating exposure to torture. Documentation of torture is thereby impeded and the preventive effect of the medical examination is jeopardised.

Moreover, in some countries (e.g. Spain) a medical document mentioning allegations of torture and describing bruises very rarely leads to investigation and prosecution. To be effective in the prevention of torture, a medical examination and its record must be of a certain quality, and documentation of torture should have consequences in terms of reporting and investigation. Doctors working in places of detention are rarely fully independent and have had little or no training in how to identify a victim and document torture (although Turkey is mentioned as a case where training has taken place).

If a medical examination routinely and with good quality is carried out and the court subsequently acts in cases where torture is documented, this can be supposed to have impact. Such cases may indicate some commitment of the authorities to fight torture and it could be supposed that the government would implement other preventive actions, i.e. indicating connections between preventive means. If, on the other hand, the quality of the medical

examination is low and no action is taken if torture is documented, the medical examination setup can be regarded as a means to blur the facts. In the worst case, authorities will use it as an argument that torture does not exist. This may in particular be the case if the torture used in general is too sophisticated to be documented by overburdened non-specialist doctors working in places of detention.

When a judge considers an allegation of torture, the assessment is based on the statements of the alleged victim, those of police officers and a medical forensic report. In general, the credibility of officers is valued much higher than that of a suspect. Furthermore, the judge may not be fully independent and may not have a full understanding of medical procedures and terms and the potential for documenting facts. Medical reports are often of low quality due to lack of medical independence and skills, i.e. doctors lack training, instructions and supervision. In addition, they may be under time constraints and under pressure from police officers, who are present within sight and/or hearing distance.

(d) 'Prompt presentation before a judge' is a component of the detention clusters, but the quality of the courts actions, inter alia, based on independence, dismissal of evidence obtained by way of torture and ill-treatment, freedom of corruption and scrupulous scrutiny of all material, including medical documents, is not dealt with in the study. The torture preventive effect of the court depends on other preventive factors, e.g. the work of the lawyer and the medical examination, underlining that some preventive factors within the same cluster (e.g. detention practice) interact.

It can be supposed that, if courts took action based e.g. on good quality medical documents and initiated investigations on possible torture (UNCAT obligation), it would impact on the practice in detention. (Some) officers might refrain from torturing due to the risk of prosecution.

(e) Exercising 'the right to a lawyer' correlated negatively to CHATS. The mere presence of a lawyer in the detention would deter officers from torturing. However, this right may be completely watered out as it has been e.g. in Spain where terrorist suspects, while in detention, may not talk with or even see the appointed lawyer, whose only role until the suspect appears in court is to witness the suspect's declaration to the police.
Preventive means may as such be used in ways that only give legitimacy to practices in torturing detentions, i.e., such means may be counterproductive when not being implemented with rigour and good quality.

(f) 'Reliance on confession' as evidence is a historical and serious problem, particularly when the confession it is given to the investigating police. This problem still exists in many countries. The Italian criminologist Cesare Beccaria (1738-1794) commented: "Torture is the surest means to acquit the robust felon and condemn the weak innocent." Particularly in combination with requirements for the police to solve a certain number of crimes, the reliance on a confession as the only means of evidence may lead to more torture; e.g. the authors found that in Kyrgyzstan, torture incidence increased at the end of the month when the police struggled to fulfil the monthly demands.

Torture can be seen as a shortcut to "solving" crimes (i.e., getting a confession), particularly if police agents are badly trained in investigative techniques, are under undue stress, including being rewarded for "solving" crimes. Occurrence of torture may, as such, in addition to lack of training and undue incentives, also be related to lack of control of the practices of the police. With the collapse of the Soviet system, oversight and discipline among police officers vanished. Officers were vested with a lot of power, little training and low salaries, a classical prescription for corruption and an incentive for police officers to extort under torture or threats money from arrestees and their families—with or without existence of democratic elections.

(g) 'Corruption/extortion' may be an incentive to use torture. Corruption was nevertheless not included in the research. If a police officer gets a salary that does not allow for making a living for himself and the family, there is a serious risk of becoming corrupt. Detainees may be forced by means of torture or ill-treatment to pay their way out of the police station or to exercise their rights. This practice has been documented by the UN Subcommittee on Prevention of Torture (SPT) in several country visits and this form of corruption is probably commonplace in many countries. It runs in parallel with torture as a way to disrespect detainees' rights. Practices of corruption may be reduced via "bookkeeping" in detention; training, instruction, supervision and oversight of officers; laws; monitoring; complaints and prosecution—and fair salaries.

The practice of corruption may indicate that individual police officers operate in their own interest without disciplinary action taken or any form of outside control; it may also be part of a pervasive institutional culture involving all those who have some power they can abuse, including strong prisoners. This underlines the connection between different means of prevention and corruption (see Figure 3).

(h) 'Complaint law and practice' components were to a low or moderate degree negatively correlated with CHATS. That law permits complaint mechanisms to compel evidence and the practice to refer cases to prosecution had the strongest correlations. Power used by authorities to prevent torture, leading to legal consequences, seems to work to some extent.
However, the complaint system may be designed in a repressive manner. In Hungary, persons who have made allegations of ill-treatment against named officers may be charged with slander for making unfounded allegations. The basis for deeming an allegation "unfounded" could, inter alia, be a medical examination, the quality of which is crucial. The charge could be seen as a kind of reprisal.

Effective complaint mechanisms, which include investigation of well-founded complaints, require freedom from all forms of reprisals, including physical punishment in detention. If the risk of reprisals is considerable, the incentive for victims to complain will vanish. Effectiveness is related to other factors, such as medical documentation of torture and risk of reprisals, law, training and control means. Complaint practice and reprisals may influence each other, e.g. the more reprisals, the less complaints and prosecutions; and the more effective the complaint

and prosecution mechanisms, the less reprisals (see Figure 3).

(i) The best 'monitoring practice' measure was that monitors are not sanctioned for monitoring activities. This is seen by the authors as the ability of monitors to do their work without threats and sanctions. This may be difficult to understand, since it cannot be assumed that it is the absence of sanctions, but rather the conducting of interviews and producing reports with recommendations for change that could cause the changes—together with the torture deterring effect of monitors' presence in places of detention. It seems logical to regard absence of sanctions for monitors as a prerequisite for effective monitoring, like law is for practice. (It should be added that the deterring effect of monitors' presence will normally require very frequent visits).
It could be interesting to know where, how often and under which circumstances monitors were sanctioned in order to really understand the significance of this finding.

