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The 6/24 rule: A review and proposal for an international standard of a minimum of six hours of continuous sleep in detention settings

Pau Pérez-Sales*

Introduction

Sleep deprivation is one of the most prevalent and widely used methods of psychological torture. Its effects on the body are without direct physical aggression and include significant somatic and psychological impacts and suffering. It is used in multiple coercive environments as a way, among other purposes, of degradation, debilitation, punishment both before and during the interrogation of detainees. In this specific context, it produces cognitive, emotional and physical exhaustion, with the aim of obtaining submission or compliance, and ultimately information or confession (Pérez-Sales, 2017; Reynolds & Banks, 2010; Sveaass, 2008).

There is no universally accepted legal definition of what should be considered *sleep deprivation* in the context of torture. There are however converging positions from the legal and jurisprudential, and especially medical and psychiatric fields that allow for establishing sufficiently clear recommendations for the international community to take a reasoned stance. Within the framework of torture as defined in the United Nations Convention (UNCAT), we propose that **intentionally forcing a person to have less than 6**

hours of continuous, restful sleep must be considered a form of degrading treatment that could amount to cruel and inhuman treatment. We also suggest that when this daily sleep deprivation is intentionally prolonged in a sustained manner for three days or more, it should be considered as a form of torture in itself, irrespective of other coexisting or cumulative elements that may aggravate the condition.

Our proposal and position will be justified with due regard to available knowledge.

Background

Epidemiological and public health studies demonstrate a slight variability in individual needs of sleep: from 6 to 8 hours on average for adults, depending on age. An International Consensus promoted by the US National Sleep Foundation (Hirshkowitz et al., 2015; Watson, Badr, Belenk, & Bliwise, 2015) agreed that a healthy normal sleep pattern for an adult should include a minimum of 7 (+/- 1) hours of daily continuous sleep¹ (see table 1). A number of

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¹ Regarding adults and older adults, meta-analyses show there is a significant difference in the distribution of Stage 1, 2 (increase) and REM (decrease), but this is only detectable in Actigraphic studies (Ohayon et al., 2004).

reviews and meta-analyses of international cohort and longitudinal studies have also consistently shown that mortality is significantly increased in persons sleeping less than 6 (Åkerstedt et al., 2017) to 7 hours per day (Cappuccio, D'Elia, Strazzullo, & Miller, 2010; Yin, J., Jin, X., Shan, Z., Li, S., Huang, H., Li, P. & Liu, L., 2017). This is due to both metabolic changes that increase the risk of death-related diseases (Trivedi, Holger, Bui, Craddock, & Tartar, 2017) and a significantly higher rate of suicide in the affected persons (Pereira, Martins, & Fernandes, 2017). In their international study of reference to date on normal patterns of sleep across a lifespan, Ohayon, Carskadon, Guilleminault, & Vitiello (2004) developed a

comprehensive meta-analysis based on 65 studies, which found that sleep duration only slightly decreased around one hour from adult to old age in healthy individuals. Additionally, reviews of the reported average time of normal duration of sleep across countries and cultures, including data from pre-industrial societies, provide similar results. Analogous results are obtained in historical studies that compare duration of normal sleep patterns from decade to decade since such records were available (Hoyos, Glozier, & Marshall, 2015; Simonelli et al., 2018; Yetish et al., 2015).

The richness of this data demonstrates that for an adult (18-65 yrs), the minimum duration of necessary sleep is no less than

Table 1: *International Consensus on Normal Sleep Pattern (Hirshkowitz et al., 2015; Watson et al., 2015).*

Age	Recommended, h	May be appropriate, h	Not recommended, h
Newborns	14 to 17	11 to 13	Less than 11
0-3 mo		18 to 19	More than 19
Infants	12 to 15	10 to 11	Less than 10
4-11 mo		16 to 18	More than 18
Toddlers	11 to 14	9 to 10	Less than 9
1-2 y		15 to 16	More than 16
Preschoolers	10 to 13	8 to 9	Less than 8
3-5 y		14	More than 14
School-aged children	9 to 11	7 to 8	Less than 7
6-13 y		12	More than 12
Teenagers	8 to 10	7	Less than 7
14-17 y		11	More than 11
Young adults	7 to 9	6	Less than 6
18-25 y		10 to 11	More than 11
Adults	7 to 9	6	Less than 6
26-64 y		10	More than 10
Older adults	7 to 8	5 to 6	Less than 5
≥ 65 y		9	More than 9

6 hours and for older adults (>65) not less than 5 hours. The minimum duration for young adults and children is higher.

Table 2 collects selected impacts of sleep deprivation in the course of coercive interrogations, ill-treatment and torture, with key references selected among the many available. It shows how sleep deprivation affects some of the most essential cognitive and emotional functions of the brain.

Each of these effects can be traced neurologically. More than a decade ago, pioneering military studies in the USA using small samples, employing magnetic resonance imaging (fMRI) had already shown that after just 24 hours of sleeplessness there was clear vulnerability of integrated decision-making to sleeplessness that was accompanied by a breakdown in task-specific neural activity in prefrontal cortex that correlated with behavioural performance (Schnyer, Zeithamova, & Williams, 2009).

In a pioneering controlled study, Dai et al. (2019) found using Functional Magnetic Resonance Imaging (fMRI), that prolonged acute sleep deprivation (lasting

20, 24, 32 or 36 h) exhibits accumulative brain atrophic effects which may provide the neurobiological basis for attention and memory impairments following sleep loss. Using a similar neuroimaging test, Chen et al. (2018) and Kong et al. (2018), found that the amplitude of low-frequency fluctuation and short-range and long-range functional connectivity density in four specific areas of the brain may be potential biomarkers of acute sleep deprivation with high discriminating value.

All these studies open the door in the future to potential detection and recognition of signals of the use of sleep deprivation as torture, as well as its impacts. It also provides a potential tool supporting the forensic analysis of credibility of allegations of sleep deprivation (SD).

These short term impacts and their neurobiological correlates are no surprise. More than fifty years ago, the CIA torture handbook, known as the KUBARK manual, warned against an excessive use of sleep deprivation: *“any attempt to produce compliant behaviour by procedures which produce...*

Table 2: *Impairments produced by sleep deprivation relevant to coercive interrogation, ill-treatment and torture.*

<ul style="list-style-type: none"> • Memory retrieval (Havekes & Abel, 2017) • Memory accuracy (Blagrove & Akehurst, 2000) • Cognitive functioning and reasoning (Killgore, 2010; Lim & Dinges, 2010) • Emotion recognition (Killgore, Balkin, Yarnell, & Capaldi, 2017) • Emotional reactions (Fairholme & Manber, 2015; Tempesta et al., 2010) • Moral judgment (Barnes, Gunia, & Wagner, 2015; Killgore et al., 2007; Tempesta et al., 2012) • Threat analysis (Goldstein-Piekarski, Greer, Saletin, & Walker, 2015), • Decision-making process and risk analysis (Horne & Harrison, 2000; McKenna, Dickinson, & Orff, 2007). 	<p>Only one night of sleep deprivation:</p> <ul style="list-style-type: none"> • Increases suggestibility and is sufficient to produce statistically significant differences in the number of false confessions during interrogation (Blagrove, 1996; Blagrove & Akehurst, 2000). • Increases the number of false memories recalled (Frenda, Patihis, Loftus, Lewis, & Fenn, 2014). • Amplifies the effects of physical pain (Lautenbacher, Kundermann, & Krieg, 2006; Schrimpf et al., 2015) • Increases fear-memory consolidation and post-traumatic stress symptoms (Feng, Becker, Zheng, & Feng, 2018).
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disturbances of homeostasis, fatigue, sleep deprivation, isolation, discomfort, or disturbing emotional states carries with it the hazard of producing inaccuracy and unreliability” (p. 88).

Sleep deprivation and mental and physical suffering

Some authors have previously proposed the existence of an antidepressant effect following 24 hours of sleep deprivation. Subsequent studies have shown that the effect is deleterious and of no clinical use (Boland et al., 2017). On the contrary, sleep deprivation has consistently been shown to exacerbate symptoms of mania (Krystal, 2012). A recent meta-analysis has provided strong evidence that insomnia is a significant predictor for the onset of depression (10 studies), anxiety (six studies), alcohol abuse (two studies) and psychosis (one study) (Hertenstein et al., 2019). A review of studies using poly-somnographic methods was also conclusive in showing that sleep continuity disturbances imply a trans-diagnostic imbalance in the arousal system, likely representing a basic dimension of mental health. Sleep depth and REM variables play a key role in psychiatric comorbidity processes and increase symptoms of affective disorders, anxiety disorders, eating disorders, borderline and antisocial personality disorders, attention-deficit-hyperactivity disorder (ADHD), and schizophrenia (Baglioni et al., 2016). Moreover sleep deprivation increases and amplifies the perception and effects of physical pain (Lautenbacher et al., 2006). Sleep deprivation, therefore, produces severe physical and emotional suffering.

Military and police regulations. Some military regulations in the past have established lower thresholds. The idea behind this is that interrogation is not a “healthy” situation and a certain level

of discomfort due to normal routine procedures must be expected. For instance, based on this reasoning, US Army Manuals during the Bush administration established a threshold of 4 hours of continuous sleep every 24 hours for up to 30 days (US Army, 2006).^{2,3} The medical evidence shown above raises questions regarding such practice, clearly showing that this constituted torture.⁴ Notably, this should be considered along with the American Central Intelligence (CIA) guidelines from a similar date, that stated that all detainees should have eight hours of uninterrupted sleep,^{5,6} a level much higher than the one proposed here.

The first 72 hours

The medical and psychiatric research reviewed shows unequivocally that the damaging effects of sleep deprivation and its impact in terms of suffering and impairment, in addition to its consequences

² FM 2-22.3, supra note 90, at M-30.

³ This has also been contested from within the US Military, as some high rank officers have publicly declared that even if it was useful, which is not evident, this threshold violates the Geneva Conventions (Bolgiano, 2010).

⁴ The idea that a person can sleep 4 hours or less a day in a prolonged manner cannot be justified by normal procedure. Medical research shows that there is a high level of suffering, a significant damage to the person and a high risk of false confessions. The person is simply not fit for interrogation.

⁵ Memorandum from Steven G. Bradbury, Principal Deputy Assistant Attorney General, for John A. Rizzo, Senior Deputy General Counsel, Central Intelligence Agency (10 May 2005): FN 36. 30.

⁶ The FBI’s new role, institutionalised under the High Value Interrogation Group (HIG), still permits manipulation of environments, prolonged isolation, and sleep deprivation, although the number of hours a detainee is allowed to sleep is not in the public domain (Greenberg, 2015).

in terms of lack of reliability of interrogations, are significant at the 24-hour mark. In the early and seminal review that provided the foundation for the CIA *Kubark Manual*, Albert Biderman and Herbert Zimmer (1961) had already established this 24-hour criterion. Furthermore, “*after forty-eight hours without sleep, some people become disorganized and ineffective, whereas some others have still been known to go with their functions largely intact*”, but “*most people deteriorate markedly after about seventy-two hours without sleep, and all deteriorate sooner or later*” (p. 44 and seq). They went further to say that “*the effects [of sleep deprivation] are intrinsically adverse, and the reaction of the individual is a factor only in determining how long these effects can be withstood*” (p. 49). Other authors have also suggested that 24 hours of sleep deprivation affects most individuals, with 72 hours as a definite limit for most human beings (Horne & Pettitt, 1985; Mikulincer, Babkoff, Caspy, & Sing, 1989). Furthermore, SERE training, designed for military surviving in extreme torturous conditions, permits soldiers 48h maximum of sleep deprivation (Intelligence Science Board, 2009).

Regarding recovery, a recent international multi-collaborative study demonstrated the need for a minimum of 14 hours of continuous sleep to recover to a normal neurophysiological sleep pattern following 58h of sleep deprivation (Hennecke et al., 2019). If this does not occur, the damage increases proportionally.

Overall, we can conclude that available medical studies provide strong grounding to the thesis that 3 days of continuous sleep deprivation is the limit for considering SD as torture in itself, irrespective of other external factors.

Sleep disruption

The emphasis on the number of hours of continuous sleep should not obfuscate the relevance of sleep disruption to the thesis proposed. Indeed, the *Kubark Manual* recommended sleep disruption as more effective than absolute sleep deprivation: “*Another objection to the deliberate inducing of debility is that prolonged exertion, loss of sleep, etc., themselves become patterns to which the subject adjusts through apathy. The interrogator should use his power over the resistant subject’s physical environment to disrupt patterns of response, not to create them. Meals and sleep granted irregularly, in more than abundance or less than adequacy, the shifts occurring on no discernible time pattern, will normally disorient an interrogate and sap his will to resist more effectively than a sustained deprivation leading to debility*” (pp. 92-93).

Sleep disruption in detention settings can be caused, intentionally or not, by multiple factors: hunger, thirst, high and low temperature, noise or sounds, isolation, overcrowding, or by routine or arbitrary practices; roll call, cell search, shouting at the detainee. Additionally, threats and other fear-inducing practices produce dread and anxiety that can induce disrupted sleep. The effects of sleep disruption are to be added to those of sleep deprivation.

A prospective study by Liu et al. (2019) on sleep disruption analysed the impact of awakening experimental subjects with a phone call every hour during a single night. The impact on the participants was dependant on the subject’s age: there were statistically significant changes in mood in young people and a decline in memory in older adults. Furthermore, a recent review has suggested that there is a relationship between sleep disruption and aggression through three converging effects: anger, perceived hostility and lowered inhibition

(Krizan & Herlache, 2016). These effects depend on disruptions and are independent of the total number of hours in bed. In other words, disrupting sleep has independent cognitive and emotional effects that add to the effects of sleep deprivation.

False confessions—linking length of interrogation and sleep deprivation

The combined effects of sleep deprivation and the physical, cognitive and emotional effects presented until this point, have been shown to produce an increased number of false confessions. This is due to increased suggestibility (Gudjonsson, 2003; Gudjonsson et al., 2016), weakness associated to physical or psychological deprivations during interrogation and the desire to put an end to the interrogation due to the prolonged suffering it entails.

Length of interrogation. The European Committee on the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) Standards state that interrogations should be avoided for lengthy periods. However, their recommendations are not concrete (Morgan & Evans, 2001). The US Supreme Court prescribes the “totality-of-the-circumstances” test. Relevant factors in this test may include the application of physical abuse or psychological coercion; the time, length, circumstances, and place of the interrogation, and the age and education of the detainee, along with other considerations.

Average length of a police interview. Across various epidemiological studies on the self-reported duration of interrogation of suspects by the police, the average duration is found to be between 1 and 2 hours (Baldwin, 1993; Kassin et al., 2007). During a naturalistic study with real interrogations in juveniles, Feld (2013) found that the average interview lasted between 30 and 45 minutes. Experimental studies have consistently

shown a direct correlation between false confessions and length of interrogation (Madon, Yang, Smalarz, Guyll, & Scherr, 2013) with maximum risk of false confession for interrogations lasting 6 hours in length. The study detected interrogations sometimes lasting even up to 16 hours (Drizin & Leo, 2004). This data combined has led different authors to propose a maximum duration of interrogation of 2 to 4 hours, and up to 6 hours in special circumstances (Davis & Leo, 2012). **Any duration of interrogation longer than 6 hours would be considered coercive, even when brief periods of rest or refreshment are provided.**

Legal aspects

There is, at present, no international regulation providing clear guidance regarding sleep deprivation. This issue of Torture Journal includes a review on the topic by Ergün Cakal. He has summarized the legal framework of sleep deprivation on the basis of the jurisprudence of international tribunals to show that there is ample documentation of cases considering sleep deprivation as a form of cruel, inhuman or degrading treatment, or torture. Of particular note, in what seems the clearest indication of a length of time rule is the case of *Sadretidinov v. Russia*, in which the European Court of Human Rights, despite no violation being found in that case, found that a minimum of six hours of sleep per night was required before Article 3 of the Convention was breached.” (§96).⁷

Conclusion

Epidemiological and public health studies show, across countries and cultures, that an adult needs a minimum of 7 (+/-1) hours of

⁷ ECHR. (2016). *Sadretidinov v. Russia*, 17564/06.

sleep per day. In other words, the minimum duration of necessary sleep is no less than 6 hours. The available jurisprudence also seems to point to a 6 hour minimum for considering sleep deprivation. Anything less than this amount produces impairments in memory retrieval and accuracy, cognitive functioning, emotional recognitions and reactions, moral judgment and threat analysis among others. This, in turn, produces a breakdown in the person that will favour false confessions. Additionally, sleep deprivation leads to physical and psychological suffering sometimes of extraordinary severity. Sleep disruption gives rise to similar effects and ultimately potentiates the effects of sleep deprivation. These effects both appear and can be detected during the first 24 hours in most subjects but are present in all subjects after 3 days (72 hours) of partial or continuous sleep deprivation.

As a mnemonic rule, this can be labelled as the 6/24 x 3 rule.

Those who oppose establishing regulations that can assist both policy-makers and the judiciary argue that some level of sleep restriction is acceptable as part of normal detention procedures. Of course, this is true. Although solitary confinement is an unhealthy situation in itself, the Nelson Mandela Rules and the UN Special Rapporteur on torture recommendations, among others, establish a threshold of 15 days as the limit between suffering incidental to legally admissible solitary confinement and torture (Mendez, 2011). It is *prolonged* solitary confinement that is considered as amounting to torture in itself, irrespective of other cumulative elements. Similar reasoning should be applied to sleep deprivation.

In this issue, Torture Journal offers a collection of papers on the topic. Ergün Cakal reviews the definition

and prohibition of sleep deprivation as torture and ill-treatment in international law, and the potential contribution of medical and psychological knowledge to the development of greater nuance in legal standards. The review is part of an international cooperative study on sleep deprivation by the Danish Institute Against Torture (DIGNITY), the Public Committee Against Torture in Israel (PCATI) and REDRESS. The three organisations explain the process of elaboration of a protocol of exploration of SD and data with preliminary validation in Israel. The Protocol itself is also included in the section. Finally, Mahmud Sehwal and colleagues at the Ramallah-based Treatment and Rehabilitation Centre for Victims of Torture (TRC) present a study in which, for the first time, they document that sleep deprivation produced a number of impacts including severe suffering. At the same time, they show that conviction rates and sentence length were not increased as a result of admissions of guilt obtained from sleep-deprived detainees. In short, the paper suggests that sleep deprivation as torture is not only ethically questionable, but useless from the perspective of the interrogator.

This issue is complemented by an epidemiological study by Brenda Van Den Bergh and colleagues on knowledge, attitudes and practice about torture and torture practices among medical professionals in Tanzania. This expands early data published in our Journal in 2018 (Aon, Sungusia, Brasholt, Van Den Bergh & Modvig, 2018).

Pearl Fernandes and Yvette Aiello from STARTTS-Australia expand their previous publication of group therapy with Tamil survivors of sexual violence in a case report that exemplifies the narratives of survivors and how are they addressed in therapy.

Finally, we include a Debate. Efrat Shir presents a recent Israeli Supreme Court ruling—the case of Mr Firas Tbeish and the implications for the fight against torture in Israel. Hans Draminsky Petersen and John W. Schiemann—members of the Torture Journal Editorial Advisory Board—provide comment.

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Befogging reason, undermining will: Understanding sleep deprivation as torture and other ill-treatment in international law

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Sleeplessness befogs the reason, undermines the will, and the human being ceases to be himself, to be his own 'I'.

— Solzhenitsyn in *The Gulag Archipelago*

Key points of interest

- Sleep deprivation is prohibited by international law but there is a dearth of informed analysis regarding its individual (subjective) and contextual (environmental) complexities.
- There is a considerable body of medical knowledge to be extrapolated in order to formulate workable definitions and limitations.

Abstract

Background: Sleep deprivation is a prevalent method of psychological torture. However, difficulties in documentation have meant that it is not adequately appreciated by courts and other quasi-judicial institutions such as UN treaty bodies. *Method:* This paper aims to review

the legal literature on deprivation of sleep, the definition, and prohibition of torture and ill-treatment, and its health impacts. A number of texts were identified and analyzed based on contextual relevance: criminal justice processes as well as medical literature on health impacts.

The texts were identified via a search of key legal and health databases using the search terms “sleep deprivation,” “sleep adjustment,” and “sleep regulation.” These texts were limited to English-language journal articles, NGO reports, court-cases and UN documents since 1950. They were then analyzed for their approaches to conceptualizing sleep deprivation from the perspective of assessing “severe pain and suffering” and the “diminishment of mental capacity.” *Results/Discussion:* Sleep deprivation is an ill-defined and, in turn, poorly documented method of torture, particularly when prolonged or inflicted in combination with other methods (e.g., threats) and conditions (e.g., disruptive environment or time of day). More nuanced legal principles, informed by medical evidence, are lacking. Applying these principles would sharpen its conceptualization.

Keywords: Sleep deprivation, sleep disruption, adequate rest, psychological torture, interrogation

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Introduction

Objective and Method

The use of sleep deprivation has been recognized by the international human rights framework as a method of torture or cruel, inhuman and degrading treatment or punishment (hereafter “other ill-treatment”). However, its temporal and contextual dimensions require a clearer definition. The related concept of “adequate sleep”—as a safeguard (or, more broadly, rest) for those under interrogation, arrest or detention—is also ill-defined and lacks clarity. This paper aims to review the legal literature on deprivation of sleep, the definition, and prohibition of torture and ill-treatment, and its health impacts.

A desk review was undertaken based on primary (i.e., case-law and institutional reports) and secondary literature (i.e., expert reports, commentaries, and meta-studies) pertaining to the deprivation of sleep, whether intentional or consequential. Particular attention was given to criminal justice contexts as well as medical literature on health impacts. The texts were identified via key legal and health databases (i.e., HeinOnline, HUDOC, UNODS and DIGNITY’s Documentation Centre) using the search terms “sleep deprivation,” “sleep adjustment,” and “sleep regulation.” The review encompasses legal and, to a lesser extent, medical literature.

These texts were analyzed for their respective approaches to conceptualizing sleep deprivation from both legal and medical perspectives, particularly with the objective of assessing “severe pain and suffering” and the “diminishment of mental capacity”. Whilst the approach taken is deductive, non-legal considerations not explicitly referenced in the text of court decisions could not be reviewed.

Some categorizations treat sleep deprivation through the broader discussion of sleep disruption, which also includes sleep interruption, adjustment, and manipulation as a consequence of other methods of ill-treatment. The discussion here, however, is primarily focused on sleep deprivation.

Definition and Purpose

There is no universally accepted legal definition of what constitutes sleep deprivation or what is sometimes referred to as “prolonged” sleep deprivation. When the broader discourse on psychological methods of torture is surveyed, the dearth of any workable definitions of methods, with the recent exception of solitary confinement (now defined in the Nelson Mandela Rules), becomes apparent.¹ In their work on Guantánamo Bay, Physicians for Human Rights (PHR) and Human Rights First (HRF) put forward a definition of sleep deprivation as the deprivation of “normal sleep for extended periods through the use of stress positions, sensory overload, or other techniques of interrupting normal sleep” (PHR & HRF, 2007, p. 22). However, what is considered “extended periods” or “normal sleep” is not concretely defined. Indeed, perhaps they cannot be defined due to contextual and subjective factors, as later discussed.