Conducting interviews, which is the main activity of monitors during visits, only came in as number two regarding strength of correlation to CHATS. The authors mention immunity for inmates for communicating with monitors as a very important factor for the efficiency of monitoring. Fear of reprisals is mentioned as a major obstacle to effective monitoring (for interrelations between reprisals and other factors, cf. above), but the issue of reprisals is not systematically analysed.

Publishing reports on monitoring and complaints was significantly and negatively correlated to CHATS. It would be an indication that *transparency* in administration of justice impact on public opinion and political will to implement changes, leading to strengthening of preventive actions and consequently to reduced incidence of torture (Figure 3)

Quality of implementation of previous actions
The authors discuss another important factor in monitoring, namely the power, commitment and competences of actors, i.e. the way the work is done, or the quality of the preventive work. This could also be a valid point in relation to other practice measures, as mentioned under training, presentation before a judge, complaint and medical examinations. Are the resources of the monitoring body sufficient to allow for a reasonable number of visits with a reasonable number of staff? Are interviews conducted in private and not in the presence of police/prison guards (e.g. Ethiopia)? How are detainees selected for interviews; are interviewees e.g. the strong leading prisoners/capos, who may have common interests with staff in collecting bribes or informal payment for services that should be offered for free, thereby sharing an interests in concealing facts?

The authors state that the record on monitoring and complaint is uneven in many of the countries studied, making it difficult to draw firm general conclusions on efficiency when all results are pooled. One could argue the other way round: rigorous (i.e. weekly) monitoring of police stations in certain areas of Georgia reduced the incidence of police torture dramatically. Such intensive monitoring is not described in other countries. It could be inferred that intensive high quality monitoring is very effective (under certain conditions).

Georgia's outstanding result was not reflected in the overall results. Monitoring in all countries taken together was found to be only weakly negatively correlated to torture. This could be interpreted as a dilution

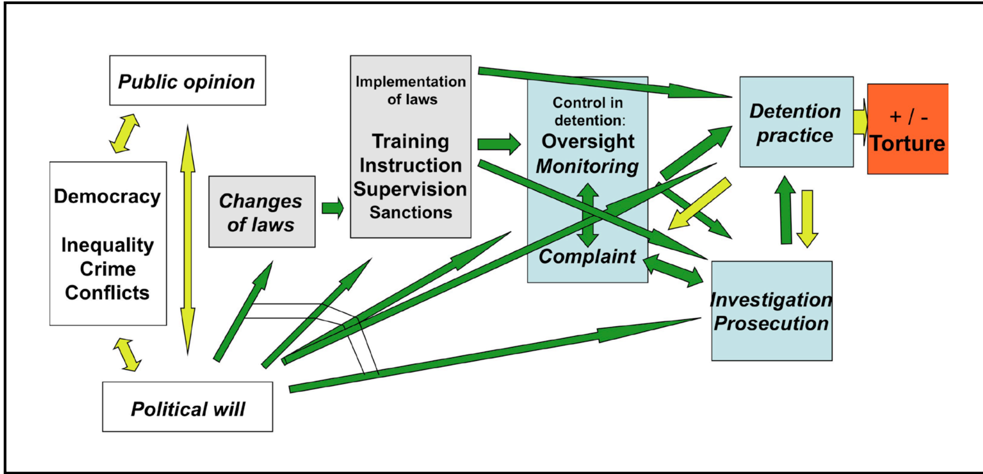

Figure 2: *An alternative model for torture prevention—elements included in 'Does torture prevention work?'*

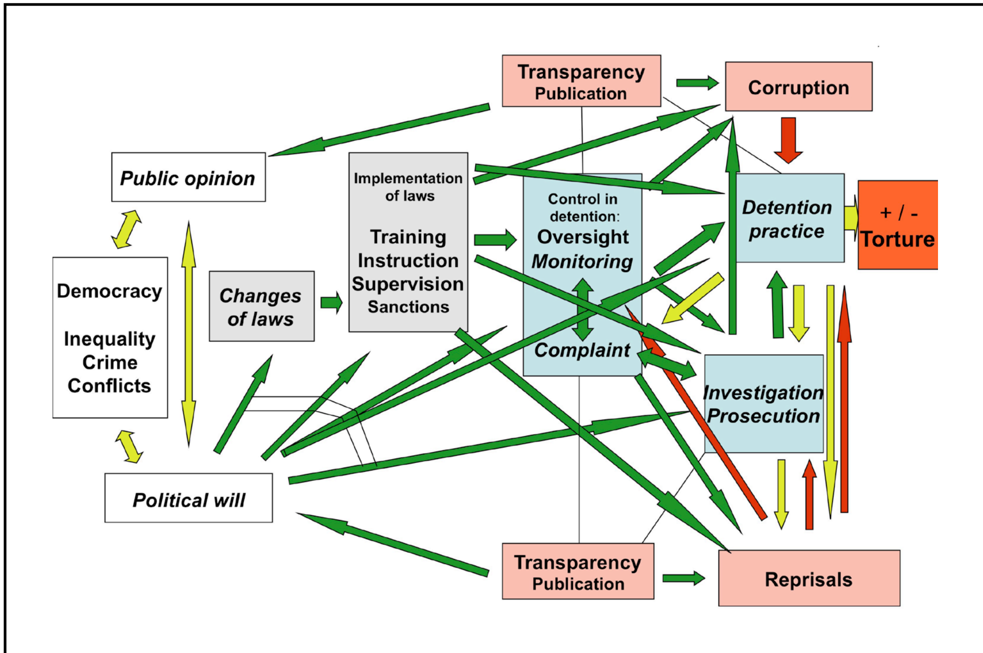

Figure 3: *An alternative model for torture prevention with the addition of reprisals, corruption and transparency*

of the remarkable results from Georgia when merged with the effect of ineffective (sporadic or low quality) monitoring in other countries. This points to a general key reflection: *The rigour and quality with which preventive measures in all categories are implemented is crucial for effectiveness. Identifying best practice could be key to develop better prevention.* However, it must be added that, simultaneously with the intensive monitoring and reporting, other actions were taken in Georgia: promoting treaty ratification and an anti-torture law, and educating the public and officials. This leads to suggesting an *interrelationship between some "first level elements" of prevention"* (cf. below)*, i.e. public opinion and political will* and *different clusters*—and *a synergy when several interventions are combined* (Figure 2).

A proposed model for prevention of torture

The impact of monitors' recommendations on other clusters e.g. detention practice was not analysed, i.e. the interrelation of effects of the different clusters and elements. The indices of the two monitoring clusters were those that increased by far the most during the study period—in parallel with the decline in CHATS values—and reached the highest scores, i.e. the highest compliance with international standards. A question here is: could it be that the practice of monitoring had influenced the detention practice, which in the authors' statistic came out with the highest negative correlation to torture?

This leads to the general reflection already mentioned many times above: the clusters of preventive means work together. If some preventive means were hypothetically eliminated, it would most likely have a negative impact on the efficiency of other means. This also works the other way round, so, if one factor is introduced or made effective, it would most likely have a positive impact on other factors.

The authors have discussed this concerning law measures that (almost) consistently were found to be more weakly correlated to torture than practice measures. They underline that this does not mean that anti-torture laws are unimportant, but only that practice is a better *predictor* for occurrence of torture. A question here is whether a predictor in itself is necessarily equal to preventive potential. A predictor may be heavily dependent on other preventive factors to exert its potential for prevention. Analysing separately the predictive value of a cluster or an element may lead to a misleading interpretation of cause-effect.

An alternative model for prevention emphasising the interaction between the elements of prevention can be seen at Figures 2 and 3.

Explanation of figures

The arrows indicate that the elements inside the boxes impact on elements in the boxes to which the arrow leads. The impact may be positive in terms of prevention, which is indicated by the arrows being coloured green, e.g. monitoring may lead to better detention practice.

- If the impact is negative, the colour of the arrow is red, e.g. reprisals will tend to lead to a reduced number of complaints and investigations, which may lead to more torture through bad practice in detention.
- If an element under some circumstances impacts torture negatively, and under other circumstances impacts it positively, the colour is yellow, e.g. a detention practice where torture is prevalent will lead to fewer complaints, while less prevalent torture in detention with smaller risk of reprisals will encourage more complaints to be lodged.

- The white boxes (first column) represent factors crucial for any change: public opinion, political will, democracy, the level of inequality and crime and conflicts in the state.
- The grey boxes represent the government's endeavours to make changes.
- The blue boxes represent the materialisation of the government's endeavours. They include the four practice clusters with which the authors worked.
- The pink boxes represent additional factors of importance for torture prevention.
- The connecting lines from transparency boxes indicate where transparency should work. Double lines indicate that the actions by the government to abolish torture could be supposed to work simultaneously.

Figure 2 only deals with the elements included in Carver's and Handley's model. The three blue boxes contain the practice clusters used by the authors. The box 'control in detention' is subdivided into (a) oversight / monitoring that interact with (b) complaint. Figure 3 adds corruption, reprisals and transparency. This figure is very complex and a reader may loose the overview. This was the reason for splitting the figure, which hopefully will facilitate the understanding of the complex pattern of interaction

Examples of interactions:

(a) Public opinion and political will interact under the influence of the levels of existent democracy, crime, conflict and inequality. The arrows are yellow since all the elements may be in favour of torture prevention; but they may also give raise to more power to security forces and reduced rights of detainees, e.g. in a "war on crime and terrorism."

(b) The political will is paramount to torture prevention. A government may undermine all elements of torture prevention, in which case all five arrows going out from the box *political will* should be red. This will imply that most preventive means will not work well and consequently most of the positive impact (green arrows from the other boxes) would vanish or could change to be negative.
However, in the model proposed in this paper, it is supposed that a certain political will exist to prevent torture, consequently the arrows from the box *political will* are green. If the political will exists to fight torture, and the government is in control of its institutions, it can be supposed that preventive measures concerning all elements will be reinforced in parallel, which is indicated by the connecting double lines between arrows going out from the box *political will* in both figures. In future studies on torture prevention the political will to prevent torture could be a main issue.

(c) Laws, including those on control measures (oversight, monitoring, complaints), as well as prosecution and detention practice, must be implemented effectively through training, instruction and supervision of all relevant personnel, as well as sanctions for not complying with laws and instructions. Effectively implemented laws would lead to a positive preventive effect.

(d) Implemented control measures (oversight, monitoring and complaint practice*)* together with real consequences for torturer in case of infractions, i.e., prosecution practice, work together forming the practice in detention where torture is committed.

(e) Good monitoring and complaint handling lead to more transparency, supposedly influencing public opinion and the political will to implement

changes—including the reduction of reprisals and corruption. Effective monitoring could also lead to more complaints and better handling of them, apart from the other effects that monitoring has on detention practice.

(f) An effective prosecution practice and good detention practice that is not too unsafe (reprisals for complaining), would lead to more complaints. Effective handling of complaints—eventually via prosecution—would lead to a better detention practice.

(g) Reprisals and corruption can be supposed to exist anywhere torture is used. They interact with monitoring, complaint mechanisms, transparency, prosecution and detention practice.

Torture prevention is here seen as a complex pattern of factors that impact on each other. In this model, good detention practice is the end objective of prevention and it is determined by and it interacts with the other elements.

Torture takes place in detention, which fits with the finding that detention practice is the most important predictor of torture. However, all preventive elements are necessary requirements for effective prevention and, together with additional factors like reprisals, corruption and transparency, they form the practices in detention, i.e. existence or absence of torture.

Summary of conclusion and main considerations

"Does Torture Prevention work?" is a very important book with a wealth of information from research in 16 countries and it is relevant for all who work with torture prevention. The book inspires the reader to reflect on the way elements of prevention work. The present paper comments on the research design and analyses the results in an alternative way to the authors.

Instead of looking at prevention as components that work independently and in parallel, this paper recommends that prevention should be seen as a complex of factors that interact in synergy.

Detention practice had the strongest negative correlation to torture. This fits the proposed model (Figure 2), but, it gives an alternative interpretation: All factors are important. They interact directly or indirectly and, taken together, they impact on the practices in detention where torture is committed, in that way produces a preventive effect.