Medical literature depicts sleep deprivation with more clarity. The following categorizations are regularly used: “long-term total sleep deprivation (>45 h), short-term total sleep deprivation (≤45 h) and partial sleep deprivation (<7 h in a 24 h period)” (Leach, 2016, p. 17). Other terms in the literature generally include sleep

¹ See Cakal (2018) for a lengthier discussion on conceptualizing psychological torture.

restriction, which is comparable with partial sleep deprivation. These are not, however, consistently used across all studies.

Historically, sleep deprivation has been used for a number of different objectives but, primarily, to cause stress and duress for the purpose of coercing information and confessions (see Rejali, 2007, pp. 290-292). According to Pérez-Sales (2016), sleep deprivation is one method, among others, to “prolong the shock of capture and prevent the detainee from recovering, regaining control or making decisions ... [and it] increases the perception of pain and it diminishes the capacity to react in complex adverse situations” (p. 186). It is often applied in interrogation settings. The detention centre with poor conditions is another context in which sleep deprivation, as a consequence of sleep disruption, takes place. This is often due to overcrowding, insufficient or no mattresses, and poor conditions of transportation between the courts and detention facilities. Although case-law on detention conditions will be touched upon, the context of interrogation is the primary focus of the below discussion.

Health Impacts

While ethical considerations prevent a scientific study from being conducted on detained subjects, controlled medical studies in an experimental setting demonstrate that sleep deprivation can lead to a number of health impacts. Studies, to varying degrees, consistently find an association between sleep deprivation and increased anxiety, higher perception of pain, emotional response, and cognitive functioning (Leach, 2016, p. 7). A multitude of reviews exist in medical literature, which support this analysis (e.g., Beattie et al., 2014; Griffith & Mahadevan, 2015; Lowe et al., 2017; Pilcher

& Huffcutt, 1996; Pires et al., 2016; Wickens et al., 2015). Similarly, there is extensive literature anchored in psychology on coercive interrogations, which identify sleep deprivation as a factor that induces false confessions (Davis and Leo, 2012; Kassin et al., 2004).

One review concluded that sleep deprivation may cause “cognitive impairments including deficits in memory, learning, logical reasoning, complex verbal processing, and decision-making” and observed that “sleep restriction of four hours per night for less than a week can result in physical harm, including hypertension, cardiovascular disease, altered glucose tolerance and insulin resistance” (PHR & HRF, 2007, pp. 22-23). It concluded that the severity of these sequelae can indeed amount to torture or other forms of ill-treatment if used for criminal investigation.

Whether the findings identified in tightly controlled scientific studies are applicable to the real-life situations is debated (see O'Mara 2015 generally). Detention and interrogation conditions are also not simulated as part of these studies. The application of scientific knowledge to an interrogation context, therefore, remains limited.

Drawing the links between what is known and the conditions of detention, Başoğlu speculates that:

“Prolonged exposure to unhygienic or unsanitary conditions, overcrowding, and restriction of movement, together with deprivation of food, water, sleep, and medical care, can pose a serious threat to life, even in the case of a healthy person. Under such conditions, a person would most likely perceive a serious threat to their life. Sleep deprivation is not only a potent stressor in itself but also likely to amplify the impact of other stressors by making effective coping with

other threatening events difficult. In addition, there is a strong element of humiliation in being exposed to such inhuman conditions.”
(Basoglu, 2017, p. 27)

However, the established association between sleep deprivation and the outlined health impacts does not necessarily *evidence* torture.

Sleep deprivation as torture

International laws pertaining to detention do not explicitly limit interrogation duration, define adequate sleep, nor state when sleep deprivation amounts to torture or other ill-treatment.

The discussion, therefore, needs to be based on authoritative principles under international human rights law, namely Article 1 of the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT).

Accepting the premise that sleep deprivation is primarily used for obtaining information or confession, two elements under the definition emerge to be particularly significant: *intentionality* and *severe physical or mental pain or suffering*. Notably, Article 3 of the European Convention on Human Rights (ECHR) has also been interpreted to require these two elements.² If these elements cannot be identified, the treatment can still amount to other ill-treatment. This is explored below when reviewing their application to sleep deprivation.

Severity and Duration

Severe pain or suffering, whether physical or mental, is inflicted by a single method or

a combination of methods and can occur on one or on multiple occasions.³ It can be either short-lived or prolonged.⁴ However, mental pain alone can constitute torture and need not be coupled with physical pain. Yet, interpreting the term “severe” has proven challenging as it hinges on the level of intensity, which is based on a plethora of factors including duration and a victim’s health, age, and sex. Deciphering when sleep deprivation amounts to torture is thus complex and is thus best determined on a case-by-case basis.

The UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNSRT) has regularly identified that sleep deprivation is indeed capable of amounting to torture.⁵ During his examination of “enhanced interrogation techniques,” as the former UNSRT, Sir Nigel Rodley pointed out that “[e]ach of these measures on its own may not provoke severe pain or suffering” but may do so in combination when “applied on a protracted basis of, say, several hours.”⁶ Therefore, he considered a certain combination or accumulation of methods and duration as a requirement before the severity threshold becomes particularly relevant. Such declarations have done little to identify a workable definition and to articulate the circumstances under which sleep deprivation amounts to torture.

² See ECHR. (1999). *Selmouni v. France*, 25803/94. §97; ECHR. (2000). *Rehbock v. Slovenia*, 29462/95.

³ ICTY. (2002). *Prosecutor v. Krnojelac*. Case No. IT-97-25 (Trial Chamber) 15 March 2002, §182.

⁴ CAT. (2006). *Conclusions on USA*. CAT/C/USA/CO/2, §13. ICTY. (2006). *Naletilic and Matinovic*. Appeal Judgement, 3 May 2006, §300.

⁵ UNSRT. (1997). Report. E/CN.4/1997/7, 10 January 1997; UNSRT. (2006). Report. CN.4/2006/6/Add.6; UNSRT. (2010). Report. A/HRC/13/39/Add.5.

⁶ UNSRT. (1997). Report. E/CN.4/1997/7, 10 January 1997, §121.

Similarly, the UN Committee Against Torture (CAT) has criticized the use of sleep deprivation by a number of states, providing clear indications of outer limits. Most prominently, its observations with respect to the United States focused on the guidelines in the interrogation rulebook in the United States Army Manual: “Use of separation must not preclude the detainee getting four hours of continuous sleep every 24 hours” (US Army, 2006, Appendix M). With the understanding that a detainee could be subjected to this for a renewable period of 30 days, the CAT found that this amounted to “authorizing sleep deprivation—a form of ill-treatment.”⁷ Of particular concern was that this rule may be interpreted to allow for 40 continuous hours of interrogation with only four hours of sleep on either side of this protracted period. The United States, when questioned by the CAT, denied that this took place. Similarly, the CAT has also criticized Israel for using sleep deprivation.⁸ Based on the understanding that it is not inherently harmful, CAT did *not* categorically state that sleep deprivation amounted to torture in all cases, as evidenced by their need to detail the durations concerned.

⁷ CAT. (2014). Conclusions on USA. CAT/C/USA/CO/3-5, §17.

⁸ It found one individual to have been: permitted to sleep for about one hour in 24 over the course of 4 days, which constituted torture from a medical point of view. In another case, brought before the High Court (HCJ 2210/96), the detainee had been kept awake for 39 hours followed by 5 hours’ rest, then for 47 hours with 2 hours’ rest, and then for 22 hours with 5 hours’ rest, 47 hours with 5 hours’ rest, 46 hours with 5 hours’ rest, and finally 48 hours with 6 hours’ rest. The situation had perhaps been urgent, but that unquestionably constituted mental torture. (CAT. (1998). Report. E/CN.4/1998/38, §24)

Falling Short of Torture: Severity or Intentionality?

Methods of interrogation that undermine will or capacity have, to date, been accepted as having the capacity to amount to torture and, more often, as other forms of ill-treatment. Principle 6 of the UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment requires other ill-treatment to be interpreted to include “the holding of a detained or imprisoned person in conditions which deprive him, temporarily or permanently, of the use of any of his natural senses, such as sight or hearing, or of his awareness of place and the passing of time.” Drawing on the range of impairments emanating from the medical literature, it is reasonable to interpret this to capture any form of sensory deprivation, blunting of the senses or temporal disorientation, including the use of sleep deprivation.

Conversely, Article 2 of the Inter-American Convention to Prevent and Punish Torture contemplates diminishment of capacity as torture in the following:

“... any act intentionally performed whereby physical or mental pain or suffering is inflicted on a person for purposes of criminal investigation, as a means of intimidation, as personal punishment, as a preventive measure, as a penalty, or for any other purpose. Torture shall also be understood to be the use of methods upon a person intended to obliterate the personality of the victim or to diminish his physical or mental capacities, even if they do not cause physical pain or mental anguish.”

The link between sleep deprivation and diminishing an individual’s personality was further enlightened by the case of *Maritza Urrutia v. Guatemala*. The Inter-American Commission requested that the Inter-

American Court find a “violation because of the use of: methods tending to obliterate or diminish her personality, such as sleep deprivation” (§78(b)). Without specifically condemning sleep deprivation, the Inter-American Court in turn ruled that:

“... according to the circumstances of each particular case, some acts of aggression inflicted on a person may be classified as mental torture, particularly acts that have been prepared and carried out deliberately against the victim to eliminate his mental resistance and force him to accuse himself of or confess to certain criminal conducts, or to subject him to other punishments, in addition to the deprivation of freedom itself.”⁹

This is also echoed in Principle 1 of the Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas, which protects individuals from “forced intervention or coercive treatment, from any method intended to obliterate their personality or to diminish their physical or mental capacities.”

To date, the European Court of Human Rights has considered sleep deprivation primarily through Article 3 assessments of detention conditions, predominantly focusing on the conditions that inhibit adequate rest such as transportation, cell overcrowding, lack of comfortable beds, and disruptions caused by the prison environment.

Although removed from the context of interrogation, the discussion of the term “adequate rest” found in this body of jurisprudence is useful. For example, *Dougoz v. Greece* is an illustrative case

where “the serious overcrowding and absence of sleeping facilities, combined with the inordinate length of the period during which he was detained in such conditions, amounted to degrading treatment contrary to Article 3.”¹⁰

There has also been a number of Russian cases where transportation conditions—“the frequency and the length of those transfers, of appalling conditions at the prison assembly sections and in the police vans, and about the intensity of the schedule”—has not allowed the applicant to sufficiently sleep and were in violation of Article 3. However, what constituted sufficient sleep was not satisfactorily explained.¹¹

Turning to interrogation-oriented uses, *Ireland v. the United Kingdom* still proves to be an illustrative case. This is perhaps the Court’s most (in)famous consideration of sleep deprivation, as part of the “five (torture) techniques.” The (now defunct) European Commission of Human Rights, focusing on the combined psychological impacts, found that the five techniques constituted torture on the grounds that intensity directly affects the personality:

“... the systematic application of the techniques for the purpose of inducing a person to give information shows a clear resemblance to those methods of systematic

⁹ Inter-American Commission on Human Rights. (2003). *Maritza Urrutia v. Guatemala*. 27 November 2003. Series C No. 103, §93.

¹⁰ ECHR. (2001). *Dougoz v. Greece*, 40907/98. §48; see also ECHR. (2017). *Boudraa v. Turkey*, 1009/16, §36.

¹¹ See the following cases from the ECHR: *Akimenkov v. Russia*, 6 February 2018, 2613/13, 50041/14, §§ 86-87; *Stepan Zimin v. Russia*, 30 January 2018, 63686/13, 60894/14, §§40-42; *Lutskevich v. Russia*, 15 May 2018, 6312/13, 60902/14, §§61-63; *Polikhovich v. Russia*, 30 January 2018, 62630/13, 5562/15, §§41-43; *Kavkazskiy v. Russia*, 28 November 2017, 19327/13, §§58-59.

*torture which have been known over the ages... a modern system of torture falling into the same category as those systems... applied in previous times as a means of obtaining information and confessions.*¹²

However, the Court challenged this interpretation and found that the application of the five torture techniques amounted to inhuman and degrading treatment but not torture.

The Court has since considered the use of sleep deprivation in other interrogation contexts. In the *Mader v. Croatia* case, for example, where the applicant was “deprived of sleep and forced to sit on a chair continuously for two days and nineteen hours” at a police station, the Court found that this alone amounted to inhuman treatment (§108).¹³ In *Bati v. Turkey*, where the applicants were subjected to sleep deprivation for several days, as well as physical and verbal assault during interrogation, the Court accepted that this treatment “was liable to harm their mental integrity” (§114).¹⁴

In *Bagel v. Russia*, the applicant alleged that he had “insufficient time to sleep on the days of transport.” Accepting that the applicant was able to sleep at least from 11pm to 5am each night, the Court ruled that he was not subjected to any sleep deprivation (§70).¹⁵ This precedent was followed more recently in *Sadretdinov v. Russia*, where the applicant complained of

the failure to ensure that he “enjoyed eight hours’ sleep on court hearing days” (§96). The Court again adhered to the six-hour rule, stating that:¹⁶

“The applicant had no less than six hours of sleep per night. Moreover, the authorities took steps to ensure that he had enough sleep during at least three nights per week (when he did not take part in court hearings).”

In *Strelets v. Russia*, the applicant complained of insufficient sleep on days of court hearings. Over several consecutive days, the applicant reported to being woken up at 6am and being brought back to the cell after 10pm. Notably, the pronouncement of the national court’s judgment started at 8.30pm and finished at 12.30am. Ruling it to be inhuman and degrading treatment, the Court reasoned as follows (§62):

“the cumulative effect of malnutrition and inadequate sleep on the days of court hearings must have been of an intensity such as to induce in the applicant physical suffering and mental fatigue. This must have been further aggravated by the fact that the above treatment occurred during the applicant’s trial, that is, when he most needed his powers of concentration and mental alertness.”

Similarly, in *Guliyev v. Russia*, a prisoner was transported for 65 hours and denied uninterrupted sleep as he was forced to change his position every two hours and subjected to constant light. The Court found the combination of “the duration of the journey, confined space, sleep deprivation, insufficiency of food and possibly inadequate

¹² ECommHR (1976). *Ireland v. United Kingdom*, European Commission of Human Rights, Yearbook of the European Convention on Human Rights, 19, p. 512.

¹³ ECHR. (2011). *Mader v. Croatia*, 56185/07.

¹⁴ ECHR. (2004). *Bati v. Turkey*, 33097/96 and 57834/00.

¹⁵ ECHR. (2007). *Bagel v. Russia*, 37810/03.

¹⁶ ECHR. (2016). *Sadretdinov v. Russia* 17564/06.

ventilation and lighting” indeed constituted inhuman treatment.¹⁷

In sum, the cases cited were all considered to amount to inhuman treatment but not torture, possibly due to the intentionality and severity criteria not being met.

There was also insufficient evidence provided to justify the six-hour criterion. We are thus left to speculate when instances of sleep deprivation do and do not constitute torture or other forms of ill-treatment. This is an all too frequent occurrence when applying broad definitions to specific situations.

Intentionality and Purpose

To locate the distinction between torture and other forms of ill-treatment, we can turn to Manfred Nowak’s statement, as the UNSRT, who interpreted the intentionality clause as follows:

*“A detainee who is forgotten by the prison officials and suffers from severe pain due to the lack of food is without doubt the victim of a severe human rights violation. However, this treatment does not amount to torture given the lack of intent by the authorities. On the other hand, if the detainee is deprived of food for the purpose of extracting certain information, that ordeal, in accordance with article 1, would qualify as torture. It is also important to underline that the intentional infliction of severe pain or suffering has to be committed for a specific purpose referred to in the Convention, such as the extraction of a confession or information.”*¹⁸

A similar distinction is therefore found in the literature between intentional and

unintentional deprivation of sleep. The former can be described as the deliberate use of sleep deprivation by officials who are aware of its impact, often through stress positions or unrelenting interrogations. The latter usually arises due to the detention environment disrupting sleep such as overcrowding and lack of hygiene or bedding.

In the wake of the widely-reported 1999 Israeli Supreme Court case (HCJ 5100/94—The Public Committee Against Torture in Israel v. The State of Israel et al.), the Israeli State Prosecutor’s Office deemed sleep deprivation as a permitted “side effect” of “prolonged interrogation,” and not as intentionally used for the purpose of tiring or “breaking” the detainee (Ginbar, 2009, p. 173). Ginbar argues this to be a fig-leaf given what interrogators have, themselves, claimed about their intentional use of sleep deprivation in coercing confessions. In the view of the CAT, this distinction is to be determined objectively, *not* subjectively.¹⁹ By extension, recklessness, but not negligence, may also amount to intentionality (Burgers & Danelius, 1988, p. 118; Mendez & Nicolescu, 2017, p. 244).

In other words, subjective intentionality on the part of the official should never be required. This is too difficult a determination to make. To do so would allow states to justify that torturing environments arise accidentally.

Preventive Safeguards

There exists a handful of minimum standards, which primarily relate to interrogation practice and detainee health.

Duration and Method of Interrogation: Principle 21(2) of the UN Body of Principles provides a broad check on harsh, lengthy interrogations and, in turn,

¹⁷ ECHR. (2008). *Guliyev v. Russia*, 24650/02, §64.

¹⁸ UNSRT. (2010). Report. A/HRC/13/39/ Add.5, §34.

¹⁹ CAT. (2008). General Comment No 2, §9.

acts as a safeguard against the use of sleep deprivation, by proscribing the use of “methods of interrogation which impair... capacity of decision or... judgement.”

The Advisory Council of Jurists of the Asia-Pacific Forum of National Human Rights Institutions also put forward its Minimum Interrogation Standards in 2005.²⁰ Principle 3 states that: “Individuals should only be interrogated for a reasonable period, taking into account the individual characteristics of the interrogated person and, if extending for a lengthy period, regular breaks should be provided.” Again, there is no guidance as to what “reasonable” entails.

Night interrogations are a related area of concern. O’Mara (2015) draws on research on circadian rhythm to find that there is a distinct lack of alertness during night-time hours when compared to the day-time (p. 152).²¹ A recent report on interrogations of Palestinian children in Israel depicts a sleep-deprivation-like use of night interrogations, despite their prohibition:

“Despite these provisions, a quarter of the boys said they were interrogated at night. Moreover, 91% of boys who provided affidavits for this report and were arrested at home were arrested at night, when most were already in bed, asleep. Even if at least in some of the cases, interrogators waited for 7:00 A.M. (the time stipulated by law) to start the actual interrogation, they were clearly doing no more than following the

letter of the law in terms of the prohibition on night-time interrogation (...) The law clearly did not intend that juveniles be taken out of their beds in the middle of the night and then spend the rest of the night at a police station, seated in painful positions without anything to eat or drink, waiting to be interrogated.”

(B’Tselem and HaMoked, 2017, p. 26)

Principle 6 of the Minimum Interrogation Standards addresses this by stating, “no method of interrogation should be employed that impairs a person’s capacity of decision-making or judgement. Save in exceptional circumstances, no interrogation should take place at night.”

While uses of minimal discomfort arguably remain legitimate (as law enforcement institutions inevitably instill some degree of anxiety), accusatorial, protracted or suggestive interviews overlaid with threats, manipulation and coercion are isolated as being problematic. Indeed, depending on their “degree, severity, chronicity and type, undue psychological pressure and manipulative practices” these behaviors may amount to a form of ill-treatment.²² In proposing a protocol for interrogation, the UNSRT recently reported that:

“Torture and ill-treatment harm those areas of the brain associated with memory, mood and general cognitive function. Depending on their severity, chronicity and type, associated stressors typically impair encoding, consolidation and retrieval of memories, especially where practices such as repeated suffocation, extended sleep deprivation and caloric restriction are used in combination. Such practices weaken,

²⁰ These standards are not authoritative and are only valuable in terms of expert guidance.

²¹ Wickens et al. (2015) refer to this as a physiological mechanism ‘a cycle of circadian day and circadian night is determined based on when the individual would naturally be awake or asleep. On earth, this is typically coupled to solar night and day.’ (p. 934).

²² UNSRT. (2016). Report. A/71/298, §44.

disorient and confuse subjects, distort their sense of time and render them prone to fabricate memories, even if they are otherwise willing to answer questions.”²³

The broader link between coercive interrogations and sleep deprivation can therefore be made.

Detention Conditions: Rule 13 of the Nelson Mandela Rules also provides that sleeping accommodation should meet all requirements of health and lists a number of key environmental factors required for healthy sleep including “climatic conditions and particularly to cubic content of air, minimum floor space, lighting, heating and ventilation”. Principle 4 of the Minimum Interrogation Standards requires similar conditions including: “adequate food, sleep, exercise, changes of clothing, washing facilities and, if needed, medical treatment taking into account any particular characteristics of the individual including age, gender, religion, ethnicity, medical needs, mental illness and any disabilities or other vulnerabilities.”

The European Committee for the Prevention of Torture (CPT) has focused on the use of sleep deprivation in interrogation facilities, particularly in its reports on Turkey. In one report, the CPT stated that: “As a rule, a detained person should be allowed within a given period of 24 hours a continuous period of at least eight hours for rest, free from questioning or any activity in connection with the investigation” (CPT, 2009, §15). In another report, it held that deprivation of sleep for up to several days could be considered as torture (CPT, 2014, §113). The CPT, it should be acknowledged, does not hold

its standards as being absolute and rejects any assessment, given the possibility of alleviating factors, that a “minor deviation from its minimum standards may in itself be considered as amounting to inhuman and degrading treatment of the prisoner(s) concerned” (CPT, 2015, §21).

UK legislation echoes the CPT in terms of requiring a continuous period of eight hours out of any period of 24 hours “for rest, free from questioning, travel or any interruption in connection with the investigation concerned”. Factoring in the circadian rhythm, it is further required that this period “should normally be at night or other appropriate time which takes account of when the detainee last slept or rested”. A number of exceptions to this follow. (UK Home Office, 2018, §12.2)

Documentation

Given the lack of means to accurately record sleep/rest and interrogation periods, there is also a significant issue with those subjected to sleep deprivation recalling the duration of their suffering. The responsibility to record a detainee’s rest, transportation, interrogations and other activities irrefutably falls on the state authorities. Principle 23(1) Minimum Interrogation Standards requires the documentation of the times and intervals between interrogations. In this regard, the European Court of Human Rights has, on a number of occasions, remarked upon the lack of records regarding prisoner rest times and its inability to fully appreciate the factual circumstances.²⁴

DIGNITY, in partnership with the Public Committee Against Torture in

²³ UNSRT. (2016). Report. A/71/298, §18.

²⁴ ECHR, Ireland v. United Kingdom, §19; Separate Opinion of Judge Sir Gerald Fitzmaurice, §20; ECHR, Strelets v. Russia, §35.

Israel (PCATI) and REDRESS, have sought to improve the documentation of sleep deprivation as found in criminal justice settings. A medico-legal protocol, which is currently being validated, developed as part of that project has relied on the research which has informed the article at hand, particularly in terms of informing the questions and the normative background for legal professionals to qualify and argue treatment as torture or ill-treatment (see this issue).

Although there is a level of agreement on the six-hour rule from a legal point of view, as reinforced by medical evidence, more is needed by way of support. Any future pursuit to develop norms vis-à-vis sleep deprivation, to support the emerging standards as advanced by international jurisprudence, must increasingly factor in literature on the health impact.

Conclusions

Sleep deprivation is a method of torture. It becomes so when prolonged or inflicted in combination with other methods (e.g. threats) and conditions (e.g. disruptive environment or time of day). The dynamics remain ill-defined and somewhat resistant to the development of more nuanced legal principles, as need be informed by available medical and psychological knowledge. Where standards have developed, however, they have been opaque and lacking in strong support, presumably on an everyday understanding on the need for sleep. Although influenced by medical knowledge, the six- or eight-hour rules as expounded by the European bodies have not been based explicitly, nor with sufficient nuance, on known health impacts. Nor have normative declarations by the CAT and UNSRT that link torture and sleep deprivation, whilst necessary, been supported by detailed and clear guidance. For one, the

level of impact on capacity and personality, mindful of subjectivities, needs to be better articulated in order to be appreciated as amounting to severe. It may be that more objective and workable rules similar to those developed to define solitary confinement (22/24 hours) and its prolonged use (15 days) under the Nelson Mandela Rules, as universal they may be, are required. As that experience demonstrates, instrumentalizing existing medical knowledge in this vein will only serve to strengthen legal prescriptions against the use of sleep deprivation.

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Development of interdisciplinary protocols on medico-legal documentation of torture: Sleep deprivation

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Key points of interest

- Our experience indicates that the likelihood of ensuring accountability for perpetrators depends upon the quality of the documentation submitted to courts and investigative bodies.
- Formulating approaches to translating the medical and legal literature and knowledge about torture methods into specific interdisciplinary instruments or protocols applicable in a local context – based on which better documentation practices could be developed.
- Development of the Sleep Deprivation Protocol as the first testing of the research-based approach.

Abstract

Background: The use of psychological torture or torture methods that leave no visible marks (stealth torture) is on the increase in various contexts. However, the difficulties in the documentation of such methods should be recognized by lawyers and health professionals who may benefit from using research-based interdisciplinary instruments to improve their documentation for legal processes - in addition to the United Nations Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1999) (Istanbul Protocol). *Objective:* With the aim to develop additional instruments for the documentation of various psychological torture methods, this article explains the recommended methodology for such research-based interdisciplinary instruments and the process of developing the first example of this approach relating to sleep deprivation. *Development and pilot-testing of the Sleep Deprivation Protocol:* The pilot-testing of the Protocol by lawyers in the Public Committee Against Torture in Israel (PCATI) has already yielded positive results. *Conclusion:* Further advanced documentation instruments, using medical evidence in non-torture contexts and legal research, should be developed to effectively identify and record other psychological torture methods.

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Introduction

Torture and cruel, inhuman or degrading treatment or punishment (“ill-treatment”) continue to be practiced widely worldwide, and the use of torture methods that leave no visible marks is on the increase in various contexts and countries (Rejali, 2007). Such methods can and will often lead to psychological long-term effects (Pérez-Sales, 2017). The apparatus of torture, its agents as well as the deleterious impact on the victim are rendered invisible. The difficulty in assessing the consequences, documenting it legally and medically, and adjudicating cases is thus amplified when it comes to psychological torture (Cakal, 2018). Examples of psychological torture methods (used alone or together with other techniques to produce a cumulative effect) include, among others, solitary confinement, sleep deprivation, sensory deprivation, sensory overstimulation, humiliations, and threats. Many of these techniques do not have specific definitions or parameters, and it will be up to lawyers in individual cases to explain how such treatment is unlawful, or how the impact on a particular individual may cross the severity threshold to make it torture.

The forthcoming review of the Istanbul Protocol, which sets out minimum standards for legal and medical investigations of cases of alleged torture, aims to provide guidelines for national authorities to ensure the collection of evidence so that perpetrators can be held accountable for their actions. One of the standards stipulates that both a physical and a psychological assessment of the

victim of torture should be undertaken (OHCHR, 2004, Chapter VI). The Istanbul Protocol provides useful guidance for health professionals and lawyers – for example regarding legal standards, interviewing techniques and general knowledge about the consequences of torture. However, the assumption is that attitude and skills with regards to documentation of psychological torture would improve further by additional research and the development of specific questions that take into consideration the complexities of the matter and existing legal and medical research.

Information collected by PCATI shows that the Israeli authorities commonly use complex techniques based on directly attacking the conscious self of victims causing pain without obvious marks (PCATI, 2016 and 2019). The Israeli Security Agency (ISA) apply sophisticated means of torture in interrogations to gain information and confessions from those interrogated, most commonly Palestinians from the West Bank, without leaving obvious evidence of physical torture behind. In practice, psychological torture, as well as the long-term psychological effects of all methods of torture, are often overshadowed by medical-legal evidence of physical torture, which is given prominence by the adjudicating bodies. As in other contexts, the scars inflicted on the mind, sense of identity and personality of the victims are often persistent and more harmful than those inflicted on the body according to PCATI’s experience. Data from the past five years indicates that sleep deprivation is used in nearly 70% of PCATI’s cases involving Palestinian detainees interrogated by the ISA (PCATI, 2019). Despite the common use of the method, its impact on the victims had not previously been systematically addressed.

Objective

With the aim to develop instruments for the documentation of various psychological torture methods, this article explains our methodology for research-based interdisciplinary instruments and the process of developing the first example of this approach relating to the documentation of sleep deprivation.

Development of the Sleep Deprivation Protocol

A conference held in Copenhagen in November 2015 highlighted the need among lawyers and health professionals for new tools to improve documentation of psychological torture. As a result, in 2016, DIGNITY – Danish Institute Against Torture, REDRESS and PCATI began a joint project perceived as a vehicle to establish a common understanding between health and legal professionals as to the reasons for the use of psychological torture, its impact, and how to improve the interdisciplinary documentation of such acts. The project aims at developing best practices on documentation of psychological torture; establishing evidence in individual court cases; strengthening jurisprudence and caselaw about psychological torture; and influencing policy debates while promoting better acknowledgement of psychological torture among key stakeholders.

Strategically, it was decided to focus on the target group of lawyers and health professionals who are independent of the state and who often meet and interview victims of torture. Better documentation on their behalf, based on research-informed tools, would lead to the collection of evidence that could be used within the judicial system and in local and international advocacy efforts to raise awareness of the severe consequences of psychological torture and of

the temptation among national authorities to use such methods to avoid accountability.

DIGNITY, REDRESS and PCATI set up a project group and an international expert group¹ who met in London in 2017 and Copenhagen in 2018 to discuss existing medical and legal knowledge with regard to psychological torture methods and the limitations of and common challenges in its documentation. It was agreed to adopt the following methodology for the development of research-based protocols to document psychological torture methods:

- 1) Review of existing legal and health knowledge regarding the specific method of torture, both in clinical and non-torture contexts;
- 2) Drafting of an interdisciplinary research-informed protocol with specific questions;
- 3) Discussion within the group of international experts;
- 4) Adjustment of the protocol to a specific local context if required, pilot-testing; and
- 5) Evaluation.

Each protocol would include specific questions to be asked during an interview with a victim of torture. This approach should address lawyers' requests for more clarity on how to understand the concept of pain and suffering and research-oriented evidence of harms resulting from psychological torture in order to guide the adjudicator when

¹ The group includes the following experts and organisations in addition to the authors of this article: Nora Sveaass, Nimisha Patel, Brock Chisholm, Pau Pérez-Sales, Ahmed Benasr, REDRESS (Alejandra Vicente), Freedom from Torture (Angela Burnett and Emily Rowe), IRCT (Asger Kjærsum and James Lin), PCATI (Efrat Bergman-Sapir), and University of Essex (Carla Ferstman).

interpreting the definition of torture in the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the scope of cruel or inhuman and degrading treatment.

The group decided to begin the process with one specific method for in-depth consideration: sleep deprivation, as it is a prevalent method used in interrogation in Israel and elsewhere. The content of the Protocol was developed following the methodology previously mentioned, and bearing in mind that sleep deprivation is often used to obtain information or a confession, albeit unreliable, during an interrogation (Cakal, 2019). The Protocol includes explanations as to the different types of sleep deprivation that are used.

Pilot experience of the Sleep Deprivation Protocol

Step I – Adapting the Protocol. As a first step in the piloting process, PCATI adapted four of the Protocol’s sections to the local context – Israel in this case. This was done based on PCATI’s on-the-ground experience, bearing in mind the legal framework in Israel, and the reality in which interviews with victims are carried out and affidavits taken. For example, interrogations are often long, commonly lasting between two weeks to a month; interviews with victims are conducted in detention, a few weeks at minimum after the interrogation ended, and in far from ideal settings (e.g. limited time and with a separating glass barrier). The adaptation led to a shorter Protocol that reflects typical interrogation patterns in Israel and enables questions that are more open (professional medical terms were not altered). The four sections were then translated to Hebrew. The translation

was reviewed by lawyers who regularly conduct prison visits. It is worthwhile noting that the adaptation and translation process was done in view of creating a practical hands-on legal tool rather than a research protocol.

Step II – Piloting. The Protocol was piloted in seven cases, all involving Palestinians who had been subjected to an ISA interrogation in the previous 12 months. In six of the cases, lawyers visited and interviewed detainees using the Protocol in full. In the seventh case, health professionals – a physician and a psychologist – supplemented an Istanbul Protocol (IP) evaluation with questions from the supplementary Protocol regarding sleep patterns and sequelae. The cases were selected in an effort to reflect existing diversity. Two of the cases were of female detainees who were subjected to psychological torture during interrogation; two cases involved male detainees whose interrogation included mostly psychological torture; and the last two cases involved male detainees subjected to an interrogation that included “enhanced interrogation techniques” (i.e. stress positions and beatings in addition to the psychological torture). All cases included deprivation of sleep, a fact that was known to PCATI beforehand, as the Protocol was piloted only in cases where affidavits had previously been taken and thus rapport established. The six interviews were carried out by female and male lawyers and took place in three different prisons over a period of three months. The IP evaluation was conducted in prison with one of the female detainees who had been interviewed by the lawyers.

Step III – Evaluation. Each interview and the IP evaluation were analyzed by PCATI based on feedback from the lawyers and health professionals involved, and in light of the quality of the information collected. The information in each Protocol was compared to that captured in affidavits previously taken in the same cases. Follow-up visits were conducted with the six interviewees.

Following the pilot, the lawyers reported that the Protocol improved their way of asking questions during the interview, and they felt more comfortable in asking about intimate issues related to sleep and rest such as re-occurring dreams. The structure of the Protocol enabled them to collect new information; the section exploring the so-called “rest time” was particularly revealing as detainees often experienced a fragmented and insufficient resting period. Interestingly, lawyers were surprised that the interviewees, male and female alike, had hardly any hesitation in talking about their sleep patterns and dreams. Health professionals added some of the questions in the Protocol to their IP evaluation. Additionally, the process of adapting and implementing the Protocol enabled staff and external professionals to better conceptualize what sleep deprivation actually “consists of.” Following the pilot-phase, PCATI concluded that the Protocol, which should and will be used in Arabic and in Hebrew, has best impact when not used as a stand-alone tool but as an integrated part of the process of taking testimony from a detainee. It is planned that the revised Protocol will be added to the standard interviewing toolkit for lawyers starting in 2020.

Conclusion

DIGNITY, REDRESS and PCATI seek to inform and influence policy debates, and ensure better acknowledgement of

psychological methods of torture and ill-treatment. Our study has shown that developing a specific interdisciplinary protocol has improved documentation practices among lawyers working with PCATI. We envisage further pilot-testing of the Sleep Deprivation Protocol in other countries as well as the development of new documentation tools for other methods that build on the Istanbul Protocol, medical and legal knowledge, and field research. We hope that the Protocol(s) will be informed by local practices and used widely in the future.

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Protocol on Medico-Legal Documentation of Sleep Deprivation

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Abbreviations

UNCAT: UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984)

Istanbul Protocol: UN Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1999)

Preface

This Protocol originates from a joint project regarding documentation of psychological torture initiated by the Public Committee against Torture in Israel (PCATI), REDRESS and DIGNITY - Danish Institute Against Torture (DIGNITY) in 2015 after the Copenhagen Conference on Psychological Torture. The project is a vehicle to establish a common understanding between health and legal professions as to how to best ensure the most accurate documentation of psychological torture.

Historically, sleep deprivation has been used for different objectives but, primarily, to cause stress and duress for the purpose of extracting information and confessions. Detention centers with poor conditions is another context in which sleep deprivation, as a consequence of sleep disruption, takes place. This is often due to overcrowding, insufficient or no mattresses, and poor conditions of transportation between the courts and detention facilities.

The aim of the Protocol is to improve documentation of sleep deprivation used in such settings (most often during interrogation) and therefore to clarify the facts of the case so that stronger legal claims can subsequently be submitted to local and international complaints mechanisms.

The Protocol has been developed based on a methodology involving: compilation

and review of legal and health knowledge on sleep deprivation, also in non-torture contexts; drafting by first author; discussion in the group of international experts;¹ pilot-testing by PCATI; and evaluation by the three organizations and the group of experts.

Despite generic elements of sleep deprivation, the context in a specific country will determine many aspects of the factual situation. Each context differs and as such this Protocol could serve as a guideline or a checklist of elements to be considered in a specific context.

We hope that this Protocol will assist in the discussions between the various stakeholders and provide guidance on what can be documented and how to document sleep deprivation.

Definitions

The Protocol refers to the following definitions that have been agreed in the group of experts:

Total sleep deprivation (TSD):

Elimination of sleep for a period of time (at least one night) after the person has been awake for an extended period. It is an absolute value (e.g. 43 hours).

Partial sleep deprivation (PSD)/Sleep restriction (SR):

Reduction in sleep time below an individual's usual baseline or the amount of sleep needed on a regular basis to maintain optimal performance. It is a relative value (e.g. 4 hours sleep in a person with an

¹ The group includes the following experts and organizations in addition to the authors of this Protocol: Nora Sveaass, Nimisha Patel, Brock Chisholm, Ahmed Benasr, REDRESS (Rupert Skilbeck and Alejandra Vicente), Freedom from Torture (Angela Burnett and Emily Rowe), IRCT (Asger Kjærsum and James Lin), and University of Essex (Carla Ferstman).

average baseline sleeping time of 7 hours, means a PSD of 3 hours).

Sleep disruption (SD): Interruption or fragmentation of sleep, where frequent arousal disrupts the normal dynamics of sleep for the person. Sleep disruption is associated with an increase in awakenings and, typically, a reduction of deep sleep although the total amount of time might seem similar to a normal night's sleep (e.g. 7 hours of sleeping time with interruptions due to hunger, heat or loud noise). It can be deliberate or not.

Minimum duration of necessary sleep:

There is a small variability in individual needs among adults (from 5 to 8 hours). There is a widely accepted consensus of an average of 7 +/- 1 hours of daily continuous sleep as part of a normal sleep pattern. For an adult (18-65) the minimum duration of necessary sleep is no less than 6 hours and for an older adult (>65), not less than 5 hours. The minimum duration for children (under 18) is higher (Hirshkowitz et al., 2015; Watson, Badr, Belenk, & Bliwise, 2015).

This is a recommendation during normal circumstances and should also be the minimum during detention or interrogation (see Editorial, this issue).²

Resting Periods: Time without interrogation or any other administrative interruption including transportation.

Legal and Medical Considerations³

Legal aspects

The use of sleep deprivation has been recognized in the international human rights framework as a method of torture or cruel, inhuman or degrading treatment or punishment. There is, however, no universally accepted legal definition of what constitutes sleep deprivation or what is sometimes referred to as 'prolonged' sleep deprivation.

The legal assessment needs to be based on the four elements found in the definition of torture in article 1 (1) of the *UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (UNCAT). Accepting the premise that sleep deprivation is primarily used for obtaining information or confession, two elements under the definition emerge to be particularly significant: *intentionality* and *severity* of physical or mental pain or suffering. Notably, Article 3 of the European Convention on Human Rights (ECHR) has also been interpreted to require these two elements. If these elements cannot be identified, the treatment can still amount to other forms of ill-treatment (i.e., cruel, inhuman or degrading treatment or punishment). This is explored below when reviewing their application to sleep deprivation.

Severe pain or suffering, whether physical or mental, is accepted to arise out of an individual method or a combination, whether occurring on one occasion or over time (ICTY, 2002: §182). Therefore, it can be short-lived and need not be

² Although some military regulations have proposed lower levels as incidental to normal routines, even a 4-hour daily minimum, medical standards show that less of a 6 hours daily level is unacceptable regardless of human variability. This is more so the case if sleep deprivation is combined with other stressors that produce cognitive and emotional exhaustion or if it lasts for more than one day and there is a cumulative effect.

³ For a fuller discussion, please refer to Cakal. E. (2019). Befogging reason, undermining will: Understanding sleep deprivation as torture and other ill-treatment in international law. *Torture Journal* 29(2).

prolonged (CAT, 2006: §13; ICTY, 2006: §300). Mental pain can constitute torture or ill-treatment on its own and need not be coupled with physical pain.

Despite such complexities, the nexus between sleep deprivation and torture has become well-established. The UN Committee against Torture (CAT) has criticized the use of sleep deprivation by a number of states, providing clear indications of outer limits. Most prominently, its observations with respect to the United States focused on the guidelines found in the interrogation rulebook in the US Army Manual that provide: ‘Use of separation must not preclude the person getting four hours of continuous sleep every 24 hours’ (United States Army, 2006, Appendix M). CAT held that, particularly with the understanding that a person could be subjected to this for a renewable period of 30 days, this amounted to ‘authorising sleep deprivation—a form of ill-treatment’ (CAT, 2014: §17). Of particular concern was that this rule could be interpreted in such a manner as to allow for 40 continuous hours of interrogation with only four hours of sleep on either end. The US, when questioned by the CAT, rejected that this was the practice. Similarly, CAT has also criticized Israel for using sleep deprivation.⁴ Based on

the understanding that it is not inherently harmful, CAT did not categorically state that sleep deprivation amounted to torture in all cases, as evidenced by their need to detail the durations concerned.

Methods that undermine will or capacity have, to date, been accepted as having the capacity to amount to torture and, more, often as other forms of ill-treatment. Principle 6 of the UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, for one, requires other ill-treatment to be interpreted to include “the holding of a detained or imprisoned person in conditions which deprive him, temporarily or permanently, of the use of any of his natural senses, such as sight or hearing, or of his awareness of place and the passing of time.” Drawing on the range of impairments emanating from the medical literature, it is reasonable to interpret this to capture any form of sensory deprivation, blunting of the senses or temporal disorientation, including the use of sleep deprivation.

This is also echoed in Principle 1 of the *Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas*, which protects individuals from ‘forced intervention or coercive treatment, from any method intended to obliterate their personality or to diminish their physical or mental capacities.’ Impairment to one’s attention, memory, and communication, as stressed by medical literature on harms, directly impinge on capacity, and hence are readily proscribed by these principles.

The link between sleep deprivation and the obliteration or diminishing an individual’s personality was further drawn by the case of *Maritza Urrutia v. Guatemala*. The Inter-American Commission requested that the Inter-American Court find a ‘violation because of the use of: methods tending to

⁴ It found one individual to have been permitted to sleep for about one hour in 24 over the course of 4 days, which constituted torture from a medical point of view. In another case, brought before the High Court of Israel (HCJ 2210/96), the detainee had been kept awake for 39 hours followed by 5 hours’ rest, then for 47 hours with 2 hours’ rest, and then for 22 hours with 5 hours’ rest, 47 hours with 5 hours’ rest, 46 hours with 5 hours’ rest, and finally 48 hours with 6 hours’ rest. The situation had perhaps been urgent, but that unquestionably constituted mental torture. (CAT. (1998). Report. E/CN.4/1998/38, §24); see also CAT/C/ISR/CO/5, para. 30.

obliterate or diminish her personality, such as sleep deprivation' (§78(b)).

The European Court of Human Rights has considered the use of sleep deprivation in interrogation contexts. For instance, in *Mader v. Croatia*, where the applicant was 'deprived of sleep and forced to sit on a chair continuously for two days and nineteen hours' at a police station, the court found that this on its own amounted to inhuman treatment (§108). In *Bati v Turkey*, where the applicants were subjected to sleep deprivation for several days, as well as physical and verbal assault during interrogation, the court accepted that this treatment 'was liable to harm their mental integrity' (§114).

In *Bagel v. Russia*, the applicant, amongst other things, alleged that he had 'insufficient time to sleep on the days of transport'. The court, accepting that the applicant was able to sleep at least from 11pm to 5am each night, ruled that he was not subjected to any sleep deprivation (§70). This precedent was followed more recently in *Sadretdinov v. Russia*, where the applicant complained of the 'authorities' failure to ensure that he enjoyed eight hours' sleep on court hearing days' (§96). Similarly dismissing this limb of his claim, the court stuck to the sufficiency of the six-hour rule in stating that:

"The applicant had no less than six hours of sleep per night. Moreover, the authorities took steps to ensure that he had enough sleep during at least three nights per week (when he did not take part in court hearings)."

In *Strelets v. Russia*, the applicant complained of insufficient sleep on days of court hearings, over several consecutive days, being woken up at 6am and being brought back to the cell after 10pm. Notably, the pronouncement of the national court's judgment started at 8.30pm and finished at 0.30am. Holding it to be inhuman and degrading treatment, the European Court of Human Rights reasoned

as follows (§62)

"the cumulative effect of malnutrition and inadequate sleep on the days of court hearings must have been of an intensity such as to induce in the applicant physical suffering and mental fatigue. This must have been further aggravated by the fact that the above treatment occurred during the applicant's trial, that is, when he most needed his powers of concentration and mental alertness."

Continuous Interrogation. Sometimes sleep deprivation is considered incidental to interrogation. There is no guidance regarding the maximum length of interrogation permitted in any international standards.⁵ According to studies, an average police interrogation lasts a maximum of two hours exceptionally repeated up to three times with enough time for rest and refreshment among interrogations (Gudjonsson, 2003; Leo, 1996).