The scores of the monitoring clusters increased by far the most and reached the highest compliance with international standards over the study period. This does not necessarily undermine the finding that detention practice was found to the best predictor of torture. It could be that monitoring exerted its preventive effect through its impact on other factors and first of all detention practice. The effect of the implementation of monitors' recommendations were not analysed in the book.

Predictive values of preventive means for incidence of torture were not documented to be equal to preventive potentials; particularly considering the interaction between different means.

Ranking the importance of factors can be problematic since it draws the focus of prevention to components that may only work fully together with other components.

Merging of many different observations concerning preventive actions of diverse quality may blur outstanding results. When designing prevention programmes inspiration should, inter alia, come from identified best practice that should be analysed in order to find out why they worked. High quality work pays off. This would apply for all preventive means.

Training of all relevant actors is a prerequisite for high quality work. The same goes for implementation of learned knowledge and skills. The quality of implementation of such learning and control measures—supervision of and oversight with actors—was not assessed in the book.

The quality with which preventive means are implemented and maintained could be a research issue and it should be a priority for monitoring bodies.

Preventive means can be used in bad faith by authorities by converting them to mere formalities with no real value (e.g. the right to a lawyer); by not ensuring a minimum of quality (e.g., low quality medical examinations); or by being repressive (if a dismissal of a complaint leads to persecution for defamation). In this way, they may give legitimacy to a badly functioning administration of justice; and, in a worst case scenario, be counterproductive.

Assessing accurately the "burden" of torture (torture vs. severe torture) is difficult and the distinction is problematic from both a legal, strategic/political and practical/research point of view.

The exclusion of intentional ill-treatment in research on torture is problematic, given the blurred border between ill-treatment and torture and given the frequent manipulation of the definition or misclassification of torture by authorities.

Transparency in administration of justice, reprisals against detainees who report torture and corruption (Figure 3) were not made subject to particular analysis. Transparency can be supposed to have a preventive effect through an effect on public awareness and decision makers.

Reprisals against detainees who report torture can be supposed to have a serious detrimental effect on torture prevention.

Like torture, corruption is an expression of a lack of respect for the rights of the detainee. Hence, torture and corruption can be supposed to exist in parallel. Bribing with the aim of exercising one's rights in detention may include the right not to be tortured.

A crucial condition for preventing torture is that authorities at all levels, particularly the government, are committed to do so. Such a commitment can be expected to influence many preventive means simultaneously.

With this paper, it is hoped that scholars and practitioners within the field of torture prevention will be encouraged to read the important book analysed here and take part in discussion on how best to design research and set priorities for torture preventive work. Such discussions and deliberations should encompass not only the existence of factors of importance for torture prevention, but also the identification of indicators for high quality torture prevention.

Does torture prevention work? Reply to Dr Hans Draminsky Petersen

Richard Carver*, Lisa Handley**

Introduction

We thank Dr Hans Draminsky Petersen for taking the time to engage so thoroughly with the arguments and findings of our book.[2] We also thank the editors of *Torture* journal for giving us the opportunity to respond. One of

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[2] Richard Carver and Lisa Handley, *Does Torture Prevention Work?*, Liverpool University Press, 2016.

the aims of our research was to open a serious debate on the impact of torture prevention measures and this is just such a discussion.

It is encouraging that there seem to be large areas of agreement between Dr Petersen and ourselves. Inevitably, in this response we will focus on the points where he disagrees with us, but we think it is important to emphasize the large amount of common ground.

We will start with a couple of general points about the methodology of our study, since these inform our response to Dr Petersen on a number of the issues he raises (and since we do not have space here to address every single point in his article). The first point is the very narrow scope of our research question. We addressed only the specific issue of whether the preventive mechanisms required in international law, or commonly recommended by treaty bodies, non-governmental organizations, and others, are actually effective in preventing torture. We did not, as Dr Petersen notes, address their impact on instances of ill-treatment falling short of torture. We also did not consider the possible impact of such factors as political will, corruption or other variables that fall within what we describe in our model as the "political environment." We strongly maintain that the success of our study was in part a consequence of the narrowness of our research question: do preventive mechanisms reduce torture? While much writing on human rights in society emphasizes a "holistic" understanding of measures to protect rights, our feeling was that we would be better able to understand the impact of measures to prevent torture by isolating these factors (a "reductionist" approach, if you will). This is not, of course, to deny the importance of other factors, such as "political will," which we, like Dr Petersen, consider important. However, these were tangential to the question that we sought to answer.

The second point about our methodology is that we used both quantitative and qualitative approaches. This may seem self-evident and, of course, Dr Petersen notes it in his article. The significance is that a number of his criticisms refer only to the quantitative findings, ignoring the fact that there is detailed discussion of many of the issues he raises in the qualitative narratives (some 80 per cent of the book), which flesh out and illuminate the statistical findings.

In the remainder of this response, we will address some of Dr Petersen's specific criticisms of the book.

Severity of torture

One of Dr Petersen's strongest criticisms is of our use of the severity of torture as an element of the scoring method that we devised. We embarked on the research hoping that we could use one of the existing indices that scholars have developed to record the incidence of torture. In the event, we quickly realized that these indices were often inaccurate both between countries and within any given country over time. Hence, we developed our own scores based upon a combination of contemporaneous reporting and primary research on the part of our team. There clearly needed to be a means to determine changes in the incidence of torture over time. Simply using the number of torture cases reported would not work for a number of reasons that Dr Petersen discussed. Our torture score (CHATS) therefore includes a number of elements: frequency of torture, geographical spread, and severity of the methods used. This approach could be applied equally in Norway and Ethiopia.

We reflected deeply on the severity question, with lengthy discussions within the research team and consultations with two past UN Special Rapporteurs. A number of points should be made clear. First, we understand that the severity of torture is always

situational and contextual. Our score does not make an assessment of any individual case. Secondly, our consideration of severity was absolutely *not* based on whether torture left visible marks. Stealth torture techniques are not, in principle, less severe than "classical" torture. The assessment is based upon a number of elements, including the duration of torture and the combination of different techniques. To answer Dr Petersen's question, we would consider waterboarding, as normally employed, to constitute a more severe type of torture.