⁵ The United Nations Body of Principles for the Protection of All Persons under any form of Detention or Imprisonment does not establish strict rules regarding the length of interrogation sessions although it does require recording of the duration of any interrogation and of the intervals between interrogations. The International Commissions of Jurist has included "adequate periods for rest and refreshment", again without more clear guidance. As does the Advisory Council of Jurists of the Asia Pacific Forum of National Human Rights Institutions in their Standards for Interrogation of detainees. The European CPT Standards also suggest that interrogations should not be held for lengthy periods, but does not give a concrete recommendation (Morgan & Evans, 2001). The US Supreme Court ascribes to the "totality-of-the-circumstances" test, that assume that all relevant factors must be assessed, including the application of physical abuse or psychological coercion; the time, length, circumstances, and place of the interrogation; and the age and education of the detainee, along with other considerations.

Given the above discussion, legal assessments of whether sleep deprivation amounts to torture or ill-treatment should be determined on a case-by-case basis.

These legal considerations have guided the questions in this Protocol.

Medical aspects

Time-limited sleep deprivation does not leave any known chronic problems, but in the acute stage—i.e. while the sleep deprivation takes place, and in the hours and days following the incident—both physical, emotional and cognitive consequences may be seen and then disappear again spontaneously. These consequences have been described in several scientific studies (see sources below) undertaken in laboratories where total or partial sleep deprivation has been induced for the sake of the study. Other studies have been undertaken among people who have been deprived of sleep as a result of their work, for example during night shifts. In the following, a brief overview of some of the most important findings from such studies will be given. The study results have inspired the questions in the Protocol.

All acute consequences of sleep deprivation described below have been presented in meta-analyses or in systematic reviews, i.e. in scientific papers presenting cumulative results from several different studies, thereby increasing the validity of the findings.

Perception of pain. Sleep deprived individuals have been shown to have a lower pain threshold and also to score higher when asked about their perception of pain (Schrimpf et al., 2015).

Anxiety, mood changes and psychosis. In some studies, sleep deprived individuals have been shown to have higher levels of anxiety

(Pires et al., 2016). They have also been shown to have less inhibition and greater emotional reactions to negative stimuli (Beattie, Kyle, Espie & Biello, 2015). Last but certainly not least, it has been shown that sleep deprived individuals may develop both visual and auditory hallucinations as well as other symptoms related to how the surroundings are perceived. This includes temporal disorientation, i.e. lack of ability to properly assess time. With sleep deprivation lasting for days, symptoms may proceed to frank psychosis and delirium (Waters, Chiu, Atkinson & Blom, 2018), the latter being a life-threatening condition that requires immediate medical attention.

Cognition. Several studies have been undertaken assessing the impact of sleep deprivation on cognitive performance. The studies are heterogeneous and therefore difficult to compare, but overall it can be concluded that studies show a clear negative impact of sleep deprivation in more complex areas of cognition. The effect on simple tasks related to attention (e.g. tests assessing a person's ability to react to a simple visual stimulus on a screen) is even more pronounced, and the effect of sleep deprivation on cognition increases with increasing amounts of sleep deprivation (Lim & Dinges, 2010; Lowe et al., 2017; Philibert, 2005). Interestingly, a person's ability to assess his or her own performance has been shown to be mostly preserved during sleep deprivation (Jackson et al., 2017).

Many studies have also investigated the long-term consequences of chronic sleep deprivation, for example as the result of a chronic sleep disorder like sleep apnea and others. An increased risk of—among others—hypertension and diabetes mellitus has been found in people with chronic

sleeping problems. This, however, is beyond the scope of a protocol on medico-legal documentation of sleep deprivation and will not be dealt with further here.

Summing up, sleep deprivation may lead to acute physical, emotional and cognitive consequences, and when documenting sleep deprivation, all these aspects must be considered. Symptoms of sleep deprivation are diverse and may range from hardly noticeable cognitive impact to life-threatening delirium.

Sleeping problems are commonly found among torture survivors irrespective of whether they have been subjected to sleep deprivation or not. Asking about current sleeping problems should therefore always be part of the clinical assessment of a torture survivor.

PROTOCOL

1. Purpose

This is a generic protocol to guide the part of an interview with an interviewee that relates to documentation of sleep and sleep deprivation. As such, this Protocol complements the Istanbul Protocol when specific documentation on sleep deprivation is required.

It is designed to be used by lawyers and health professionals during interviews in a detention facility or after release. The average time of application in its entirety is estimated at 40 minutes.

Combined or cumulative effects of the general detention and interrogation context and the various methods used are of importance. Ill-treatment and torture are often not based on single individual techniques (which may or may not be damaging if considered one by one) but is the result of the combined interaction of methods. Thus, sleep deprivation is often not a single element but part of a wider context that must be assessed in the interview (see below).

While some information may be collected by both health and legal professionals (i.e., sections 1-5), two sections of the Protocol require specific qualifications (i.e., sections 6 and 7). An organisation may consider whether to train staff so that they can be qualified to ask certain questions outside their usual professional skill-set. However, this approach has its limitations and should always be guided by the principle of doing-no-harm.

The following key aspects of the context should be highlighted:

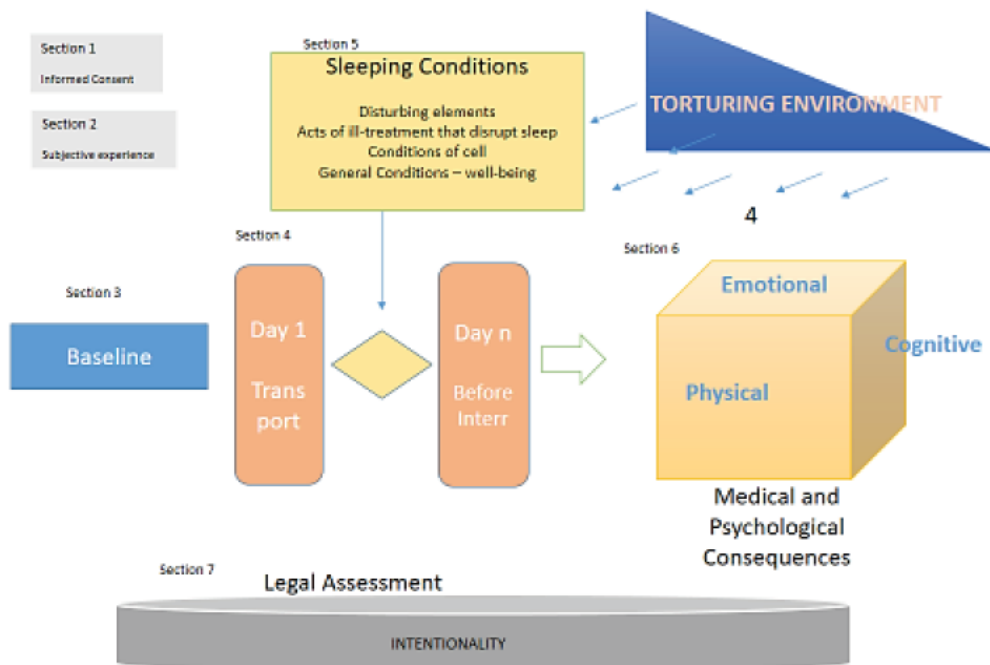
- a. **Importance of time:** The Protocol is used to assess the consequences of sleep deprivation after an interval of time following the pertinent event(s). It can be days but more often the interview is undertaken weeks or months after the event(s). At this point, no biological measures or tests would be possible (e.g., Actigraphy, EEG or Evoked potentials).
- b. **Torturing environment:** Imposing sleep disruption is usually part of a more overall *torturing environment* that often involves threats, humiliation, deprivation of water/food and/or sensory deprivation (e.g., blindfolded). A *torturing environment* is defined as “a set of conditions or practices that obliterate the control and will of a person and that compromise the self” (Pérez-Sales, 2017)).
- c. **Verification of the information obtained during the interview:** The interrogator must record the hour of beginning and ending of interrogation and time allowed for rest. In some countries, the interviewer may have access to the logbook of the interrogation and will be able to compare the information obtained during the interview with the information in the logbook.

- d. **Each country has its specific political and local context** and each detaining institution has its specificities regarding methods allowed or prohibited. This should be taken into consideration when applying the Protocol.

2. Overview of the Protocol

You will be taken through seven different sections:

- Informed Consent and General Considerations for Interviews;
- Subjective Experience;
- Baseline: Sleep Pattern before Detention;
- Diary of Sleep: What Happened?
- Sleeping Conditions;
- Medical and Psychological Consequences; and
- Legal Assessment of Sleep Deprivation.



2. Protocol

Section 1. Informed Consent and General Considerations for Interviews

Informed consent involves making sure that when the interviewee consents to an interview (and to the subsequent use of the information that has been provided), the interviewee is fully informed of and has understood the potential benefits and risks of the proposed course of action. Each case must be assessed individually considering the seriousness of the allegation and what the potential risks could be at every step of the process.

The interviewer should obtain informed consent from the interviewee according to the ethical guidelines mentioned in the Istanbul Protocol (see Chapter II).

Key elements of informed consent:

- *Information:* About yourself and the purpose and objectives of the interview.
- *Comprehension:* Assess whether your interviewee has really understood the information. Mental ability, language, age, and other aspects may affect the individual's ability to give informed consent. The higher the risk, the higher the obligation to ensure a proper understanding of potential risks.
- *Voluntariness:* Agreement to be interviewed should be voluntary and no pressure should be exerted or promises made in an effort to gain the information.

Approach:

- Explain to the interviewee the purpose of the interview and how the data will be used in the future and then obtain the interviewee's acceptance of the interview and each of the follow-up steps (verbal or written).
- Explain that the interviewee has the right to withdraw from the interview at any

point and how this can be done.

- Tell the interviewee how you plan to follow-up on his/her situation.
- Follow the general considerations for interview as mentioned in the Istanbul Protocol, and explain to the interviewee how the interview will be conducted. Explain that the interviewee will be asked about the sleep pattern and eventual lack of sleep. This should be done without influencing or prompting answers by highlighting the potential consideration of sleep deprivation as ill-treatment or torture.⁶
- Please stress that as in any assessment, it is important to be as accurate as possible.
- The interviewer should also be aware of the risk of re-traumatisation (see the Istanbul Protocol, Chapter IV).

⁶ The potential relationship between sleep deprivation and torture can be raised at end of the interview with the purpose of providing meaning to the victim's experience and eventually alleviate guilt or trauma symptoms.

Section 2. Subjective Experience

This section is intended to describe the sleep deprivation in the interviewee's words. Please collect the answers as verbatim as possible.

Do you think you were sleep deprived? Why?

Horizontal lines for writing the answer to the first question.

Horizontal lines for writing the answer to the first question.

Does this still affect you today? If yes, can you explain how?

How do you think that this affected you during detention and/or interrogation?

Horizontal lines for writing the answer to the second question.

Horizontal lines for writing the answer to the second question.

Section 3. Baseline: Sleep pattern before detention

This section is intended to assess potential vulnerabilities linked to the interviewee's minimum duration of necessary sleep and circadian rhythm. It is especially relevant if the interviewee was submitted to interrogation during the night or at changing times.

Taking the months before detention as reference point, ask the following questions on normal sleep pattern and previous sleep problems before detention.⁷

1. How many hours on average do you sleep to feel well?
2. If you have to do a very difficult task, which hours of the day would be the best for you to get perfectly concentrated?
 - (a) Early morning
 - (b) Midday
 - (c) Afternoon
 - (d) Evening
 - (e) Late in the night
3. One night you *remain awake* to do a task between 3-5 AM. How will you feel?
 - (a) Perfectly fine
 - (b) Sleepy but fine
 - (c) A bit slow and confused
 - (d) Very slow and confused
 - (e) I could not do it
4. One night you *are awakened* by others to do a task between 3-5 AM. How will you feel?
 - (a) Perfectly fine
 - (b) Sleepy but fine
 - (c) A bit slow and confused
 - (d) Very slow and confused
 - (e) I could not do it
5. Previous sleep problems. Did any of the following happen to you at least 3 times a week at any time during the months before detention?
 - (a) Cannot get to sleep within 30 minutes [Early insomnia]
 - (b) Wake up in the middle of the night or too early in the morning and cannot go back to sleep [Maintenance insomnia]
 - (c) Have bad dreams [Nightmares and disturbing dreams]
 - (d) Have other sleep problems (for instance, bruxism, constant movement of the legs, snoring, snoozing...)

Explain

6. Describe contents if there were already bad dreams before detention:

⁷ The questions are based on selected items adapted from the Morningness-Eveningness Questionnaire (MEQ) and Pittsburgh Sleep Quality Index (PSQI) (see Annex).

Section 4. Diary of Sleep: What Happened?

This section is intended to provide a quantitative account of sleep deprivation as objectively as possible.

If the person, who has been subjected to the deprivation can remember each day, individualize them and give an accurate

account of what happened almost day-by-day then use Option 1. If the person is not able to remember each day separately, then use periods of detention as in Option 2.

If in doubt, use Option 1 whenever possible.

Note that there may be some gaps in the information but try to collect the facts in as detailed a manner as possible.

Option 1: *What happened, day-by-day.*

	How many hours were you interrogated continuously?	How many hours could you sleep continuously?	Were you deliberately or accidentally awoken or kept awake during the resting period? 1. Never 2. Sometimes 3. Regularly 4. All the time
1 st day			
2 nd day			
3 rd day			
4 th day			
5 th day			
6 th day			
7 th day			
8 th day			
9 th day			
10 th day			
Etc.			

Option 2: Description by periods of time.

1. How did you keep track of the time?

2. Hours and distribution of sleep:

Time	Estimated total duration (hours or days)	How many hours could you sleep continuously? (estimate)	How many hours were you interrogated continuously? (estimate)	Were you interrogated during the night? 1. Never 2. Sometimes 3. Regularly 4. Always	Were you awakened during periods of sleep or rest? 1. Never 2. Sometimes 3. Regularly 4. Always
Event ^a					
During Transport		n/a	n/a	n/a	n/a
Before Interrogation(s) ^b			n/a	n/a	n/a
During Interrogation(s) ^c					n/a
After Interrogation ^d			n/a	n/a	

^a If your case does not involve an interrogation, you need to change these categories and adapt them to your needs. You may prefer to order periods according to locations (for example places of detention), authority in charge, or according to acts of mistreatment (before/after subjected to certain acts). Listen to the interviewee's account and decide which markers would be most appropriate to organize the diary of sleep.)

^b From arrival until first interrogation.

^c From the first to the last interrogation.

^d After the last interrogation.

Maximum Sleep Deprivation

During this period, please note:

- What was the longest time (number of hours) of continuous interrogation throughout the entire period of detention?
- What was the maximum number of hours that you were forced to be awoken? (you can specify more than one time, if there were different very significant situations)

- Average number of hours in which the person is allowed to sleep by day, by the number of days that the person was detained (when using the description by stages during detention): _____

Chronic Sleep Deprivation⁸

- Total number of hours that the person slept during sleep deprivation (when using description day by day): _____

⁸ Please note that the absolute number of hours or days (see schema) may not give the full picture or even be misleading when the hours of sleep vary. By way of example, in a detention facility where regulations establish minimum sleep of 6 hours per 24 hours, the detainee may be allowed to sleep 6 hours in the beginning of day X and 6 hours at the end of the following day. Thus, the person will be sleep deprived for a total of 40 out of 48 hours within the two days—without contravening the regulations. This is why the distribution is as relevant as the total number of hours.

Section 5. Sleeping Conditions

The following questions explore conditions that might affect sleeping during the time allocated to it by the authorities. If the person could not sleep during these periods,

ask why. Please include all situations without taking into consideration whether this was intentionally done or not.

	YES	Explain
1. Disturbing elements		
General noise or music		
Screaming, shouting or other disruptions coming from other detainees.		
Shouts or other noises produced by staff or interrogators		
Being taken somewhere for exercise, shower, bathroom etc.		
Roll call or cell search		
Other elements		
2. Acts intentionally aimed to disrupt sleep during resting periods		
Water in face/body		
Stress positions		
Use of restraints		
Forced standing or walking		
Other acts causing pain that prevents you from sleeping		
3. Conditions of the cell		
Temperature		
Constant light		
Hygiene, sanitation		
Rats, mice, lice, bedbugs or other insects or animals		
Overcrowding		
Lack of ventilation		
Size of the cell		
Other elements		
4. Person's physical or emotional state impedes sleeping		
Pain		
Anxiety		
Fear		
Rumination		
Shame, humiliation, guilt		
Rage		
Hallucinations		

Section 6. Medical and Psychological Consequences

This section of the Protocol should be applied by a medical or psychological expert.

- Have you ever required medical treatment for insomnia?

YES NO

If yes, describe: _____

- Have you suffered from previous diseases that affected sleep (especially neurological or endocrinological disorders)?

YES NO

If yes, describe: _____

Checklist of cognitive symptoms linked to detention⁹

This checklist assesses the person's cognitive symptoms during detention and interrogation and afterwards.

Column A: While you were sleep restricted, did any of these items occur to you and if yes, how often?

Column B: Did any of these symptoms improved or worsened when all situations of sleep deprivation ended, and you could sleep again (usually after your period of detention)? (only ask for items marked as "Often" or "Always" in column A)

During your time in detention, did the following happen:	A: During sleep deprivation	B: After sleep deprivation
Items	1. Never 2. Sometimes 3. Often 4. All the time	1. Improved 2. Not changed 3. Worsened
1. Consciousness. Did you ever lose it? If yes: Reasons for losing consciousness: (a) Beatings in head/traumatic brain injury (b) Suffocation/Asphyxia (c) Emotional fainting (anxiety, fear...) (d) Other forms of pain (e) Other		
2. Orientation. Were you able to say more or less how much time you had been detained?		
3. Orientation. Did you usually know, approximately, the time of the day? (morning, afternoon, evening or night)		
4. Awareness. Did you feel sleepy while not being interrogated?		
5. Awareness. Did you feel sleepy <i>most of the day</i> while not being interrogated?		
6. Concentration and Memory. Did you ever notice that you could not remember basic information about yourself (e.g. the name of very close family members or details of your infancy)?		
7. Concentration and Memory. Did it happen that you were not able to understand even simple questions from others (detainees, relatives, interrogators or prison staff)?		
8. Concentration and Memory. Were you able to recall, immediately after detention, how your cell was (do not use if the person was blindfolded)?		

⁹ Items selected and adapted from MOCA and Brief Neuropsychological Assessment questionnaires to a context of detention and sleep deprivation (see Annex).

During your time in detention, did the following happen:	A: During sleep deprivation	B: After sleep deprivation
Items	1. Never 2. Sometimes 3. Often 4. All the time	1. Improved 2. Not changed 3. Worsened
9. Perception. Did it happen to you that you perceived your surroundings altered (e.g. walls and/or ceiling as moving or as falling upon you?)		
10. Perception. Did you hear voices or see figures <i>outside your head</i> , which you later realized were unreal?		
11. Judgement. Were you presented with documents (e.g., probes, confession, statement, etc.) that you were not able to understand?		
12. Judgement. Were your legal rights explained to you, but you were not able to understand the contents of the conversation?		
13. Judgement. Did you experience any situation when you tried to talk but found it difficult to find the right words and you felt blocked?		
14. Subjective Self-Assessment. Do you think you were fit for interrogation while in detention?		
15. Subjective Self-Assessment. Do you think you were fit to make decisions?		

Please explain or give details of any of the above if necessary (e.g. circumstances, symptoms, subjective experience or whatever can help to understand the item).

Checklist of emotional symptoms linked to detention¹⁰

This checklist assesses the person's emotions during interrogation and detention and interrogation and afterwards.

Column A: While you were sleep restricted, did any of these items occur to you and if yes, how often?

Column B: Did any of these symptoms improve or worsen when all sleep deprivation ended and you could sleep again? (only ask for items marked "Often" or "Always" in column A)?

During your time in detention, did it happen to you that:	A: During sleep deprivation	B : After sleep deprivation
Items/symptoms	1. Never 2. Sometimes 3. Often 4. All the time	1.Improved 2. Not changed 3. Worsened
Emotions, Feelings and Somatization		
1. Sadness		
2. Anger (at yourself or others)		
3. Terror, Fear.		
4. Anxiety including problems breathing, or panic attacks		
5. Pain without apparent reason (i.e. stomachache, headaches or others)		
Acting emotions		
6. Self-Harm. Urge to act against himself/herself (e.g., cutting or hitting)		
7. Suicide ideas. Thoughts about taking your own life		
8. Suicide plans or actions. You had a defined plan or even tried to kill yourself		
9. Apathy. Abandonment due to complete hopelessness		
Secondary Emotions – Emotions related to others		
10. Shame. Intense humiliation or debasement		
11. Guilt. Self-accusation. Intense remorse		
Detaching emotions		
12. Dissociation. Feeling everything unreal or dazed, like if everything did not really happen to you.		
Positive Emotions		
13. Control. Calm, feeling in charge.		
14. Happiness. Moments of joy despite everything		

¹⁰ Items selected and adapted from the Positive and Negative Affect Schedule (PANAS) and Profile of Mood States (POMS) to a context of detention and sleep deprivation.

Severity of pain and suffering.¹¹

A person under sleep deprivation may feel pain and suffering due to it. The level of pain and suffering is relevant in the legal world and needs to be assessed. Pain is the unpleasant sensory experience associated with sleep deprivation. Your body is in pain.

It relates to how you feel it. Suffering is the unpleasant subjective experience associated with sleep deprivation. You suffer because of your pain. It relates to how you live it.

Please, according to what happened during your worst moment of sleep deprivation mark a cross in each line as appropriate

PAIN	SUFFERING	TIREDDNESS	SLEEPINESS
Can you rate the pain experienced due to not being allowed to sleep?	Can you rate the suffering experienced due to not being allowed to sleep?	Can you rate tiredness experienced due to Sleep Deprivation?	Can you rate sleepiness during interrogation?
100 – Worst imaginable pain	100 – Worst imaginable suffering	100 – Cognitive and Emotionally Exhausted	100 – Worst imaginable sleepiness
100			
90			
80			
70			
60			
50			
40			
30			
20			
10			
00			
0 – No pain	0 – No suffering	0 – No tiredness	0 – No feelings of sleepiness

¹¹ Measures based on the Visual Analog Scale for Pain (See for a review Hawker, Mian, Kendzerska, & French, 2011).