However, Dr Petersen's core objection to our approach is that there is something inherently, perhaps ethically, wrong in distinguishing different levels of severity of torture. We disagree. A distinction is already made between different forms of ill-treatment, with some rising above the threshold required to be defined as torture. Once it is accepted that a severity threshold is possible, logically it makes no sense to say that all ill-treatment above that threshold is equally severe. Practically, we observed that the effect of prevention measures, in some instances, was a change in the methods used towards less severity (while still above the torture threshold). We certainly do not dissent from Dr Petersen's observation that this is not "within the spirit" of the instruments prohibiting torture. But as a matter of social science, we considered the finding relevant.

The exclusion of ill-treatment from the study

As noted above, ill-treatment not constituting torture was not considered in this study, essentially in order to make the research question manageable. It is reasonable to assume that had our question been different, so our answer might also have been different.

We do not accept Dr Petersen's suggestion that this lets governments off the hook because they redefine torture as ill-treatment, since we did not use national definitions of torture but the one to be found in Article 1 of the UN Convention Against Torture.

A related point does deserve discussion. Where does purposive ill-treatment that falls short of the severity threshold fit into this? As we note in the book (p. 37), we are in agreement with leading scholars in the field (Rodley, Nowak, Evans) that the key distinction is between purposive and non-purposive ill-treatment and that torture could be simply defined as the former without departing from Article 1. At the outset, that was the approach that we took. The problem, of course, is that most of the secondary sources we drew upon did not share that definition. So, we found ourselves back with the severity threshold. We doubt that this greatly affected the scores that we assigned (just as the shifting legal definition that Dr Petersen alludes to had little impact). The reason is simply that our five-point scale was not fine-grained enough to capture these distinctions, and nor could it have been while maintaining any credible coder reliability.

Best practices

We were somewhat baffled by Dr Petersen's contention that "The merging of many different observations concerning preventive actions of diverse quality may blur outstanding results." The specific example that he cites on a couple of occasions is the intensive programme of monitoring visits to police detention in Georgia in the mid-2000s. First, we discuss this explicitly in the book (p. 414). Secondly, outstanding preventive interventions are not "blurred" in the quantitative analysis, but rather contribute to the overall finding. Each independent variable is coded on a three-point scale, so a less complete monitoring body will receive a lower score (contrary to what Dr Petersen seems to be arguing).

Finally, it is important to understand that the definition of "best practice" must be what works most effectively, not an *a priori* set of practices that are commonly believed to be good. For example, we concluded that independent complaints bodies (as distinct from independent prosecutors) had no detectable preventive impact. If that finding is correct, then any number of "best practices" in the complaints field would not result in a reduction in torture.

Preventive measures that fall short of "best practice"

Dr Petersen is surprised at our finding that medical examinations are an important measure in preventing torture. Given his long involvement with this issue, we are surprised at his surprise. We can only conclude that he has misunderstood the process by which we coded the presence or absence of preventive variables. In the example of medical examinations, if these were invariably compromised (for example by non-objective doctors or the presence of security officials during the exam) this would be coded as 0—in other words, the same as if there were no examination. Only if examinations were almost invariably independent would the maximum score of 2 be allocated. We completely concur with Dr Petersen's observation on how such examinations are typically conducted—a point that is addressed in a number of the country chapters (and see also p. 72). Similar considerations apply to many of the preventive measures that he discusses. In our codebook, for example, if a lawyer's presence is typically delayed, limited or otherwise compromised, this would not be allocated the maximum score of 2.

Interaction of preventive measures and environmental factors

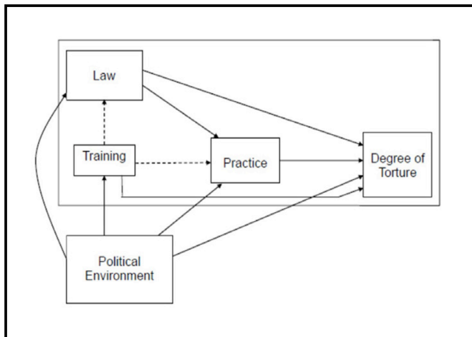
The central argument of Dr Petersen's piece is that different preventive measures interact with each other and with various political and social factors to result in an effective reduction in torture (and ill-treatment). Dr Petersen criticizes us for not taking account of such interaction.

Our multiple regression analysis did examine the interaction between different preventive measures. We also analysed those measures found to be closely related, such as law and practice (although there was considerable divergence for the most important variables) and the role of training in bringing practice closer to law. We also, as Dr Petersen notes, observed a high degree of correlation between the different sets of preventive measures, with governments interested in reform bringing in a variety of different prevention mechanisms.

Moreover, all the country studies consider the impact of all the sets of preventive measures in concert. As a general proposition, for example, we would accept that a monitoring body might make recommendations on detention safeguards, which are then put into practice resulting in a reduction in torture. However, according to our findings, it is still the detention safeguards that have the primary effect, not the monitoring body. The safeguards could equally have been put in place without any intervention from a monitoring body (the United Kingdom among our case studies offers a clear example, see p. 116 ff).

The aim of our model is modest. It is designed to illustrate those aspects of torture prevention that we addressed in our study. (Dr Petersen's rendition of our graphic actually omits one element from the original version—a box indicating what falls within the scope of our research and what does not.) All the relationships in our model are testable and were indeed tested in our analysis. The box labelled Political Environment is important and no doubt interesting but was not the focus of our study for reasons explained above. In each country chapter there is some

discussion of the political environment, since this enables us to understand whether preventive measures were initiated and how effectively they were implemented. Of course, the answer is different in each case. To take one example, "political will" in Northern Ireland derived from a desire to end decades of conflict, in Turkey from a wish to join the European Union, in Chile from the effort to rebuild democratic governance, and so on. Our concern was simply to determine, if the political will *were* present to end torture, what methods would achieve this most effectively. Dr Petersen's models unpack the Political



Environment box, introducing a series of factors that are doubtless relevant in a broad sense but do not help us to understand the simple question of whether preventive mechanisms work and which are most effective at reducing torture. They lead us into territory that is well-trodden, but which provides little practical guidance to the human rights community. Likewise, the claim that everything interacts with everything else is not, we think, a very helpful way of proceeding, leaving us back where we started—with a long list of preventive measures, each of equal and indemonstrable value.

Response by the author

Hans Draminsky Petersen, MD*

Thank you to Mr. Carver and Mrs. Handley (C&H) for their response to my paper and to the editor for the opportunity to respond.

I see discrepancies in expressed views as reflecting disagreements as well as misunderstandings. In the following I'll respond to C&H's reply.

The distinction between torture and severe torture: C&H argue as follows: a distinction already exists between different forms of ill-treatment, with some reaching above the threshold required to be defined as torture; logically it makes no sense to say that all ill-treatment above the torture threshold is equally severe, when seen as a matter of social science.

Seen with my medical eyes a key problem is that severity of torture and ill-treatment is very difficult to "measure." Duration and application of different methods in combination are obviously relevant indicators. However, the problem could be illustrated by asking where exactly is the threshold drawn between ill-treatment and torture and between torture and severe torture? In my view an impossible question to answer in precise terms according to a formula within medical science. Hooding and forced standing for one hour may not be classified as torture, but if it goes on for weeks it certainly should. But drawing an exact "quantitative" line is in my view too difficult and may lead to exclusion of cases that assessed "qualitatively"/individually would be found relevant for the purpose of preventing torture and ill-treatment.

C&H's view is that torture is "situational and contextual." I don't know whether this includes personal factors: the victim's vulnerabilities, his/her own and those related to his/her network. It could be argued that assessing the severity of ill-treatment should include its impact on the victim, psychologically as well as physically. As an example, the impact is different if forced standing for a given period of time is applied to a fit young man, a frail or disabled person or a pregnant woman. In this example a cut-off value would not make sense. In my view classification of cases as torture would very often need an individual assessment.

In individual cases a court may have to draw a line between ill-treatment and torture since the distinction exists in international law. However, I disagree that this juridical distinction, based on profound deliberations in every individual case, can be used as an argument to apply the same distinction *generally* in medical or social science without appraising the individual cases or a sample.

Exclusion of ill-treatment from the study:
Some national governments and courts *misinterpret* the definition of torture in national and international law and *misclassify* acts that amount to torture as less serious crimes. Additionally, the national definition may be insufficient. These means are used by some national authorities to get themselves "off the hook"—and it leads to the perpetuation of impunity.

Whether or not the inclusion of purposive ill-treatment in the study would have affected research results is a matter of speculation. But it remains that it obviously is an objective to prevent ill-treatment as well as torture, including the cases that are difficult to classify which fall into a grey zone between torture and ill-treatment.

Best practice:
I agree with C&H that best practices should be appraised by their results. The finding that intensive Georgian monitoring lead to the dramatic reduction of police torture was among the very important ones. Maybe our disagreement stems from misunderstandings. An *outstanding* result should of course be analysed as to the reasons for achievements. One crucial characteristic, but probably not the only precondition for effectiveness, was that visits to problematic police stations were frequent, an observation that makes a lot of sense and could be applied in other settings.

Quite another issue is what happens when merging such an achievement with the results of "ordinary" monitoring in other countries. In C&H's overall results monitoring was not very strongly correlated to CHATS, while the Georgian monitoring supposedly was. I apologise in advance for using the following simplistic example to explain my view, but find that it provides a vivid picture: If we mix a cup of boiling water with 15 cups of water that are at an *average* temperature of 20 centigrade, the temperature in the mixture will be 25 degrees. If we only look at this we would not infer that one contribution to the whole was very hot. In the merging of research results an outstanding preventive potential may be overlooked/ blurred. Clearly, C&H's presentation of qualitative as well as quantitative data prevented this from happening. However, if merged results are used to recommend specific prioritisation of preventive means it becomes very problematic since an evident preventive potential is ignored.

C&H's example concerning complaints: if all identified attributes of an independent complaint mechanism are assessed to work well and the mechanism nevertheless is

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ineffective in preventing torture it could be that unidentified factors would have importance. According to my model such a factor could be the interaction with effective prosecution of torturers and/or reprisals.

The preventive effect of medical examinations: I appreciate the comments in response to my article. I am not sure that I have fully understood the way the scorings on medical examinations works, i.e. which attributes were used and how they were used, e.g. the quality of the medical examination; but I am somewhat reassured that the findings reflect that the medical examination in the 16 countries of the study on average were done in a more effective manner than what I have witnessed in some countries (which were incidentally not included in the study).

Interaction of preventive measures: Here we disagree. As argued in my paper I think the interactions of factors are crucial for effective prevention (cf. also above concerning complaints). Hence, assessing only the effect of individual factors and clusters may be misleading if we are looking for preventive *potentials*. For example, effective monitoring is one among various factors that may change practices in detention.

C&H's example from the UK is interesting. I read p. 117 as follows: In the study period "dramatic improvements in detention practice" were seen as corresponding to changes in legislation—in combination with better discipline among police officers, new police interviewing techniques, moving away from confession evidence, and better complaints and disciplinary procedures. In my view this points to the likelihood that preventive means interact and work in synergy.

I apologise for the omission of the box in C&H's figure illustrating the focus for the study. However, as expressed in my own figures, I think that an analysis of how torture is prevented should include "political environment"/"political will" and that the example from the UK illustrates this well.

We disagree as to the helpfulness of including interaction of preventive means in the analysis of how torture prevention works and can be improved. C&H express that if everything interacts with everything it leaves us with a long list of preventive measures each of indemonstrable value. My view is different: understanding how factors interact may help us to make each of them effective, e.g. if complaint handling has no observable effect it could, inter alia, be an idea to look at the possibility to link it to prosecution of torturers and the existence of reprisals. When attempting to improve a complaint mechanism it is clearly helpful to have an updated assessment of its efficiency and the efficiency of the prosecution of torturers—as well as an analysis of the reasons for (in)efficiencies.

As appears from several of my remarks here, and from my paper, I regard the design of C&H concerning the elements of prevention and the grouping of them as a very useful starting point in the analysis of how torture prevention works and how it can be improved. It may be that a refinement based on experience/observations could improve the design further, e.g. introducing an item on the existence of, and police officers' compliance with, a protocol for interrogation in detention, cf. the UK example. That being so, as a conclusion I see an interesting perspective in combining this part of C&H's approach with an analysis of reasons for (lack of) effects of preventive means in the light of factor interaction.