Specific Symptoms. Use the World Health Organization's criteria (ICD) for sleep related disorders in force at the time of assessment. Consider here only those sleep disorders in which *emotional or physical*

causes during detention are considered to be a primary factor, and which are not due to other identifiable physical or psychological disorders that appeared after detention. Consider, at least:

-
- | | |
|---|---|
| <p>1 Insomnia. A condition of unsatisfactory quantity and/or quality of sleep, which persists for a considerable period of time, including difficulty falling asleep, difficulty staying asleep, or early final awakening.</p> | <p>[0] No insomnia
[1] More than 1 hour for falling asleep
[2] Difficulty staying asleep
[3] More than two hours early wakening
[4] Difficulties in all areas</p> |
| <p>2 Hypersomnia. Hypersomnia is defined as a condition of either excessive daytime sleepiness or sleep attacks not secondary to insomnia.</p> | <p>[0] No
[1] Sometimes
[2] Always</p> |
| <p>3 Inversion of circadian/sleep rhythm. The person sleeps during day and is awoken during nights.</p> | <p>[0] No
[1] Sometimes
[2] Always</p> |
| <p>4 Sleepwalking [somnambulism]. The individual gets out of bed, usually during the first third of nocturnal sleep, and walks about, exhibiting low levels of awareness, reactivity, and motor skill. Upon awakening, there is usually no recollection of the event.</p> | <p>[0] No
[1] Sometimes
[2] Always</p> |
| <p>5 Sleep terrors [night terrors]. Nocturnal episodes of extreme terror and panic associated with intense vocalization, motility, and high levels of autonomic discharge. The individual sits up or gets up, usually during the first third of nocturnal sleep, with a panicky scream. Quite often he or she rushes to the door as if trying to escape, although very seldom leaves the room. Recall of the event, if any, is very limited.</p> | <p>[0] No
[1] Sometimes
[2] Always</p> |
| <p>6 Nightmares. Dream experiences loaded with anxiety or fear. There is very detailed recall of the dream content. The dream experience is very vivid and usually includes themes involving threats to survival, security, or self-esteem. Quite often there is a recurrence of the same or similar frightening nightmare themes. During a typical episode there is a degree of autonomic discharge but no appreciable vocalization or body motility. Upon awakening the individual rapidly becomes alert.</p> | <p>[0] No
[1] Sometimes
[2] Always</p> |
| <p>7 REM Sleep Behavior Disorder . The person physically acts out vivid, often unpleasant dreams with vocal sounds and sudden, often violent arm and leg movements during REM sleep. It is sometimes called dream-enacting behavior. Differential diagnosis with Sleep Terrors requires Actigraphy or Polysomnographic Tests.</p> | <p>[0] No
[1] Sometimes
[2] Always</p> |

Section 7. Legal Assessment of Sleep Deprivation

The legal qualification of sleep deprivation (torture per Article 1 of the CAT, or CIDT per Article 16 of the UNCAT or below the threshold of Article 16 of the UNCAT) would depend upon the specific circumstances of the case, including whether other forms of ill-treatment occurred or not. Try to seek information that may be useful for the legal assessment of the case. The below questions relate

to two key elements to be analyzed to distinguish torture and CIDT in the legal domain: (1) Purpose and Outcome and (2) Intentionality

Purpose and outcome

These questions are essential if you are going to do research. In case that sleep deprivation was linked to interrogation, these are the main variables that you will use to compare and relate to all the other measures. They are less useful if you are collecting information for medical documentation of cases.

Purpose of Sleep Deprivation¹

1.	Was sleep deprivation related to obtaining information?	Yes	No
2.	Was sleep deprivation related to obtaining a confession?	Yes	No
3.	Did you sign a confession (whether true or not)?	Yes	No
4.	Did you have fabricated memories? “Fabricated memories” are statements that the person recognized as true while they were not, and the person honestly thought at that moment that they were true. It is an <i>induced answer</i> prompted under disorientation/confusion by suggestions made by the interrogator. The person rejects them when recovers control.	Yes	No
5.	Did you have false memories? “False memories” are elements that the person believes as true while they are not, produced by the pressure of the situation. The person doubts if they are real memories or not even after recovering control.	Yes	No
6.	Did you have false memory after interrogation? Some persons can have false memories months or even years after the events. The person cannot distinguish new and false memories.	Yes	No
7.	Do you think that sleep deprivation was related to any other purpose? Can you explain or provide examples: (punishment, humiliation, submission etc.)	Yes	No

¹ Questions that may help to answer the scale: *Can I ask you whether there was confession? We do not need to enter details, unless you specifically wish to do so; Did you provide any information against your will? Did you sign a statement or confession? – We do not need to know if the*

contents were true, partially true or untrue; Did you ever during the interrogation recover in memory anything that were not able to remember before interrogation? Were these memories kept in time or new memories appeared that did not exist before the interrogation?

Assessment of the intention behind the use of sleep deprivation¹²

These questions aim to document the intention of using sleep deprivation and as such, the use of sleep deprivation was not incidental or simply a regular aspect of the normal interrogation or detention conditions.

1. *Purpose made explicit.* During the interrogation, the interrogator mentioned sleep manipulation/deprivation (either positive (“let him sleep”), or negative (“you will continue until...”).

a. No b. Yes. Explain:

2. *Purpose made explicit.* You heard that someone gave orders related to your sleep.

a. No b. Yes. Explain:

3. *Pattern.* Night interrogations.

a. No b. Yes. Explain:

4. *Context criterion.* Physical environment impeded sleeping.¹³

a. No b. Yes. Explain:

5. *Context criterion.* Actions that impeded sleeping (e.g., shouting/opening the door. *without any other reason*).

a. No b. Yes. Explain:

6. *Aim/Objective.* Any change occurred after signing a confession or statement.

a. No b. Yes. Explain:

¹² Items selected and adapted from the Intentionality Assessment Checklist (IAC). (Pérez-Sales, 2017)

¹³ If you know the answer from previous questions, no need to repeat the question.

7. *Fragmentation.* Person is allowed rest time in cell in a fragmented and insufficient manner (in various times of day and for short and variable periods of time)

a. No b. Yes. Explain:

8. *Prolongation.* Sleep deprivation is maintained after the person's explicit complaint of need to sleep.

a. No b. Yes. Explain:

9. *Viciousness criteria.* Reiteration in spite that the person falls asleep during interrogation (awakening manoeuvres).

a. No b. Yes. Explain:

10. *Systematicity - Planification.* Other persons explained a similar pattern (Do you know of other persons who experienced similar problems with sleep?).

a. No b. Yes. Explain:

11. *Prolongation:* More than 24 hours without being allowed to sleep.

a. No b. Yes. Explain:

Annex—Additional Questionnaires

The Protocol can be complemented with the following assessment tools.

Torturing Environment

Torturing Environment Scale	Measures profiles of torturing environments in 8 dimensions: Manipulation of environment, fear/threats, moderate pain, critical pain-amputation-death, sexual identity, need to belong- collective self, identity, meaning, purpose and coercive interrogation. References: Pérez-Sales P (2017). <i>Psychological torture. Definition, Evaluation and Measurement</i> . Routledge. Chapter 18 and Annex 5.
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Interrogation Practices

<i>The Scale for Coercive Interrogation</i>	The scale for coercive interrogation has 36 items and includes 9 dimensions: rapport-building, cognitive interviewing, threats, confrontation-imposition, deception, emotional manipulation, cognitive manipulation, moral manipulation and physical coercion.
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Clinical measures

Posttraumatic Stress Disorder	The Posttraumatic Checklist Civilian Version – 5 (PCL-C-5), a 20-item questionnaire that provides a diagnosis of PTSD according to DSM-V Criteria. ¹ There are also short screening versions available, like the BSS for PTSD. ² The International Trauma Questionnaire is a 12-item measure that provides diagnoses of PTSD and Complex PTSD according to ICD-1. The Dissociative Experiences Scale (DES-II) provides a measure of states of dissociation. Can be tailored to reaction within detention periods.
Daily Functioning	Consider measures that assess the autonomy of the person after release from detention (e.g., work, study, community and family life).

¹ <https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp>

² Brief Screening Scale for PTSD.

The following tools are referenced in the Sleep Deprivation Protocol

Morningness-Eveningness Questionnaire (MEQ). Horne JA and Östberg O. (1976) A self-assessment questionnaire to determine morningness-eveningness in human circadian rhythms. *International Journal of Chronobiology*. 4:97-100.

Pittsburgh Sleep Quality Index (PSQI). The measure consists of 19 individual items, creating 7 components that produce one global score, and takes 5–10 minutes to complete. Buysse, Daniel J.; Reynolds, Charles F.; Monk, Timothy H.; Berman, Susan R.; Kupfer, David J. (May 1989). “The Pittsburgh sleep quality index: A new instrument for psychiatric practice and research”. *Psychiatry Research*. 28 (2): 193–213. doi:10.1016/0165-1781(89)90047-4.

Montreal Cognitive Assessment (MOCA). 30 items assessing neurocognitive functioning. Administration takes around 15’. Ziad S. Nasreddine MD, et al, The Montreal Cognitive Assessment, MoCA: A Brief Screening Tool For Mild Cognitive Impairment, *Journal of the American Geriatric Society*, 30 March 2005.

Brief Neuropsychological Assessment – Mini Mental State Examination. 30 items measure that screens for cognitive impairment linked to medical conditions. Folstein MF, Folstein SE, McHugh PR. “Mini-mental state”: a practical method for grading the cognitive state of patients for the clinician.

J Psychiatr Res . 1975;12:189-19.

Positive and Negative Affect Schedule (PANAS). Short scale that consists of two 10-item mood scales to measure

emotional reactions to a given situation. D. Watson, L.A. Clark, and A. Tellegen (1988). Development and Validation of Brief Measures of Positive and Negative Affect: The PANAS Scales. *Journal of Personality and Social Psychology*, 54, 1063-1070.

Profile of Mood States (POMS). 65 items assessing 7 different mood domains. McNair, D., Lorr, M., & Droppleman, L. (1971). *Manual for the Profile of Mood States*. San Diego: Educational and Industrial Testing Service.

Intentionality Assessment Checklist (IAC). It is an aid to assess the alleged torture perpetrator’s intent. It helps to systematically assess all potentially pertinent elements, without aiming to provide a score but an overall perspective of elements relevant to intentionality. Pau Pérez-Sales, *Psychological Torture*, Routledge. p. 375

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Sleep deprivation does not work: Epidemiology, impacts and outcomes of incidental and systematic sleep deprivation in a sample of Palestinian detainees

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Guest Editor: Nora Sveaass, PhD

Key points of interest

- Systematic sleep deprivation is widely used as coercive interrogation method.
- The use of sleep deprivation seems ineffective in terms of gathering useful information whilst generating physical and psychological suffering in the detainees

Abstract

Background: Sleep deprivation (SD) is a method used in the context of interrogations aimed to obtain submission, information and confessions. Its impact on producing false confessions has been documented. Even information obtained is true, it will be unreliable as it cannot be separated with what has been suggested by interrogators. The use of SD has been documented in the interrogation of detainees in Israel and two patterns can be identified: one incidental due to the conditions of detention set out here as secondary sleep deprivation (SSD), and one systematic, intentional and linked to continued interrogation, set out here as primary sleep deprivation (PSD). This paper aims to study the prevalence of PSD and SSD in a sample of Palestinian detainees, compare its usage before and after the 1999 Israeli Supreme Court judgment, and compare the impacts and outcomes of SD. *Method:* The study included a sample of 600 ex-detainees who answered questions related to psychological and coercive methods, subjective psychological impact, clinical measures, psychosocial measures, and medical impact. Classification of SD was built taking into consideration the items related to SD and interrogation. *Results:* Most detainees reported SSD with around

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13% reporting PSD. Prevalence of PSD has been found larger among people over 25 years old who were detained before 1999. Related to the psychological suffering from the overall detention environment including SD, detainees with PSD and SSD reported significantly higher acute and chronic suffering. It has also been found that detainees with PSD reported long term family, social and physical impacts. Regarding the outcome of SD, the number of signed confessions with either true or false statements increases with SD, but in this case, this did not lead neither to a significantly higher number of convictions nor longer sentences. *Conclusion:* Sleep deprivation in the framework of interrogations seems ineffective.

Introduction

Sleep regulation, also referred to as sleep adjustment, sleep manipulation or sleep deprivation is a coercive method used in the context of the interrogation of detainees to foster cognitive, emotional and physical exhaustion aimed to obtain submission or compliance, and ultimately information or confessions (Pérez-Sales, 2017; Reynolds & Banks, 2010; Sveaass, 2008).

There is no universally accepted legal definition of what constitutes sleep deprivation or what is sometimes referred to as 'prolonged' sleep deprivation, although different sentences in international courts have considered that less than 6 hours could amount to ill-treatment or torture, especially if prolonged in time or added to other circumstances¹. According to medical studies, although there is a slight

variability in individual needs (from 6 to 9 hours for adults, depending on age), an International Consensus agrees that a healthy normal sleep pattern should include a minimum of 7 hours of daily continuous sleep (Hirshkowitz et al., 2015; Ohayon, Carskadon, Guilleminault, & Vitiello, 2004).

Sleep deprivation impairs memory retrieval (Havekes & Abel, 2017) and accuracy (Blagrove & Akehurst, 2000), cognitive functioning (Killgore, 2010; Lim & Dinges, 2010) and reasoning, emotion recognition (Killgore, Balkin, Yarnell, & Capaldi, 2017) and emotional reactions (Tempesta et al., 2010), moral judgement (Barnes, Gunia, & Wagner, 2015; Killgore et al., 2007; Tempesta et al., 2012) and decision taking (McKenna, Dickinson, & Orff, 2007). Furthermore, sleep deprivation fosters physical pain amplifying its effects (Schrimpf et al., 2015) and increases fear-memory consolidation and post-traumatic stress symptoms (Feng, Becker, Zheng, & Feng, 2018; Seyffert & Berofsky-Seyffert, 2015).

Different studies have documented the impact of sleep deprivation in the production of false confessions. Davis and Leo (2012) developed the IBRD model (Interrogation-Related Regulatory Decline) which proposes that a person's self-regulation capacities must remain intact to confront stressful situations like an interrogation. In their experimental model, they found three situations in particular (emotional overload, sleep deprivation and glucose deficiency linked to food and water restrictions) that undermine the capacity to self-regulate, making the person more vulnerable to pressure during interrogation. In their model, coercive interrogation (most frequently, hours of exhaustive questioning with interrogators shifting roles, taking turns and using emotional and cognitive manipulation tactics) leads

¹ Differences sentences of the ECHR, but specially in *Sadretdinov v. Russia*.

the person to either reveal pieces of information (which may be true but are most likely fabricated) in an attempt to stop the situation, or confess to whatever is demanded of him or her. Even if some of the information provided by detainees may be true, the weakness causes the detainee's memory to be partial and unreliable; merging what might be true with what has been suggested or fabricated, causing inaccurate information.

There is ample documentation on the frequent use of sleep deprivation in the interrogation of detainees in Israel (Ginbar, 2009; Lein, 2007; OMCT, 2019). A study based on the testimonies of 121 Palestinians who were held, some for up to two months, in the Petah Tikva interrogation facility of the Israel Security Agency (ISA) in the first and last quarters of 2009 showed that 13 (11%) of the detainees reported sleep deprivation during interrogation lasting for over 24 hours (Wolfson, 2010). Some detainees were interrogated continuously for a stretch of several days, with only short sleep breaks. The detainees reported that the conditions in both the cell and the interrogation room damaged their ability to sleep, even when sleep was not interrupted (Wolfson, 2010). In a similar study on the conditions in which inmates are held and interrogated, based on affidavits and witness accounts provided by 116 Palestinians held for security reasons and interrogated at the Shikma detention center from August 2013 to March 2014, 28 (24%) reported prolonged sleep deprivation. 12 (10%) detainees reported being continuously interrogated for more than 24 hours without being allowed to sleep at all, some of them being interrogated for up to 72 hours. One detainee reported one week of continuous interrogation with a maximum of 2 hours of continuous sleep. Eight detainees

reported that if they fell asleep during the interrogation, interrogators made sure to wake them by shouting or banging on the table. Fifteen stated that while they were in the cells, guards and interrogators deliberately kept them from sleeping for days on end (Kadman, 2015).

The Al-Mezan Center conducted a study with 107 Palestinians detained in Gaza by the Israeli Security Forces between 1 November 2013 and 31 October 2014. They reported sleep deprivation in 69 (64%) cases. This was mostly incidental sleep deprivation due to harsh conditions of collective detention (overcrowding, no access to toilet facilities, food and water deprivation, humiliation). Only 6 detainees underwent interrogation (Al Mezan Center for Human Rights, 2014).

The interplay between sleep regulation, sleep disruption and sleep deprivation can be better exemplified by the following. A Palestinian human rights organization presented the case of Ahmed Isleem, a 17 year old boy who was interrogated over 5 consecutive days. During the first day he was under night interrogation from 8 PM to 5 AM. After 4 hours rest, the interrogation was resumed at 9 AM and lasted until 3 PM. After 1 hour of rest, it was resumed from 4 PM to 4 AM. After 8 hours of rest, the interrogation began again from 12 AM to 6 PM and after half an hour rest, from 6.30 PM to 5 AM. In brief, the detainee (a) was interrogated most of the time during night hours (b) was allowed to sleep 13.5 hours in 5 days (120 hours); an average of 2.5 hours/day. This was in addition to threats, physical pressure, stress positions, shackling and hunger (Addameer, 2013). Notably, Ahmed was a minor, although interrogated as if he were an adult. This is not the only case in minors. Different reports suggest that sleep

deprivation through night interrogation is not an uncommon practice with children in detention (MIFTAH, 2012).

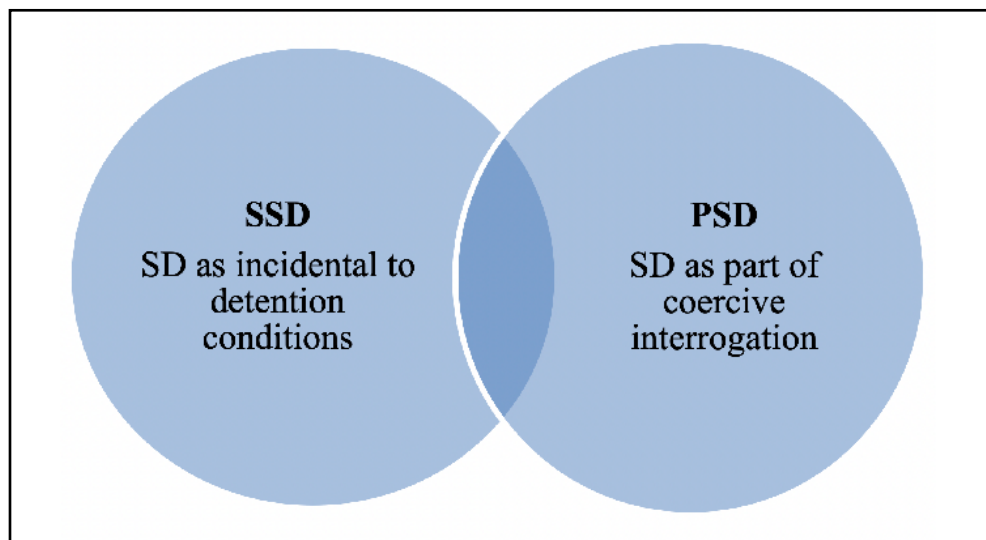
In sum, there are two patterns of sleep deprivation described by detainees: one incidental to harsh conditions of detention (overcrowding, heat, hunger, thirst, noise...) that by itself or combined with other elements could amount to cruel or inhuman treatment. We call this incidental or secondary sleep deprivation (SSD). The other is systematic, intentional and linked to continuous and harsh interrogation, which we call primary sleep deprivation (PSD), and that can amount to torture.

The distinction between PSD and SSD is not always absolute. Quite often the person is interrogated continuously (PSD), and when apparently allowed to rest between interrogations, the person is then put under harsh conditions (noise, thirst...) or being interrupted for apparently involuntary or routine reasons (someone inside the cell, checks...) (both considered as SSD). So, in the interplay between PSD and SSD are those situations in which

there is no true reparatory sleep during non-interrogation times through the use of elements of the environment (noise, fear production actions, permanent light, hunger and others)

Israel authorities acknowledge that both kinds of sleep deprivation happen. At different times during the last decades since the Landau Commission Report was published, these forms of treatment have been considered an acceptable practice by judiciary² while at other times they have been restricted to certain legal conditions. The use of PSD in coercive interrogations is, nowadays, considered acceptable by the Israeli Supreme Court according to what is defined as a “necessity defense”, which is roughly coincident with the so-called “ticking bomb scenario”: a detainee has essential information that must be urgently obtained

² Commission of Inquiry into the Methods of Investigation of the General Security Service Regarding Hostile Terrorist Activity, 1987, [also known as the Landau Commission Report]



Primary Sleep Deprivation (PSD)—Sleep Deprivation as part of coercive interrogation

- Intentional
- Complementary to prolonged continuous interrogation
- Creates:
 - Mental confusion
 - Acute suffering—information or confessions to avoid suffering
 - Inability to think and decide clearly
 - Potential induction of false memories
- Complementary to accusatory interviewing style—fosters wrong answers —false confessions

Secondary Sleep Deprivation (SSD)—Sleep deprivation as incidental to detention conditions

- Intentionality cannot be ascertained
- Creates physical and psychological suffering
- Creates physical and emotional exhaustion
- Fosters irritability and breaks solidarity among detainees
- Fosters compliance and submission through tiredness

to save lives. This position is an attempt to justify torture in certain cases, something which is in clear violation of the non-derogable nature of the prohibition of torture in Article 2 of the UN Convention Against Torture, and which has been criticized by different United Nations bodies, in particular the Committee Against Torture (CAT) in its communications to the Israeli Government³. Israeli human rights organizations have also protested this justification.⁴

Knowing that PSD in the framework of coercive interrogation is torture, and in answering a complaint by the Public Committee Against Torture in Israel (PCATI), the authorities stated that sleep deprivation was “not used as interrogation technique” but because “this was necessitated by the gravity of the suspicions

against the complainant and the urgency of obtaining the information he possessed.” The authorities consider that sleep deprivation was incidental and a “side effect” of “prolonged interrogation,” as opposed to its being imposed “intentionally... for a prolonged period of time, for the purpose of tiring him [the detainee] out or “breaking him”” (as cited in Ginbar, 2009).

No study to date has explored specifically the use of PSD and SSD among Palestinian prisoners detained and interrogated in Israel in light of its impact. Our study aimed to (a) establish the prevalence of PSD and SSD (primary—systematic sleep deprivation and secondary—incidental sleep deprivation) in a sample of Palestinian detainees (b) compare its use after and before the 1999 Israeli Supreme Court judgment that issued a legal position on the use of certain torture methods by investigative bodies (c) compare the psychological impact of each type of sleep deprivation to a control group of non-SD detainees (d) assess the efficacy of each type of SD from the point of view of the perpetrator in terms of getting signed confessions and convictions.

We hypothesize that the use of primary

³ Torture Convention/Israel special report—CAT meeting—Summary record. 9 May 1997; Committee against Torture. Concluding observations on the fifth periodic report of Israel. CAT/C/ISR/CO/5. (3 June 2016). See also Special Rapporteur Manfred Nowak (2006).