Recent ruling exposes leniency of Brazilian Courts to police violence

Alexandre Leal*

On August 9, 2017 the Court of Appeals of the State of São Paulo, in Brazil, absolved police officers of allegations of torture, claiming the infliction of physical and psychological pain was not used with the purpose of obtaining a confession, information or statement about a crime.

The facts of the case date back to 2003. Police officers investigating a kidnapping entered a house in the outskirts of São Paulo in search of the victim. A middle-aged woman and a child were in the house and told the police that they did not have any information about the crime or know where the victim was. The following night, the kidnapped victim managed to escape and get help from police officers who were patrolling the area. It turned out that the victim was being held in a bedroom in a house adjacent to the one police officers had visited.

Police officers then returned to the house, although they did not have a warrant. They allegedly "knocked the middle-aged woman in the face" and "used offensive language against her". They also supposedly beat up a female neighbour who "insisted on looking at what was happening." This woman was pregnant and lost the baby a week later. Police officers arrested the middle-aged woman, her husband and a third male using violence, locking them in a jail cell where tear gas was thrown in twice, while verbal threats and physical beatings took place.[1]

The Court ruling

The court took the view that, while it was likely that the police officers used some violence, state officials had not explicitly asked for a confession, statement or declaration from the victims. This was found on the basis of the testimonies, despite one of the plaintiffs stating "he was physically and verbally assaulted by the police when being put inside the police car […] while officers called him the mastermind of a kidnapping."

It was also found that the evidence did not show that the physical violence had been intense enough to be characterized as torture, or that there was any psychological torture. The court admitted the narrative and evidence pointed to "some excesses" in the operation, which could be characterized as infractions of abuse of police power and infliction of bodily injuries, but this conduct did not amount to torture.

It was also found that there was no clear causal link between the actions of police officers and the neighbouring woman's miscarriage.

[1] The Court's opinion is available in Portuguese at https://www.conjur.com.br/dl/agressao-policial-objetivo-confissao.pdf.

Concerning the psychiatric harm experienced by another plaintiff, the Court understood they were a natural "development of the situation as a whole, considering she was arrested without a warrant, for a crime she did not commit, and detained as a suspect of kidnapping."

Shortcomings of the Court's decision

The decision was subject to much criticism.[2] Police offers' actions are not held sufficiently accountable for their actions and the ruling clearly impedes the reduction of police brutality and protection of human rights, especially those related to the prevention, reparation and accountability of torture in Brazil.

The Court's interpretation of torture reduces its scope and application to a limited nature of cases, negating national and international definitions of torture, and implying that state officials would have to explicitly enunciate that their violent acts are perpetrated with the purpose of obtaining a confession or declaration from the victim.

The decision disregards the domestic law that states torture can also be motivated by "discrimination", or the intention to "apply personal punishment or preventive measures" (Law 9455/97)[3]. Likewise, it neglects the Convention Against Torture, ratified by Brazil, which sets out in Article 1 that torture is inflicted on a person also to "punish him *(sic)* for an act he *(sic)* or a third person has committed or is suspected of having committed."

The decision further highlights a considerable gap in the Brazilian institutional structure for combatting torture. Since its democratization, Brazil has not yet built capacity to investigate and respond to torture cases. Forensic institutes are subordinated to the police (if not legally, *de facto*), and modern tools to investigate and document torture like the Istanbul Protocol are marginally, if at all, applied in the country. In this case, the Court overruled the plaintiffs' claims by making superficial assessments on the severity of physical and mental pain inflicted on them. Such conclusions can only be meaningfully reached with the assistance of an independent multidisciplinary team, including medical doctors and psychiatrists, according to the internationally applied guidelines of the Istanbul Protocol.[4]

Since 2003, when the facts referred to above took place, some progress has in fact been made, partly due to several critical reports issued by the United Nations.[5] 'Custody hearings' were established, in which individuals are brought to court immediately after their arrest and judges are asked to check for signs of torture. Likewise, a National Mechanism for the Prevention and Combating of Torture was created, allowing authorities to visit facilities, issue reports, and follow up on court cases, which should increase accountability from both the Executive and the Judicial Branches.

[2] Consultor Juridico, "Agressão policial sem objetivo de obter confissão não é tortura, diz TJ-SP" [Aggression by police authorities with no aim to obtain a confession is not torture, São Paulo State Court rules"]. Available in Portuguese at: http://www.conjur.com.br/2017-set-19/agressao-policial-objetivo-confissao-nao-tortura-tj-sp

[3] Available in Portuguese at http://www.planalto.gov.br/ccivil_03/leis/l9455.htm

[4] *Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment*, 1999, United Nations.

[5] See for example UN reports: A/HRC/31/57 and E/CN.4/2006/6/Add.2.

At the same time, since before the country's last Universal Periodic Review in 2017, civil society has repeatedly called attention to the spike in occurrences of police violence, with increasingly aggressive tactics and a rising number of extrajudicial killings by state authorities, largely aggravated by a climate of impunity.[6] Brazil has been called upon to "strengthen prevention and effectiveness of investigation of cases of police violence."[7]

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6 Amnesty International "Brazil: Police Killings, Impunity and Attacks on Defenders", submission to the UPR Review in May 2017. Available at: https://www.amnesty.org/download/Documents/AMR1954672016ENGLISH.pdf

7 For a full list of UPR recommendations see https://www.upr-info.org/sites/default/files/document/brazil/session_27_-_may_2017/response_to_recommendations_brazil_2017.pdf .

Sealing the Border: US refuses asylum torture survivors

Gerald Gray*

Dear Editor,
The Republican Administration has already built The Wall, unknown to the U.S. public. It has done so quietly, administratively, in the large section of the Texas-New Mexico border called the "El Paso Sector." A physical fence covers most of this border. The El Paso legal crossing appears to exist, but in fact does not function. The field director of this sector has been promoted to Assistant Director of the ICE Enforcement Division (Enforcement and Removal) in Washington, DC.

These two facts make it clear the El Paso Sector is an experiment to be implemented on the entire border.