⁴ See Efrat Bergman-Sapir (2016). A Veil over Torture: Israel’s “Necessity Defense”. In <http://blog.omct.org/veil-torture-israels-necessity-defense/>

sleep deprivation (intentional and linked to interrogation) as compared to secondary sleep deprivation (incidental to detention conditions) and a control group (detainees that had not been sleep deprived) produces a significant increase in (a) acute suffering (b) long-term sequelae (c) percentage of detainees signing incriminating documents and (d) a higher number of convictions, compared to the effects of SSD (incidental) and a control group. Additionally, that the 1999 sentence significantly diminished but did not eradicate the use of sleep deprivation as part of a potentially torturing environment.

Methods

Definition of sleep deprivation in the context of detention.

For the purpose of this study, we define sleep deprivation as not allowing 6 or more hours of continuous rest in a 24h period (6/24 rule). We define *prolonged sleep deprivation* as three or more consecutive days of sleep deprivation (6/24 x 3). As previously defined, we distinguish between sleep deprivation that can be intentional (PSD) or incidental (SSD). We define *sleep deregulation* as breaking a detainee's ordinary sleep schedule reversing the sleep cycles from night to day without necessarily depriving the detainee of sleep.

Sample: We conducted the study from an initial community sample of 600 released ex-detainees from 1983 onwards. We calculated a minimum sample size of 400 in order to detect 2-point differences in the instruments used between individuals detained before or after the year 1999, considering a 90% power and a 2-sided 0.05 alpha level, assuming SD=4. After assessing for missing data, the final sample of the study is 567

ex-detainees.

Participants were contacted through a snowball sampling method in communities all over Palestine, including in Jerusalem, West Bank and Gaza. The ex-detainees, once contacted and agreed on participating, were visited at their own home by psychologists from the Treatment and Rehabilitation Centres for Victims of Torture (TRC) with offices in Jerusalem, Ramallah, Hebron and Jenin.

Measures: The interview lasted between two and three hours and included:

- (1) TRC Checklist of psychological and physical coercive methods. A 140-item checklist gathered in 22 categories used in daily clinical work in the TRC center. Each item is ranked on a 4-item Likert-scale: Never happened, Happened once, Happened twice, Happened three or more times. Each of the 22 categories also included a measure of subjective impact with three levels: No or low impact, Mild or severe acute impact (indicating suffering at the moment) and Mild or severe chronic impact (indicating suffering at the moment that lasted for years or even until the moment of the interview).
- (2) Clinical measures including:
 - (a) The Post-Traumatic Stress Disorder Inventory (PTSDI), a list of symptoms of PTSD that follow DSM-IV Revised criteria, culturally adapted to the Palestinian population,
 - (b) the Arabic version of the Beck Depression inventory and
 - (c) The Arabic version of the Symptom Checklist – 90 (SCL-90-R).
- (3) Psychosocial measures including: (a) Family Impact Scale (FIS), a 5-item measure of the impact of detention

on the role of the detainee in the family (b) Social and Community Impact (SCI), a 5-item measure on the impact of detention on labour and social functioning. All items are dichotomous with an overall score range from 0 to 5.

- (4) Medical impact. A 12-item checklist of medical consequences of torture, with dichotomous answers and values ranging from 0 to 12.

Sleep deprivation was measured with the Ramallah Sleep Assessment Scale, a 7-item scale that included 2 questions on PSD and five on SSD according to what detainees described as more prevalent reasons for sleep deprivation (overcrowded cell, frightening acts, gun shots, night snap-checks, freezing room).

The question on sleep deprivation was as follows: *Sleep deprivation is defined as not being able to sleep for 6 hours a day. According to this, were you deprived of sleep, in some form of another? (a) This never occurred (b) It happened once (c) It happened twice (c) It happened more than three times.* For the purpose of this study, sleep deprivation was considered only when the person informed that it happened at least three or more times during detention.

Interrogation and outcome were measured with the Arabic version of the items: (a) *Did you face interrogation around true or false allegations against you?* And (b) *Did you sign a form or confession whether true or false in its contents?* We considered a case as PSD when giving a positive answer to the question on SD and interrogation, and SSD when giving a positive answer only to the question on SD. Thus, some detainees subjected to PSD could also have been subjected to SSD, although detainees who undergo interrogation are usually not

merged with other detainees and are kept alone or with another prisoner.

Statistical Analysis: As most variables had non-normal distributions, we used non-parametric comparison of means (Kruskal-Wallis Test) and cross-tabulation with chi-square statistics for frequencies. All calculations were done using SPSS (23rd version).

Ethical aspects: The Ethical Committee of the TRC Center approved the study. It complied with the ethical standards and procedures for research with human beings of the World Health Organization⁵

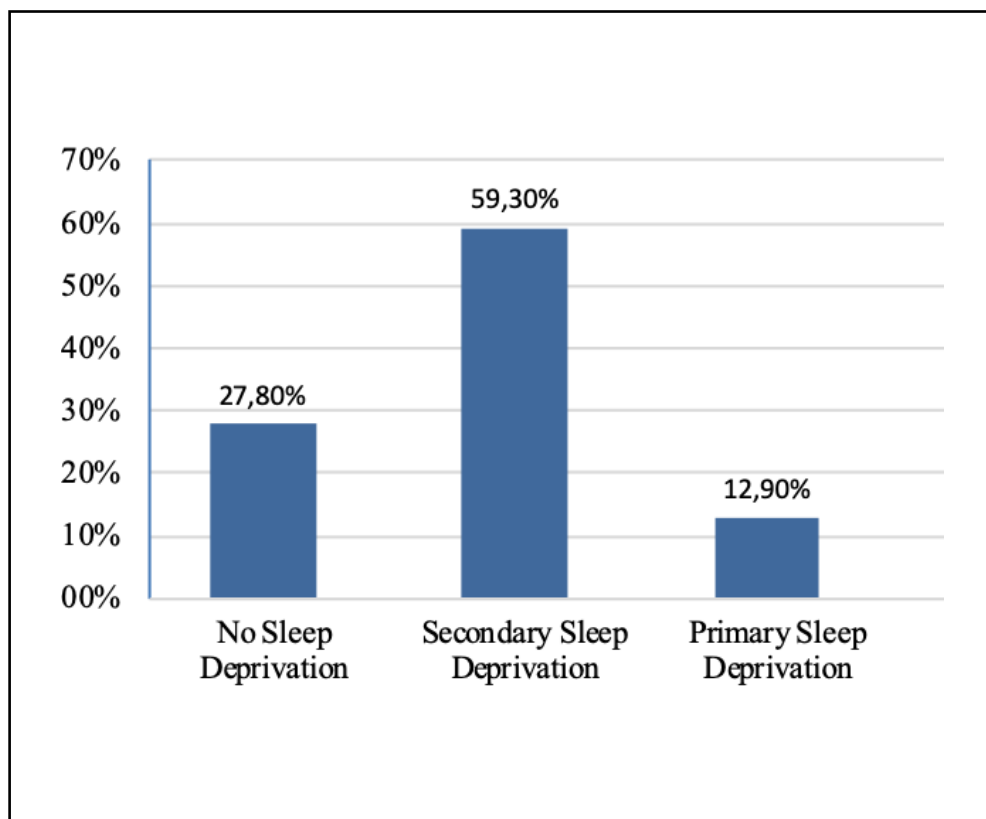
⁵ Standards and operational guidance for ethics review of health-related research with human participants (see <https://www.who.int/ethics/research/en/>)

Results

Prevalence of sleep deprivation

Most detainees (59.3%) reported SSD, 12.9% PSD and 27.8% did not declare suffering sleep deprivation (see *Figure 1* and *Table 1* and *2*).

Figure 1: *Prevalence of incidental and intentional sleep deprivation*



There are no differences between the three groups according to gender, educational level or region (West Bank versus Gaza). However, there is more PSD in people over 25 years of age and in people detained before 1999 (see *Table 1*).

Table 1: *Epidemiology of sleep deprivation among Palestinian detainees.*

	Sleep Deprivation (N=567)			X ² (DF)
	NSD (N=158; 27.9%)	SSD (N=336; 59.3%)	PSD (N=73; 12.9%)	
Gender				
Male	28.5%	58.7%	12.8%	1.413(2)
Female	24.7%	65.8%	9.6%	
Age				
<18 years	35.2%	56.6%	8.2% a	18.557(4)***
18-24 years	26.1%	63.2%	10.7%	
>25 years	21.7%	54.8%	23.5% ^a	
Educational level				
Primary and Secondary	29.2%	54.6%	16.2%	4.081(4)
Tertiary	28.2%	58.5%	13.4%	
Graduate	25.9%	64.6%	9.5%	
Region				
West Bank	26.3%	59.6%	14.2%	3.148(2)
Gaza	32.5%	58.3%	9.2%	
Year of detention				
Before 1999	20.2%	66%	13.7%	13.753(2)***
After 1999	34.8%	53%	12.1% ^a	

NSD: No Sleep Deprivation. SSD: Secondary PSD: Primary; Chi.Square test. * = p<.05; ** = p<.01; *** = p<.001. a = significant difference.

Conditions of detention that potentially foster SSD as reported by detainees included overcrowded cells (56%), nightly

snap checks (70%) or being exposed to disturbing sounds (48%) among others (see *Table 2*).

Table 2: *Conditions of detention—self declared*

Item	%
Nightly snap-check while you were in the cell	70.5
Exposed to frightening acts in cell during night	56.2
Overcrowded prison cell	54.1
Held in freezing room	42.7
Food deprivation	61.7
Water deprivation	48
Being left in obscurity for long hours	52.3
Exposed to disturbing, boisterous sounds	48.2

Clinical impact: When assessing the overall environment, including sleep deprivation, 81.9% and 70.7% of detainees with PSD or SSD reported acute suffering as compared to 46.5% in NSD. For a significant 36.1%

and 27.1%, subjective suffering persisted for years (see *Table 3*). In other words, sleep deprivation *per se* was a factor that significantly increased overall suffering derived from detention conditions.

Table 3: *Subjective psychological suffering derived from overall environment of detention in relation to sleep deprivation*

	Sleep Deprivation			$X^2(DF)$
	NSD	SSD	PSD	
Acute PI	46.5%	70.7%	81.9%	35.47 (2) ***
Chronic PI	14.4%	27.1%	36.1%	14.59 (2) **

NOTE: * = $p < .05$; ** = $p < .01$; *** = $p < .001$. PI= Psychological impact.

Table 4 shows clinical measures of long-term sequelae as related to SD conditions. There were no significant impacts in terms of depression and

PTSD. But detainees with PSD that underwent coercive interrogation reported long term family, social and physical impacts.

Table 4: *Psychological, physical and social impacts related to sleep deprivation*

	Sleep Deprivation			$X^2(DF)$
	NSD	SSD	PSD	
Depression (Beck) <i>M (Mean rank)</i>	13.97 (274.53)	14.44 (283.07)	15.63 (300.99)	1.31(1)
PTSD (PCLC 4) <i>M (Mean rank)</i>	35.04 (165.70)	39.42 (182.60)	43.25 (205.78)	4.93 (1)
Family impact <i>M (Mean rank)</i>	0.72 (252.34)	0.99 (286.32)	1.57 (330.98) ^a	14.65 (1)**
Social impact <i>M (Mean rank)</i>	0.76 (260.36)	0.91 (283.94)	1.43 (312.44) ^a	6.62 (1)*
Physical impact <i>M (Mean rank)</i>	1.92 (217.32)	2.95 (292.13) ^a	2.81(358.29) ^a	43.43 (1)**

Kruskal-Wallis Test. * = $p < .05$; ** = $p < .01$; *** = $p < .001$. PI= Psychological impact.

Regarding the outcome of sleep deprivation and its relationship with signed confessions (see *Table 5*), persons who underwent PSD increased from 7.8% and 6.7% to 38.4%, which means a fivefold increase ($X^2:2$, $p<0.000$). But this does not lead to a significantly higher number of

criminal convictions (75 for non-deprived, 79% for SSD and 80% for PSD (X^2 : 6.58, n.s.). Moreover, the mean time of convictions in months is similar between people with PSD and SSD (28.03 vs 31.89), although higher as compared to non-sleep deprived detainees (X^2 : 6.89, $p<0.000$).

Table 5: Comparison of signed confessions, convictions and detention time based on sleep deprivation

	Signed forms (%)	X^2 (DF)	Convicted (%)	X^2 (DF)	Time of conviction ¹ (Mean)	F (DF)
NSD	7.8%		75.8%		18.1	
SSD	6.7%	40.08 (2)***	79.5%	6.58 (6)	28.03	6.89 (2, 503)***
PSD	38.4%		80.3%		31.89	

NOTE: * = $p<0.05$; ** = $p<0.01$; *** = $p<0.001$. NSD=No sleep deprivation; SSD=Secondary sleep deprivation; PSD=Primary Sleep deprivation. 1= Measured in months.

Discussion

We have compared the prevalence, the impacts, and the outcome in terms of confessions and convictions in a large sample of 600 former Palestinian detainees who suffered sleep deprivation during detention from 1983 until now. 59% of detainees report sleep deficiencies resulting from general conditions of detention (table 2): overcrowding of cells (54%), being exposed to frightening acts (56%), nightly snap-checks (70%), freezing rooms (42%), food (61%) and water deprivation (48%) among others.

These are self-declared conditions of detention and not the result of a monitoring visit inside detention facilities. The results must therefore be considered with caution. Israel has not signed the Optional Protocol of the Convention against Torture, and thus lacks a National Prevention Mechanism (NPM). Monitoring visits are also rare.

Lacking official data and NPM reports, available data depends on retrospective studies from human right groups, sometimes interviewing detainees in prison, but mostly using retrospective interviews after release. The figures reported in our study are slightly higher than other reports (Kadman, 2015; Wolfson, 2010). This cannot be attributed to the conditions of the interview, as the assessment was not done as linked to any forensic or legal process, and thus, the detainees did not have any direct benefit other than participation. There is an urgent need for an independent National Prevention Mechanism that can assess prison conditions and provide uncontested evidence to this issue. Nevertheless, the appalling high figures reported by former detainees leave little doubt regarding the very harsh conditions of detention for the majority of them.

In approximately 13% of the detainees, there was an intentional use of sleep

deprivation (PSD) as a mode of coercion in the framework of interrogations. This means that they were not allowed to sleep 6 hours continuously three or more times during interrogation. The study does not have a detailed description of the hours of interrogation of each former detainee because the investigators could not access the official record of the interrogation in the Israel Security Agency files, which is only available to official lawyers under request. Nor was it specifically asked whether, when there was more than one day of sleep deprivation, if the days were consecutive days and whether there was a cumulative effect. So, again, the data requires careful consideration.

The prevalence of PSD and SSD does not change with gender, most likely due to the low level of women under detention and interrogation as compared to men. We would require studies with bigger samples to confirm this. Sleep deprivation is higher among men with older than 25 years of age, most likely coinciding with what can be considered a “high-value detainee”.

Sleep deprivation, incidental or intentional, causes high levels of acute suffering and this subjective experience persists for years. However, contrary to what was expected, this does not seem to convert into clinical disorders as measured by depression and posttraumatic stress disorder scales. Interrogation in itself seems to have an impact at the family, social and community levels, with a deterioration of the quality of life and functioning of the former detainee. To our knowledge, there is no data from similar previous studies to which we can compare these results. There are no differences when comparing the use of SD in former detainees from West Bank or Gaza. This will require confirmation with bigger samples including a greater number

of detainees from Gaza. Finally, the Israeli Supreme Court judgment of 1999 seems to have had an effect on the use of SD in interrogations. A significant decrease was found, although SD was still used in almost half of the detainees.

From the point of view of interrogators: is sleep deprivation a useful way to obtain information in interrogations conducted under coercion? As expected, PSD (but not SSD) translates into a greater number of detainees signing documents. The number of persons signing a form after PSD increases fivefold, from 6.7 to 38.4%. But, it is important to say, whether the documents that the person signed were true, partly true, fabricated or from induced information is unknown. Obviously, this question was not presented to interviewees due to ethical reasons: to avoid any possibility of putting these persons in danger and risking potentially severe reprisals.

As a proxy measure of the value of these signed forms, we used subsequent conviction rates by a judge and the length of that conviction. Contrary to our hypothesis, this higher number of signed documents does not translate into a higher number of convictions. It is important to say that most detainees (up to 75%) were convicted in any case. However the number of additional convictions related to interrogations using SD is statistically irrelevant. In other words, these forms provide information that most of the times will not be supported in court hearings by any evidence other than self-incrimination. The number of people convicted is extremely high and similar in all three groups.

Therefore, the use of sleep deprivation as a form of coercion in the framework of security interrogations does not provide useful or relevant information that the state needs to indict a detainee.

Furthermore, if one compares the length of the subsequent sentences, there are no significant differences between the length of the sentence of general prisoners with incidental sleep deprivation and prisoners under tortured interrogation with intentional sleep deprivation. This result enforces the idea that using PSD does not lead to relevant information that changes the severity of the sentences.

Conclusions

We have studied the impact of sleep deprivation as part of a detention environment and as part of coercive interrogations. Sleep deprivation of 6 hours or less causes severe acute psychological distress. It does not appear to cause serious clinical sequelae *per se* in the long term, although it has family, community and social consequences. This pain and suffering does not result in information or confessions that lead to a greater number of convictions or longer sentences. In other words, sleep deprivation does not work. Possibly the false information generated by the victim's attempt to avoid and interrupt the suffering associated with sleep deprivation will cause many of the statements obtained to be fabricated or false and thus generate an unnecessary effort of verification. Primary sleep deprivation in the framework of interrogations seems not only inhumane but largely ineffective from the point of view of those who impose it on detainees. Even if effective in obtaining information it should be totally prohibited in Israeli law, but in this case the *necessity argument* claimed by the Israeli Supreme Court to justify its use, cannot even be sustained from a scientific point of view. SD is not only ethically wrong: our data also suggests that it simply does not function.

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Torture and torture practices in Tanzania: Knowledge, attitudes and practices among medical professionals

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Key points of interest

- Many medical professionals in Tanzania report treating torture victims, but their general knowledge about torture is found to be low.
- Many medical professionals in Tanzania perceive that torture could be accepted under certain circumstances.

Abstract

Introduction: Medical professionals have a key role in addressing torture and need an awareness and knowledge of torture in relation to rehabilitation approaches, prevention and international standards. This study was undertaken with the aim of assessing the current knowledge, attitudes and practices of medical professionals in Tanzania, creating a baseline for possible future interventions. *Methods:* Both quantitative and qualitative data were collected. A cross-sectional survey was carried out using an interviewer-

administrated structured questionnaire with 31 questions. Five focus group discussions were held. 386 medical professionals participated in the study representing primary, secondary and tertiary levels of health care in five regions of mainland Tanzania: Arusha, Dar es Salaam, Kigoma, Mara and Mbeya.

Results: Around 95% of all professionals acknowledged the existence of torture in Tanzania, but only 7% could correctly identify six different acts as being actual acts of torture according to the definition of the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Less than 15% were aware of relevant international standards like the Istanbul Protocol and the Mandela Rules. Up to 57% perceived that torture could be acceptable under certain circumstances. About 68% of all professionals reported to have encountered torture victims. The majority (82.9%) saw themselves as competent in the management of torture victims, but only 22% had received training specifically focusing on torture and its consequences. Most were interested in learning more on the subject. *Conclusion:* While medical professionals may be aware of the

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existence of torture in the country and report encountering torture victims in their daily work, both the professionals' skills and attitudes with regards to torture require development to intensify the work against torture in Tanzania. Intervention strategies should target training in medical schools and in-service training for medical professionals at all levels within the health care system.

Keywords: Torture, Tanzania, KAP study, medical professionals

Introduction

The medical profession has a key role in addressing torture. This includes early identification, medical documentation of cases and rehabilitation of torture victims. Furthermore, the medical profession plays an important role in the prevention of torture, including by being part of independent monitoring mechanisms that visit places of detention. To prevent torture and to treat its victims, it is crucial that medical professionals have knowledge of torture and its consequences, and of key international standards such as the Istanbul Protocol (UN, 2004) and the World Medical Association's Tokyo Declaration (WMA, 1976).

Studies about medical professionals' and medical students' knowledge and attitudes with regards to torture have been carried out in the US, Mauritius, India, Israel and the US (Agnihotri et al., 2007; Bean et al., 2008; Benninga et al., 2017; Dubin et al., 2017; Sobti et al., 2000; Verma & Biswas, 2005), but to our knowledge never in Sub-Saharan Africa.

Tanzania is a unitary presidential democratic republic and is classified by the World Bank as a low-income country, with a population of about 57 million (reference

year 2017).¹ The issue of human rights in Tanzania is complex. In July 2009, the UN Human Rights Committee issued its concluding observations after considering Tanzania's fourth periodic report submitted under article 40 of the International Covenant on Civil and Political Rights, expressing concerns about several human rights issues including gender-based violence, ill-treatment of detainees by law enforcement officials and failure to recognize and protect minorities and indigenous people (UN, 2009).

Tanzania has not ratified the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT), but torture is prohibited in its Constitution (article 13(6)(e)) (United Republic of Tanzania, 1977). The exact prevalence and nature of torture and the number of torture victims in Tanzania are unknown. Individual cases of torture have, however, been documented by several human rights organizations (HRW, 2013; LHRC & ZLSC, 2017) and a recent qualitative study by some of the authors of this article found that informants had been exposed to deliberate torture including advanced torture methods so far not reported (Aon et al., 2018).

The health system in Tanzania is decentralized and framed most explicitly by its National Health Policy.² The role of the medical profession in combatting torture in Tanzania seems fairly limited to date. The authors have been unable to locate organizations providing specialized

¹ <https://data.worldbank.org/country/tanzania>

² Accessible at: http://www.tzdp.org.tz/fileadmin/documents/dpg_internal/dpg_working_groups_clusters/cluster_2/health/JAHSR_2017/8.The_Nat_Health_Policy_2017_6th_24_October_2017.pdf

rehabilitation for torture victims, even though a few institutions have handled trauma cases. Medical documentation of torture rarely takes place, and health professionals are not systematically involved in monitoring places of detention.

The immediate aim of this study was to assess the current knowledge, attitudes and practices of medical professionals in Tanzania regarding torture, as well as to assess the role that medical professionals see for themselves in relation to prevention of torture and treatment of torture victims. The study was undertaken in collaboration between the Medical Association of Tanzania (MAT) and DIGNITY-Danish Institute Against Torture, with a long-term view of involving the medical profession in Tanzania in anti-torture work.

Methods

The study used a sequential mixed-methods study design. Results included both quantitative and qualitative data, where quantitative data was collected first. A cross-sectional survey was carried out using an interviewer-administered, structured questionnaire consisting of 31 questions. In addition, five qualitative focus group discussions (FGDs) were conducted (one in each region included in the study). Both in the interviews and in the FGDs, participants were asked questions relating to their knowledge, and regarding torture and their awareness of international standards and protocols. The data collection took place in March 2016.

Questionnaire and Focus Group Discussions

The questionnaire (annex 1³) was developed

in English and translated into Swahili. No part of the questionnaire contained items that captured the identity of the medical professionals beyond age, cadre, gender, and region/district in which they work. The questionnaires were administered by research assistants who all were medical doctors and Tanzanian nationals. All had received a one-day training on the study objectives, methodology and study tools prior to their field work. During the training, each question in the questionnaire was asked so that the interviewers could interpret its purpose. The various answers given during these pilot interviews enabled the facilitator to gauge what each question would mean to the interviewees. Each question was restructured so its correct interpretation could be presented to the medical professionals. Similarly, the Swahili translations were also presented to the interviewers so that they could see if the response would accord with the English meaning of the original question. Each interview lasted between 20 and 30 minutes.

A semi-structured interview guide was used to conduct the FGDs (annex 2⁴). The guide was translated from English into Swahili to ensure a smooth discussion. Probing was done following responses to the questions whenever necessary. The primary purpose of the FGDs was to gain a deeper understanding of the responses from the quantitative questionnaires. Each FGD was facilitated by two research assistants. One of the research assistants was the moderator of the discussion and the other one operated the recorder and took notes. All FGDs were audio recorded. The FGDs were conducted at the regional hospitals, referral hospitals

³ Please see the Torture Journal website (<https://tidsskrift.dk/torture-journal/issue/view/8380>).

⁴ Please see the Torture Journal website (<https://tidsskrift.dk/torture-journal/issue/view/8380>).

and the national hospital, as these facilities included a good composition of participants from various fields of work. The FGDs lasted between 45 minutes and one hour and took place in the board rooms of the health facilities, out of hearing and sight of others to ensure the safety and privacy of the participants. All members were coded by numbers and the use of names was avoided throughout the discussions. The number of participants in the FGDs ranged from a minimum of seven participants in Arusha to twelve in Dar es Salaam.

Sampling Procedures

A multi-stage sampling approach was adopted. At the first stage, five zones of Tanzania were selected purposefully based on anecdotal information on the existence of various forms of torture. The selected zones were: North, East, West, Lake and Southern Highlands. At the second stage, from each zone one region was purposefully selected based on anecdotal information on the degree of torture within the regions in that zone. The regions chosen were Arusha (in the northern zone), Dar es Salaam (in the eastern zone), Kigoma (in the western zone), Mara (in the lake zone) and Mbeya (in the southern highlands zone). At the third stage, from the selected regions three districts were selected purposefully based on the existence of public health facilities and the number of medical professionals available in those districts as obtained from the regional records.

Study Participants

The study involved medical professionals from all three levels of health care in Tanzania, i.e., the primary level (district hospitals and all facilities below), the secondary level (regional hospitals) and the tertiary level (zonal referral consultant hospitals and the national hospital). A

medical professional was defined as any person practicing clinical medicine with a medical qualification, from a certificate (minimum two years training) up to PhD level. Although attempts were also made to include medical professionals working within prison settings in the study, these attempts were unfortunately unsuccessful. Permission from responsible authorities was not obtained, allegedly related to the nature of the study.

Convenient sampling was used to recruit the study participants at the health facilities involved. Medical professionals who were available during the days of data collection, and who consented to participate in the study, were included. Participants for the FGDs were purposefully selected to ensure representation of cadres and fields of work. No compensation or reward for participating in the study was provided.

A total of 92 medical professionals, the majority from Dar es Salaam, refused to participate in the study, or offered to fill in the questionnaire but did not return it (rejection rate 19,2%). Of the 92, half stated constraint of time due to busy work schedules as the reason for non-participation. However, a significant number (16 persons) requested to be excused due to security concerns. Another seven persons offered to complete the questionnaire but did not sign the consent form and were consequently excluded from the study.

Data Analysis

All quantitative data collected by means of the questionnaire was coded, cleaned and checked for inconsistencies. All questionnaires were included in the analysis. The data was entered into Statistical Package Software for Social sciences (SPSS) version 21 for analysis. Descriptive analysis was done, where results were summarized

in tables and figures to reflect the study objectives and responses of the participants.

The audio-recorded FGDs were first transcribed word for word/*ad verbatim* and translated from Swahili into English. The files were analyzed using qualitative content analysis and NVivo software was used for the analysis. The transcripts were first analyzed by reading and re-reading to become familiarized with the data. Transcripts of whole FGDs were analyzed as a meaningful unit to ensure analysis of the context as well. Condensed meaningful units were formed through data reduction and read and re-read to extract codes. Similar codes were grouped together and through constant comparison these were abstracted into sub-categories, which were sorted to form categories to reflect the manifest content of the text.

The FGDs focused on the same topics as the questionnaire and aimed to gain a deeper understanding of the issues. In the analysis of the results, equal weight was given to both types of data and no data was left out of the analysis because of contradictions among responses.

Ethical considerations

This research obtained ethical approval from the National Institute for Medical Research (NIMR) in Tanzania. Permission to carry out the study was also obtained from the Regional Administrative Secretaries and District Executive Directors from the involved regions and districts. Besides ethical approval in Tanzania, the research obtained internal ethical approval within DIGNITY through the organization's ethical committee. Due to the nature of the study, the sensitivity of the topic and the imaginable defaming of the medical profession by possible immoral or disadvantageous results, specific attention was given to ensuring the safety of the participants. All participants were informed

about the study objectives, how confidentiality would be ensured and how results would be disseminated, and they were asked for written informed consent at the beginning of the interviews and FGDs. Data was subsequently collected in a non-attributable and anonymous way, FGDs took place out of hearing and sight of others not participating in the study, and during the FGDs no names were used to guarantee as much as possible the participants' privacy and safety.

Results

A total of 386 medical professionals were interviewed according to the structured questionnaire and 5 FGDs were conducted with the number of participants ranging from 7 in Arusha to 12 in Dar es Salaam and a total of 49 participants altogether.

The mean age of the participants was 34 years (range 20-68 years) and 68.1% were male. Although the study was carried out in five specific regions, ten of the study participants were from other regions as they happened to be on the study sites during data collection and volunteered to participate. The regions they represented were Shinyanga (2), Singida (1), Manyara (1), Iringa (1), Kilimanjaro (1), Dodoma (1), Tanga (1), Coastal (1) and unknown region (1).⁵ Table 1 (see appendix⁶) also shows the socio-demographic characteristics of the study participants.

When medical professionals were asked whether they think torture takes place in their country, 95.6% answered "yes". Participants in the FGDs commented that the prevalence

⁵ The region was unable to be identified during the analysis due to an omission in data collection on this question.

⁶ Please see the Torture Journal website (<https://tidsskrift.dk/torture-journal/issue/view/8380>)

of torture might be higher compared to the general perception because torture happens in secret: “...*(the) magnitude of torture may be very high as in many cases our criminal justice system is involved in torturing people...police sometimes torture suspects under arrest...prisoners are tortured by prison officers...all these have nowhere to complain...*” (FGD Member no. 4 - Region C).

However, the majority of the participants could not correctly identify acts of torture. When provided with a list of six acts of torture in the questionnaire (public officials giving electric shocks to a prisoner, blindfolding a prisoner for many hours, suspending the arms of a convict, beating and kicking a convict, isolating a prisoner from all other prisoners, and depriving a prisoner from food), only 7% of the medical professionals indicated all six answers as acts of torture. Moreover, a total of 13.7% indicated two or less, which reflects a relatively low level of knowledge.

The FGDs elicited further insights, where some participants confused torture with gender-based violence, and some defined torture as the deprivation of any human right: “...*for me torture is any action done to someone to deprive him/her rights which s/he was supposed to get ... even not given certain service to a person is torture ... any act which is against human rights is torture.*” (FGD member no. 9 – Region C).

Respondents’ knowledge on international standards and protocols was also found to be low. The UNCAT was shown to be best recognized (52% of the respondents). However, when asked whether the UNCAT focuses solely on people in places of detention, 18.3% wrongly answered “yes”. Knowledge of the existence of the Istanbul Protocol and the Mandela Rules was shown to be very low (13.6% and 17.3% respectively).

When asked about their attitudes towards the use of torture, 46.9% of all participants felt that torture was acceptable under certain circumstances or with certain persons, whereas 47.8% of the respondents perceived that torture should not be allowed under any circumstances, and 5.3% did not know. When asked whether torture should be allowed for acquiring ‘life-saving information’ from someone, an even higher number, 57%, felt that torture should be allowed. The different points of view were reflected in the FGDs.

Some respondents viewed that, in light of modern science and technology, suspects can be interrogated without necessarily being tortured, and one of them stated,

“... *imagine someone has been tortured to confession of the crime s/he committed, if it was theft of property, justice will prevail to the owner of that property but how about the torture effects to this person? ... It is not justice to torture the suspect.*” (FGD member no. 4 – Region D).

Others felt that torture could be justified in certain instances: “...*in my opinion, torture should be allowed in some issues of national interest, if one person endangers life of other people, for instance a terrorist, there should be a room for torture to that person...important is to ensure a controlled degree of torture...*” (FGD member no.8 – Region B). However, the majority of the respondents (67.4%) were of the opinion that perpetrators should be punished in all cases.

When asked about their actual experience with victims of torture, the majority of the medical professionals stated that they had encountered both self-declared cases (66.8%) and suspected cases (67.6%). It should be noted that 57.3% had treated patients who were detainees at the time. These encounters gave rise to challenges, e.g., breach of medical confidentiality, which were not normally seen

in their daily practices:

“...sometimes the police officer is with the client even at the consultation room...the victim will not tell the real story... you have to request the police to stay by the door side so at least he can speak, but still there is a lot of fear...” (FGD member no. 6 – Region D).

The majority (82.9%) reported that they felt competent at treating victims of torture. However, only 22% had covered torture issues and how to treat and document cases of torture as part of their medical education. When asked if they were interested to learn more about the physical and psychological effects of torture and about torture as a human rights issue, 98.4% answered “yes”, and 96.6% were interested in taking up training to become a counsellor for victims of torture to be able to provide treatment, counselling and rehabilitation. A total of 94.8% of the medical professionals recommended that the subject of medical treatment and documentation of cases of torture should be included as a special module in the curriculum of the medical education.

Most participants indicated that they would report a torture case to at least one institution (e.g., legal authorities, Commission for Human Rights and Good Governance (the national human rights institute), Legal and Human Rights Center (a Tanzanian NGO dealing with human rights violations), Medical Association of Tanzania), but 8% did not know what they would do if they encountered a victim of torture or specifically said that they would not report it to anyone nor take any action. Some participants admitted that most of the time they focused on physical treatment alone, as they were not aware of what should be done next: *“... the challenge we have, me specifically, I do not know about others... When we encounter a torture victim, we know*

that our role is medical care, treat the physical wounds resulted from that torture... I cannot go further...” (FGD member no. 4 – Region A).

When asked if they saw a need in Tanzania for the establishment of rehabilitation centers for torture victims, 96.6% answered “yes” and 2.3% “no”, while 1.1% did not know. Most of the FGD participants stated that a rehabilitation center is important and needed in the country: *“...to my side, rehabilitation of a tortured victim is very important for several reasons... Victim may have been affected physically... psychologically and mentally...”* (FGD member no. 7 – Region A).

When data were analyzed further, no statistically significant gender differences were found except for significantly more men than women being of the opinion that perpetrators of torture should be punished in all cases (χ^2 p value=0.032).

Discussion

A considerable number of medical professionals in this study perceived that torture takes place in Tanzania, and at least two-thirds had come across victims of torture or suspected victims of torture in their daily practice. To our knowledge, no systematic studies have been done on the prevalence of torture in the country. However, the findings are consistent with the experience of human rights organizations and with the general impression of the authors that torture may be the rule rather than the exception in the investigation of criminal cases in the country and is also linked with the security forces.⁷

Some medical professionals were not

⁷ This impression is based on the extensive experience of the authors with working on human rights issues in Tanzania.

willing to participate in the study, citing concerns about their own security. Some explicitly cited the case of Dr. Steven Ulimboka, who was severely tortured in 2012 during a doctor's strike. The perpetrators were never identified. Thus, torture is deemed to be a very real risk if the medical professionals are too outspoken. This gives an indication of how the presence of torture in Tanzanian society may lead to fear and self-censorship.

Often medical professionals are a first point of contact for torture victims (Eisenman & Kim, 2000), and awareness and accurate identification is necessary for an informed history taking and physical examination of the patients and the subsequent planning of treatment and rehabilitation. However, only few medical professionals in this study could correctly identify acts of torture and many confused the meaning of torture with that of gender-based violence or human rights violations in general. The results might be influenced partly by the fact that medical professionals, as defined in this study, included professionals from all professional levels in the country including the so-called 'specific cadres', i.e., professionals trained at certificate level with only two years of training. However, all medical professionals interviewed attend to patients, and they may come in contact with victims of torture. It is therefore a necessity that knowledge of torture is ensured amongst all professionals.

In the study, 12% reported that they did not feel competent to treat torture victims. This is a very small figure considering that the majority of the medical professionals did not receive any training on torture during their medical education. This proportion involved professionals ranging from specialists by training to those in the least trained cadres. Lack of training on

torture among medical professionals is not unique to Tanzania. In a clinical review on the role of doctors in investigation, prevention and treatment of torture in the United Kingdom, McColl, Bhui and Jones documented that there is lack of education on torture and related ethical and legal issues at undergraduate and postgraduate level and that many doctors are not aware of opportunities to work with organizations for the prevention of torture in the UK (McColl et al., 2012). To be able to attend to torture victims, one needs to be knowledgeable on torture issues. Lack of training on torture issues among medical professionals, in a country where torture acts exist, poses a question on the quality of care that torture victims receive.

Tanzania is among the countries that lack rehabilitation centers for torture victims. Not only is training on torture-related issues lacking, also is the national health policy silent on torture issues. The findings indicate that a high proportion of the medical professionals lack knowledge on torture issues, and due to a general lack of well-trained staff—especially mental health staff—in the Tanzanian health care system, an integrated treatment approach is often likely to be lacking.

Our findings show that medical professionals in Tanzania have limited capacity to refer torture victims given the low proportion (30% in some cadres) that is aware of the different organizations dealing with torture. Advocacy and training are needed to raise awareness of the existence of the (so far few) bodies in Tanzania that can provide help to victims of torture, and of the need for more organizations to offer those services.

The fact that a large proportion (up to 57%) of the medical professionals deemed torture to be acceptable under certain

circumstances is deeply concerning, but is similar to what has previously been seen among medical students in the US, Mauritius, and India (Bean et al., 2008; Dubin et al. 2017; Agnihotri et al, 2007; Verma & Biswas, 2005), among physicians in India (Sobti et al., 2000), and among physicians and medical students in Israel (Benninga et al., 2017). Acceptance of torture is patently in complete opposition to the general medical ethical principle of ‘do no harm’. It also raises questions on their deeper understanding of the consequences of torture. The physical and/or psychological consequences of torture may have a devastating and a lifetime effect and may influence not only the individual but also his or her family and society at large (Alayarian, 2009; Carinci et al., 2010). The finding points to the importance of including the topic in the curricula of medical professionals.

Some medical professionals would not report a case of torture to the relevant authorities. The reasons for this were not further investigated in the study, but one might speculate that it is due to the fear of becoming involved with police or security forces. This could contribute to long-term sequelae to victims of torture due to denial of some rights and compensation which they might have received following legal support. Health facilities are, in most cases, the first point of contact to help torture victims. A well-prepared health care system that will support the victims physically, socially and psychologically is very much needed (McCull et al., 2012; Mollica, 2011; Kanchan et al., 2007).

Limitations

One obvious limitation of this study is the fact that many respondents could not correctly identify torture. Responses should be viewed in that light. For example, the

proportion that has actually treated torture victims may be lower than reported because they may have included victims of spousal violence. The same type of over-reporting may have influenced the high proportion of respondents believing that torture takes place in their country.

The data collection was made by doctors. Given the perceived hierarchy between professions, this may have limited some medical professionals from expressing their true attitudes and practices with regard to torture. Furthermore, some participants may have been reluctant to share their views given that the interviews and FGDs were administered by someone they did not know, took place at their workplace and—with the FGDs—in the presence of colleagues. The results may therefore be affected by information bias.

Because the data collection in this study adopted convenient sampling and not a random sampling strategy, we must conclude that the observed proportions of professionals’ knowledge, attitudes and practices may not be nationally representative. For instance, election of zones with anecdotal information on the occurrence of torture may have caused an overestimation of the perceived occurrence of torture by medical professionals. However, considering the design of this study, the careful selection of the regions with varying characteristics and the inclusion of medical professionals from all cadres, the study provides comprehensive baseline information on the prevailing situation regarding torture knowledge, attitudes and practices among medical professionals in Tanzania. The use of a mixed-methods approach and the consistency between quantitative and qualitative data make the study findings more reliable (Tashakkori & Teddlie 1998).

Conclusion

Torture is prohibited in Tanzanian law, but the country is still far from having implemented this prohibition and has not yet ratified the UNCAT. Medical professionals may play an important role in raising awareness of the extent to which torture happens in the country, and in treating those who suffer the immediate or chronic effects of torture. The results of this study, together with the reports from NGOs, form the baseline on which intervention strategies and further investigations may be developed. Such initiatives would aim at developing a comprehensive anti-torture strategy for the country considering the important role that medical professionals play in this endeavor. One obvious place to start is in medical schools and with postgraduate training for medical doctors and other health professionals.

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From echoes of silence to whispers of hope: Narratives of survivors of sexual torture

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Key points of interest

- Survivors of sexual torture could be assisted to overcome the stigma, impunity and the psychological sequelae of shame by a strategy that sensitively integrates testimony therapy.
- There is a need to develop gender neutral approaches that target multiple levels; family, community and the international community to address the stigma and silence that perpetuate sexual violence/torture.
- Group therapy can instil courage in survivors to revisit their past.

Abstract

Sexual torture continues to be used indiscriminately against both women and men, combatants and civilians, in armed conflict and war. Specialised interventions that sensitively assist survivors to release and integrate these traumatic memories are likely to assist with healing and recovery. As survivors reconstruct their past, they view their experiences from new perspectives and rediscover their resilience. This gives them hope.

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Keywords: Asylum seekers, sexual torture, specialised interventions, narrative inquiry

Introduction

Sexual violence and torture has consistently been used as a weapon in war and armed conflict, but it has only recently been recognized as a war crime (Tappis et al., 2016). Perpetrators were first successfully prosecuted and sentenced in 1996 at the International Criminal Tribunal for the former Yugoslavia (ICTY). Following this, the Rome Statute (1998) was passed by the International Criminal Court (ICC) that defined sexual violence as an individual crime, a war crime and a crime against humanity (Askin, 2003; Zawati, 2007). However, very few perpetrators of sexual violence and sexual torture have been prosecuted. This impunity partly explains why sexual violence, sexual torture and rape are so rampant (Vu et al., 2014). This trend of impunity, as well as cultural taboos associated with sexual torture, perpetuate survivors' tendency to remain silent (Doja, 2018). Designing effective mental health and psychosocial support services for survivors of sexual violence and sexual torture has remained a challenge.

There is a dearth of research on mental health and psychosocial support interventions in the context of sexual violence in armed conflict. However, the

provision of psychosocial interventions—particularly using culturally adapted interventions, group therapy approaches and elements of exposure therapy—appear beneficial in addressing the psychological sequelae resulting from sexual violation (De Jong, 2014). Schopper (2014) suggests that specialised interventions are required to address the complexity of trauma responses and the need to raise awareness of sexual violence in conflict. Some literature suggests that the impact of sexual and gender-based violence during conflict may be different for men and women and they may need distinct intervention strategies to address these impacts (Linos, 2009). However, both women and men are reluctant to seek assistance to deal with the consequences of sexual torture and this often results in overwhelming distress, symptoms of anxiety, depression and post-traumatic stress which are exacerbated in the face of additional stress (Berman, 2006; De Jong, 2014).

The NSW Service for The Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) in Australia developed a group therapy programme for male asylum seekers. All were of Tamil background, from Sri Lanka, and reported experiences of sexual torture. The group intervention was dubbed MANTRA, an acronym for ‘MAN Torture and Rape’. Mantra is a Sanskrit word that translates as ‘instrument of the mind’ (Fernandes & Aiello 2018). Participants in MANTRA communicated that women could also benefit from such a group intervention. Consequently, the Surviving Torture Rape and their Intrusions (STRI) group was trialled; an intervention for women requiring assistance. Stri, the Sanskrit word for women, integrated strategies that were already successfully implemented in MANTRA, which is a narrative exposure

therapy that incorporates breathing and relaxation, cultural stories and metaphors in a culturally sensitive manner.

This paper presents the narratives of a male client who participated in MANTRA¹ and a female client who participated in STRI and reveals their journey of courage and survival. Using the journeys of Vijay and Jaya,² this paper attempts to provide an overview of the complexity of the experiences of refugee survivors of sexual torture, paying particular attention to the cultural specificities of their backgrounds. This paper illustrates that the underlying terror associated with sexual violence and torture, at least in these two cases, is equally debilitating for both genders. There is a need for therapeutic interventions to assist survivors to break their silence as a possible path forward to make meaning and rediscover their resilience.

Methodology and overview

MANTRA and STRI³ were comprised of ten weekly group sessions that were facilitated with the assistance of interpreters accredited by the Translating and Interpreting Service (TIS) and each session lasted at least 2.5 hours.

In addition to the group sessions, individual sessions were offered to all participants to assist them with reconstructing their narratives. Draft

¹ See Fernandes & Aiello (2018) for a detailed description on the method and outcomes of the MANTRA group.

² Vijay and Jaya are pseudonyms in an effort to protect the identity of both participants. The names Jaya and Vijay are derived from the Sanskrit word “jai” (जय) that translates as “victory” or “success” in English.

³ MANTRA commenced in 2014 and STRI was piloted in 2016.

testimonies were read back to participants to make additions or deletions to ensure that what they had shared was accurately captured in the testimony.

The cases of Vijay and Jaya: A journey of courage and survival

Vijay: Vijay is a young man in his 20's. Vijay is single. He has been a student and is keen on continuing his studies. Vijay smiled shyly when we met him outside the counselling room. Vijay had a prosthetic limb; however, when he first entered the counselling room, Vijay displayed no abnormality of gait, posture or movement. He indicated that he had been brutally tortured and sexually assaulted.

Vijay was keen to be part of MANTRA. During initial group sessions, he was assertive and took the lead despite being the youngest member; sharing personal experiences and thoughts about issues being discussed in group.

However, as group sessions progressed and participants began to share detailed narratives of their experiences, Vijay became subdued. He admitted that thinking and talking about his past was a challenge and the “*pain*” was not easy for him to connect with. There were moments when he grew pensive and silent, in stark contrast to the initial sessions, and appeared to be in deep thought. Vijay appeared to be struggling with his internal conflict and urge to avoid traumatic memories from his past.