This letter is a summary of the report "Sealing the Border," a 44 page report documenting the current US government's virtual refusal to recognize political asylum for torture survivors, those receiving death threats, and other forms of danger. It also points to a de facto racial and ethnic barrier to all immigrants at the southern border of the U.S. The document was produced this January, 2018, by a coalition of church officials, academic researchers, attorneys, and other professionals in the El Paso Sector.[1]

Some of the main points of the document at issue:

1. Informally and off the radar, at the border asylum applicants are told such things as that the U.S. no longer accepts political asylum seekers. Here also, families are first separated. Misinformation is deterrence at the border; if a person persists, the next step is detention.
2. If not deterred at the border, virtually all those applying for political asylum or immigration are imprisoned in one of three prisons on the U.S. side of the Sector, where they await the processing of their applications—which in effect never happens. They are held months until they give up their appeals and return to Mexico. They used to be allowed to live in the U.S. awaiting success or failure of their applications
3. Family members are put into separate desert prisons, children divided from parents, couples from each other, and those imprisoned are moved around among the prisons. This way, parents

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[1] The complete report can be found online at https://www.hopeborder.org/sealing-the-border or https://www.borderlandimmigrationcouncil.org/sealing-the-border

do not know where children are, and in case an applicant happens to have an attorney, the attorneys cannot readily find clients. Attorneys cannot afford leaving their offices to go hundreds of miles from prison to prison. In effect, this means most of the imprisoned cannot have legal representation even if they can afford it

4. ICE attorneys have been appointed immigration judges. In 2017, according to an ICE report, there were 21,420 persons imprisoned along the border here. Two of the three prisons used are for-profit institutions, and private subcontractors work in the Immigration and Customs Enforcement (ICE) prison. The Border Patrol is permitted to stop anyone for questioning within 100 miles of the border, with the possibility of imprisonment.
5. Should a person get as far as an immigration court hearing, the definition of "torture" has been subverted in political asylum appeals alleging danger. Asylum applicants are asked if they themselves were directly victims of just physical torture, and only this counts; witnessing or knowing of the torture of others, suffering disappearances of family or colleagues or friends—these are not allowed. In short, psychological torture is disallowed, while being forced to watch or otherwise experience torture is a common form of torture.
6. Bail bonds are essentially unavailable because bail prices are raised so high that most imprisoned asylum applicants and immigrants cannot wait for their hearings outside a prison.
7. A variety of other serious issues abound: deportation of asylum seekers and immigrants without notice to their attorneys, inadequate language translation in hearings, extraordinarily high rejections of asylum applications (in the high 90% area), loss of papers or denial to attorneys of the right to see them, etc. Deportation is high even among prisoners not voluntarily giving up appeals.
8. The separation of children from parents into unknown prison locations is forced disappearance, a form of torture. The separation and imprisonment of all family members is institutional torture. Sealing the border entirely consigns many to torture and summary execution.

References

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Call for Papers: Perspectives on sexualized torture and gender-based torture

Background

Traditional perspectives on torture are repeatedly challenged by contemporary debates on gender analysis of human rights violations in general and specifically in relation to sexualized torture. Theoretical reflection aimed at a wider conceptualization of torture, including important contributions from a feminist critique, is therefore needed. The scope of analysis must be cast wide to ensure that e.g. rape, attacks on sexual integrity, and suffering inflicted on a human being based on gender identity, including but not limited to LGTBQI discrimination, genital mutilation, abortion, reproductive freedom, are properly considered torture demanding protection under the UN regime.

There is a need to develop specific tools and approaches in detecting and assessing sexual and gender-based torture. Sexual violence extends to many different groups and is specific to various contexts e.g. systematic rape as a weapon of war, sexual torture as part of interrogation, cultural shaming or revenge.

These issues further highlight the need for including a clear and reflective gender perspective in the rehabilitation of victims, which arguably requires a gender-based and culturally sensitive approach to therapy, one which is based on scientific knowledge and clinical experience, and adapted to the needs and situation of the individual. Not less significant are issues with respect to holistic rehabilitation and especially stigma which must also be addressed.

Objective

To gather and disseminate scientific perspectives and experiences in relation to sexualized torture and gender-based violence within the wide field of institutions and bodies working against the crime of torture, and for the right to rehabilitation and reparation, in order to strengthen ways of identifying, assessing and assisting victims of torture in their fight for justice and in their treatment.

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Torture Journal encourages authors to submit papers with a rehabilitation and/or legal orientation, particularly those that are interdisciplinary. We welcome papers on:

(a) what is sexual torture? The definition and interplay between sexual-based violence, sexual torture and gender-based violence;
(b) epidemiological studies;
(c) stigma and dealing with societal consequences of sexualized human rights violations, both when this is performed inside and outside of detention;
(d) discussions and case studies based on, among others, the General comments to the UN Convention against Torture, in particular General Comments No 2 & No 3;
(e) access to justice,
(f) prevention of rape, and domestic violence,
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(h) human trafficking in systematic and non-systematic contexts,
(i) particular victim groups, types of torture, specific vulnerabilities, special risks, children born of rape, social impact, special needs, national legislation, geographical areas etc,
(j) medical diagnosis, forensic assessment and appropriate referral mechanisms of victims, and the significance that documentation has regarding obtaining asylum /residence permit, i.e. legal implications;
(k) psychosocial and community impacts and interventions;

(l) recommended practice when resources or conditions are limited/scarce/not optimal;
(m) national policies and legislation; legal practices; traditional practices (traditional harmful practices);
(n) therapies regarding psychotherapy and group therapy;
(o) psychosocial assistance in emergency contexts;
(p) the social impact in societies that host refugees who are survivors of sexual violence/rape/torture, and studies on sociological views;
(q) cultural and gender-specific issues in situations of torture survivors in places of detention and/or refugee situations;
(r) gender-violence committed in situations of emergencies – where helpers are perpetrators (emergency workers, peace keeping forces);
(s) particular focus on sexual violence/ torture directed towards men; and,
(t) justice and reparation for survivors/ victims of sexual torture.

Submission guidelines

For general submission guidelines, please see the website (http://irct.org/research-development/torture-journal). Papers will be selected on their relevance to the field, applicability, methodological rigour, and level of innovation.

Deadline for submission of abstracts by 30th June 2018 with full articles being submitted on request by 31st August.

For more information

Contact Pau Pérez-Sales, the Editor in Chief (pauperez@arrakis.es) or Nicola Witcombe, Editorial Assistant (naw@irct.org)

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