Jaya: Jaya, a middle-aged woman and a widow, fled her home in Sri Lanka along with her four-year-old son. When we first met with her, she and her son were being held in an immigration detention centre (IDC) as illegal maritime arrivals. She initially attended three individual sessions where she revealed

that she had been sexually assaulted on multiple occasions. She displayed a plethora of emotions and concerns throughout these sessions: how her life had been devoid of “*peace and happiness because she was born a Tamil*”; periods of silence and listlessness; and crying uncontrollably.

By the third session, however, Jaya was unable to access her past and could not complete her narrative. She did not visit STARTTS until a year later when she was referred following her release from the IDC.

It is likely that being detained failed to provide Jaya with a sufficiently safe environment for her to begin to process traumatic memories and hence she was not ready to engage in reconstructing her past. However, following her release, participation in STRI helped Jaya to once again resume her journey to rediscover the past she had struggled to forget. Jaya narrated multiple acts of violence that she had witnessed since she was a young child. Her sexual violations were by far the most difficult for her to articulate.

Jaya requested individual sessions, in tandem with the group sessions, to assist her with processing the horrors of her past. Her memories continued to torment her and she confided that these details were not easy to process on her own. Jaya communicated that the group activities and reflections had, once again, helped her to understand the importance and the need to visit her past.

Common themes: What Vijay and Jaya shared

Theme One: Early Years; Living in Fear and Expecting Danger

Vijay recalled memories of trauma since he was a child:

“I would be in my house and shelling would start and we would run. We wouldn't even

take basic needs. At those times when we were caught between the fighting, we would hide within the boundaries of the rice farm areas. These sectioned off areas had metre high boundaries made of mud brick to store water for the paddy fields. The fighting could go on for half an hour to a day or more. By the time I was eight years old the war between the Sri Lankan Army (SLA) and the Liberation Tigers of Tamil Eelam (LTTE) was well under way. It felt like there were flowers burning all around me. I felt like a tree burning in the desert.”

Jaya also recalled a life of fear and shared how her brother was taken away by the Army when she was a young girl, leaving him disabled:

“I thought the SLA was going to kill us. (...) They took my brother away in a tractor along with a few other boys. They kept him in the camp and we could hear shooting coming from the camp. We went every day to the camp, four or five miles from our home, in the early morning around 4 or 5 am and we would stay until around 8pm on the road side, rain or shine. We didn’t have any food but neighbours would offer us some food. We would use a plastic bucket to get some water from the well. It was so hard that one day my sister fainted. My brother was released a month later. He has not been the same since then.”

Theme Two: Significant Loss

Vijay recalled how his leg was severed. Initially Vijay stated, “I do not remember much about what happened that day”. He clarified that the memory was so painful that he has not tried to think about it since the day it had occurred:

“I think it was August 2006 on a Saturday that I was on my way to school...I then

heard the noise of the shells exploding. It was a deafening sound. It was all very quick. One shell landed right next to me. It hit me from an angle on my right side and I was thrown onto my back by the impact of the shell. I remember noticing my leg away from me. It looked like a banana tree that had been chopped...I only remember that one sound and the blast that followed. I remember lying on the ground and noticed the sun shining through the lids of my slightly closed eyes. At that time, I understood what pain meant. In addition to the physical pain I also had mental pain that I could not handle. I was broken down. I could not put myself together. I thought my life was destroyed.”

Jaya also recalled her conscription to the LTTE and the murder of her husband who was an LTTE member: we were “targeted by the Sri Lankan authorities because of our membership in the LTTE”. Jaya also recalled the following occurrence about a year after the birth of their son:

“Some masked men dressed in black came to our home in a white van and took my husband away. My husband had my son on his lap and kissed him on the head, before giving him back to me and leaving with the men. My husband never came back. Forty-one days later I met a friend of my husband’s friend when I went to a shop to buy milk powder. He informed me that my husband was no more. My husband was shot dead the same day he was taken by the men who arrived in the white van. The man said they had performed the last rites for my husband.”

Theme Three: Being Isolated and Vulnerable

Jaya communicated how she was “terrified as I was alone and isolated” when her son was born and how she had to continually move as

being a former LTTE member endangered family members and friends.

Vijay was separated from his family when he was unable to find a bunker during further shelling attacks, whilst he was still recovering from the injuries to his severed leg. An LTTE cadre lifted him and took him to their camp in a forest. He recalled how he was young and how the LTTE members provided food, medicine and advice on how to take care of his legs, but stated:

“I was upset always wanting to know if my parents were alive or if they had died in the conflict. The bomb blasts start again and again we had to move so I was taken by the LTTE to PTK (Puthukkudiyiruppu). I lost my hope of returning to my parents.”

When fighting broke out in the final stages of the war between the LTTE and the SLA, Vijay injured his other leg and was taken to a makeshift hospital in the war zone for medical treatment. He recalled the following:

“Whilst in the hospital I cried more than when I had lost my leg, because I was alone. I had no one to comfort me. I know I have the strength to handle the pain when I got wounded again but I did not have the strength to handle the loneliness. I was then cornered along with other civilians as the Sri Lankan forces (Navy and Army) advanced in the final war. Both my legs were injured at this time and I was dependent on people to carry me. Wherever they took us I had to go alone. Other patients had their family come for them, but I was all alone. I had no family around me and no one to comfort me.”

Vijay was captured in the ‘final war’ by Sri Lankan forces and explained that the Sri Lankan authorities “stamped me as an LTTE member because I had lost my leg and I didn’t

have my family”. Vijay clarified that the authorities may have perceived that he had lost his leg during combat, particularly as he was on his own with no family members to care for him.

Theme Four: Shame; Silence Prior to Disclosure
Both Vijay and Jaya felt challenged by remembering their loss. They needed reassurance and support before they could re-visit their experiences of sexual violation; by far their most difficult experience that they were yet to disclose.

Vijay needed multiple sessions before he managed to provide a coherent narrative about his incarceration in an SLA camp. It was apparent that he was overwhelmed by memories that led him to edit and adjust his narrative in progressive sessions.

Vijay recalled different stages of sexual torture where he was restrained and beaten when interrogated on multiple occasions. He reported one stage as follows:

“At each stage they would do the torture in different ways. Sometimes I was taken to a room where there was a table and chairs. They stripped off my clothes and made me sit on the chair with my hands tied behind my back. They started to beat me with sticks and the Palmyra tree stalks which were spiky. They started to beat me in my private parts and across my stomach and chest with their hands. With my hands tied behind my back I couldn’t do anything to help with the pain. I think I was put on this chair frame about twenty to twenty-five times. Some of the interrogators were crazy. (...) From the severity of the torture I could tell who the more sadistic people were.”

Vijay described a gradation in the intensity of sexual torture and described a final stage as follows:

“In the final stage of torture, they stripped all my clothes off and covered my whole body with a hot chilli sack. (...) Each and every part of my body was burning, though especially my eyes and my private parts. (...) (another day) they urinated on me from both sides in front and behind. (...) I was so angry because they tried to penetrate their penis into my mouth and ejaculate on me. I found this revolting. I told them I am a man and they could not do this. At that time, I suddenly had a lot of energy. After I yelled at them, they pushed me down and beat me up very badly. It was the worst beating I had. They used a baton and stick to beat me all over my body and especially on my knees to the point they were bleeding. I have wounds from the beating though the scars are fading but the psychological scars/pain is still there.”

Jaya also needed multiple sessions that were interspersed with periods of dissociation and teary outbursts to disclose details of how she was sexually violated by both the Karuna faction and Sri Lankan authorities. Jaya recounted how the young man who was sent to protect her abused her trust and raped her. She reported this as follows:

“He was much bigger than me. It was in the middle of the night. When he came for the water, he was wearing his clothes but he took these off and he was naked. I do not know what I was thinking. I was only thinking of my child. I was frightened. I could not cry or shout for help and my body was shivering. If anyone heard they would think bad things about me. It was very painful and I was struggling to try and avoid him but I could do nothing to fight back. He held me with just one hand and used the other to strip me. I could smell the liquor on him. He was drunk. He pushed his penis into my vagina

and when he was finished with me, he went to sleep. I could hear him sleeping after he had achieved what he wanted. I could call no one, not even my relatives to tell them what had happened to me. Even the people assigned to protect me did this to me. The more I think about it the more it makes me sick.”

Jaya recounted that, when she was interrogated about the whereabouts of her husband, she was gang raped by Sri Lankan authorities on multiple occasions, such as the one she described below:

“They pulled my hair and shoved me into the kitchen up against the bench. They then pushed a pestle into my vagina. When I first saw the pestle, I thought they were going to hit me and kill me with it. It was so painful and I screamed. The pestle was made of iron and was about 10 inches long and the width of my wrist. I was bent over the bench with my face down and I couldn’t do anything. They used horrible words to talk to me; they were saying ‘cottee’ (the Sinhalese word for tiger) and ‘utti’ (a derogatory way of saying vagina). When I screamed, they covered my mouth to stop me. One of the men was holding my head down and not allowing me to move. I think the other three all took turns in raping me. I think they used their penises as well to penetrate me. It was a different type of pain. When they did this to me, I thought I was going to die. After they finished raping me, I was weak and I felt numb. I was unable even to scream.”

Jaya’s intense sense of shame and fear of being stigmatised by her community made her reluctant to work with onsite interpreters from Sri Lanka. She was open to work with the Tamil interpreter who was not from Sri Lanka and was present when she first

disclosed. She requested offsite telephone female interpreters when the interpreter she trusted was not available.

Theme Five: The Compelling Need to Flee

Jaya and Vijay could not tolerate the fear of being assaulted and the ongoing harassment they experienced. Vijay shared the following:

“I still had to go to the SLA camp every week to report and the CID began to harass me every week. They would call me in for an enquiry and verbally abuse and beat me. They would make threats that they would shoot me and even put a gun inside my mouth. Sometimes if they came to my house I would run away and because of this they would harass me more.”

They had tried moving homes, on multiple occasions, to escape from the Sri Lankan authorities but were always tracked down. Jaya began to consider suicide.

Their fear of being repeatedly tortured by Sri Lankan authorities led both Jaya and Vijay to risk their lives and undertake a dangerous journey to Australia by boat with the hope that they would find peace and safety.

Theme Six: From shame to ‘Whispering Hope’

Jaya and Vijay gradually began to tolerate their memories and gained confidence in talking about their traumatic past. As they began integrating their fragmented memories, they started to reconnect with their hopes and dreams. Vijay expressed this as follows:

“I have not fully recovered. No one can fully recover especially mentally from an incident like this. But I keep two things in mind. One: I need to be happy for my parents to be happy. Two: I need to study

to have a good future. Remembering these things helps me.”

Likewise, Jaya reflected on the importance of moving forward to create a future for herself with her son. She also began to speak about the possibility of remarrying and continuing to build her family.

In addition, Jaya began to believe and understand that her ethnicity and close links to the LTTE movement could have influenced the reasons why her perpetrators may have symbolically replaced the “battleground” of the civil war in Sri Lanka with her physical body. She shared this realisation and clarified that despite her experiences she was motivated and determined to continue to have a positive outlook and sustain hopes for the future.

Jaya and Vijay’s journey: Interpretation and lessons

Jaya and Vijay’s journeys illustrate how a cumulative, continuous series of torture and traumatic experiences can lead to a pervasive sense of dread as the anticipation of ongoing trauma is difficult to cope with. This anticipatory distress forces many refugees to flee their homes in fear of their lives (Doja, 2018). Due to stigma and impunity related to sexual torture, it is not easy to disclose. The complex networks that these memories are imbedded in, often make them difficult to access. These case reports suggest that re-constructing the past in a supportive environment at a pace that is determined by survivors could lead towards recovery and healing.

Vijay and Jaya experienced sexual torture as intensely humiliating, painful and dehumanising despite their circumstances and the form of torture that they experienced being different. Their narratives indicate that they were both put

to the trial when being sexually tortured and when they had to manage the impact of the sexual torture; including retrieving and disclosing details of the brutality they endured. This similarity in their experiences and its aftermath challenges unfounded assumptions that suggest that men are stronger and better able to deal with sexual torture or that sexual torture only occurs to women (Touquet & Gorris, 2016).

Once Jaya and Vijay were able to face and find meaning in their horrific ordeals, their shame began to dissipate. This helped them to, once again, connect with themselves and begin to make plans and share their hopes for the future.

The therapists' ability to "hold" the emotional pain and listen in an open and non-judgemental way that conveyed solidarity may have encouraged Jaya and Vijay to commence their narrative. However, progress achieved was a collaborative effort, and was assisted by Jaya and Vijay's willingness to embody their narratives in sessions, which allowed for recognition of their own strengths and meaning making.

Learnings from both Jaya and Vijay's journeys suggest that recovery could be maximised by appropriate interventions that target shame and secrecy at various levels; not just the individual level, but also family, community, national and international levels. The MANTRA group also provoked men to advocate for a comparable project to be initiated for the women who had survived rape in their community. Therefore, working with and validating the experiences of sexual torture of men could motivate them to assist in campaigns to renounce violence against women.

Further, given the widespread occurrence of sexual violence, identifying survivors through an appropriate screening

tool would help to provide intervention in a timely manner and hence speed recovery.

Conclusion

The narratives of two survivors of sexual torture highlight how both men and women need support to assist them to recover from their traumatic experiences of sexual violence and torture during conflict.

The lessons that can be gleaned from these illuminating cases is perhaps limited by the absence of clinical forensic documentation using the Istanbul Protocol to assist in verifying claims of experiences of sexual torture. However, clinical forensic evidence that is diagnostic and highly consistent with narratives of sexual torture is extremely difficult to obtain after a lapse of time, can risk re-traumatisation, and may cause clients to leave therapy. In light of this context, the consistency in verbal and nonverbal expression of emotions, cognitions and behaviours during the interviews and when recording testimonies of both survivors can be considered as proof of a 'psychological forensic analysis'.

These narratives highlight the increasing need to identify and document incidents of sexual violations to assist in the development of specialised therapeutic interventions to support survivors of sexual torture and sexual violence. Whilst acknowledging that conducting psychological assessments requires skill, empathy, cultural understanding, and a careful exploration of the history of torture experiences (Patel, 2016), there is a need to improve the identification of victims of sexual violence and torture. The international humanitarian community must support and deal with the sequelae of sexual and gender-based violence and torture with a gender neutral and gender inclusive approach.

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How do you say Istanbul Protocol in Hebrew? The case of Mr Firas Tbeish

Efrat Shir*

On 26 of November 2018, Israel's High Court of Justice decided that Mr Firas Tbeish had not been tortured. This concluded a six-year legal battle undertaken by Mr Tbeish and the Public Committee Against Torture in Israel (PCATI).

This case review presents some of the complexities which on-the-ground anti-torture work in Israel entails. Specifically, it touches upon the seeming effortlessness with which a recognised international standard such as the Istanbul Protocol (IP; UN OHCHR, 2004) can, and is, dismissed, at the same time dismissing the experience of persons tortured. As always, local context is important. Israel does not have an official position on the IP, and the state does not utilise the IP to examine allegations of torture. On a broader scale, while torture is outlawed based on a High Court of Justice ruling, and while Israel has signed and ratified the Convention Against Torture, it has never criminalized torture *per se* in domestic legislation, and has no mechanism to screen or identify victims.

And so, while the court's conclusion was hardly surprising, the reasoning behind the decision, and the court's disregard of the IP, was nonetheless... disturbing.

Who is Mr Tbeish?

A Palestinian from the Hebron area in the West Bank, Mr Tbeish was a member of the Hamas organisation when he was arrested by Israel and put under administrative detention in November 2011. In his mid-thirties at the time, this was neither his first nor second such arrest; the practice is common in Israel, which detains Palestinians without trial for periods of 6 months to 3 years (as of July 2019, 454 Palestinians were known to be held in administrative detention; B'Tselem, 2019). At the beginning of September 2012, after nearly 10 months of administrative detention, Mr Tbeish was subject to a security interrogation undertaken by the Israeli Security Agency (ISA), an interrogation that lasted in one form or another for over a month.

The interrogation at the heart of this case

Some facts regarding what took place are not disputed: For nearly a week, Mr Tbeish was continuously transferred between various detention facilities; he was denied access to legal counsel for 28 days; "exceptional interrogation techniques" were

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used on him; he vomited in his interrogation and complaints as to his treatment were recorded in medical and Military court records; he signed a confession; and following his interrogation the army seized a Hamas ammunition dump.

Was Mr Tbeish tortured? PCATI says yes. According to Mr Tbeish's own account, and based on the limited external documentation made available to the organisation, PCATI argued that he was shuttled for no apparent reason between detention facilities for seven days while shackled, which drained him physically and mentally. He was subject to extreme sleep deprivation for long periods, including six consecutive days without regular sleep, his interrogation sessions began at 8 in the morning and lasted till dawn the next day with only three 20-minute cell breaks; and his interrogation included threats, curses and complete isolation. The "exceptional interrogation techniques," employed over three days indicating he was classified as a "ticking bomb," comprised stress positions, beating, and other forms of physical violence in addition to psychological pressure. For example, this is how he described the "banana":

"No one could be in the chair, tied in the banana position for more than 3 to 5 minutes. After that they pick you up for 30 seconds and then lower you again. I cannot say for how long they did that to me... hours... hours in which you are bent down, bent up, asked again, bent down... The level of pain is more than a human being can resist... I was put beyond all limits... During this situation I fainted... Sometimes they [prison guards] poured water [over me]."

(It is worth noting that while the use of stress positions, sleep deprivation and other components of the "exceptional

interrogation techniques" set are regarded as torture and outlawed in international law—at times on their own and at times in conjuncture with other acts—Israel does not view them as such.)

The medical aspects

As a result of his interrogation Mr Tbeish suffered from scotoma in his left eye due to a direct punch, which is still present, pain and paraesthesia along the entire left leg, and epigastric pain. He also testified to vomiting and losing consciousness more than once during his interrogation, though this was disputed by the court. In the meagre medical file, four physical examinations by physicians working with the Israel Prison Service are recorded during the three days in which "exceptional means" were used, in which pain in the right molar, bilateral swelling of the knees, swelling and pain with palpitation, and limited movement of the left knee were recorded, as well as a medical record of "bloodshot eyes, did not sleep tonight—interrogation". None of the records elaborate on the cause of the findings. Disturbingly, some of these examinations were carried out in the interrogation room itself.

Torture in Israel

Much has been written about the concept of the "ticking bomb scenario" and the use of torture (e.g., Luban, 2005; Shue, 2006; Sussman, 2005). Israel's ISA interrogations and legal mechanisms have similarly received attention from professional bodies and academics alike (e.g., Bergman-Sapir, 2016; Chachko 2018; Kremnitzer & Shani, 2018). For our purpose, it is important to note that Israel ratified the Convention against Torture in 1991 but has neither outlawed nor defined torture in domestic legislation. However, the country's High Court of Justice prohibited the use of torture in its now famous 1999

ruling (Public Committee Against Torture v State of Israel), finding that “a reasonable investigation is necessarily one free of torture, free of cruel, inhuman treatment, and free of any degrading conduct whatsoever,” and outlawing shaking, the “Shabach” and “frog” methods, and sleep deprivation when used for reasons other than the needs of the interrogation. However, the High Court of Justice also left the door open for the State Attorney General to establish his or her own guidelines in regard to security interrogations. These confidential guidelines include the instances in which interrogators will be exempt from criminal prosecution—as long as their practices do not amount to torture, which has not been further construed. The debate in Israel is circumscribed by this ruling and these guidelines, and takes place in a narrow arena: Given certain acts took place, do they constitute torture—which is forbidden, in theory, though undefined—or are they legitimate, if extreme, interrogational techniques? In effect, there is a loophole into which complaints of torture and ill-treatment fall, and through which are almost always dismissed. That is, if the allegations are believed in the first place. Mr Tbeish’s case exemplifies this.

The legal process

Was a lengthy one. A complaint of torture was submitted by PCATI on Mr Tbeish’s behalf in April 2013. His testimony was taken by the responsible state investigator in August 2014 and again in January 2015, more than 26 months after his interrogation ended. The final decision of the High Court of Justice was published nearly 47 months later (Firas Tbeish et al. v the State Attorney General et al.). And yet, despite the prolonged examination process and the thousands of working hours and documents, the result was a dismissal.

The burden of proof

“In their arguments, the Petitioners have focused on the component of “pain or suffering, whether physical or mental” caused to the Petitioner, according to his claims, during his interrogation, as a result of the violence used against him by his interrogators...

The Petitioners believe that there is “objective real-time evidence of pain and suffering” supporting the Petitioners’ version.... Contrary to the Petitioners’ arguments, I do not believe that all of the above is sufficient to prove the Petitioner’s version.”

[Firas Tbeish et al. v the State Attorney General et al., paras 47-50]

But, how does one prove one’s “version”? In a reality in which interrogations are not recorded, medical files are lacking and interrogees’ rights frequently ignored, how could Mr Tbeish have proven that what he claims happened really did take place? And how can his claim that these acts caused him great pain and suffering be established?

As is too often the case, the interpretation of the severity of pain and suffering was the legal hinge on which Mr Tbeish’s account hung—whether he was tortured or simply subjected to “exceptional interrogation means,” which according to the established legal convention in Israel, do not rise above the legal and personal tolerable levels of pain and suffering, and hence do not amount to torture. (On a side note, it is worthwhile mentioning that the court ignored the possibility that Mr Tbeish was subjected to cruel, inhuman or degrading treatment if not torture, though this was claimed in the petition.)

To substantiate the claims of torture, PCATI initiated two expert IP assessments.

The first was written by a physician who met Mr Tbeish in prison for a relatively short time in 2013, four months after his interrogation ended. A second IP assessment was carried out in December 2017, after Mr. Tbeish's release from prison. An experienced Israeli clinical psychologist and an international IP expert, a psychiatrist, met and interviewed Mr Tbeish for over eight hours on a mild winter day in a West Bank location accessible for both Palestinians and Israelis. This second report focused more heavily on the mental and emotional consequences of the interrogation, and explored in-depth the aspects of the interrogation that are difficult to define and document, and thus are readily dismissed—the threats, the isolation, the lack of sleep.

The Court, the State and the Istanbul Protocol

The court's decision was handed down in November 2018. The first IP opinion, from 2013, was given low evidentiary weight because it—apparently—failed to substantiate Mr Tbeish's medical complaints through a medical examination—though it did find his narrative credible and the physical findings consistent with his story. Yet it was the court's stance on the second opinion that was the more surprising:

“... this medical opinion was prepared on 14.12.2017, over five years following the Petitioner's interrogation, and it is almost completely based on the Petitioner's version. Obviously, these two factors greatly weaken its evidential value, and in fact it cannot be given any real weight, nor can it be determined that any connection exists between its findings concerning the Petitioner's physical, cognitive and emotional condition, and the manner of

his interrogation, as described by him in his complaint.” [para 56, emphasis added]

It is probably useful to point out here that the IP and its practical manifestations are regarded as a “strange creature” in Israel. The country does not have an official position on the IP. It does not utilise this tool to examine allegations of torture, nor does the state independently train its own investigators and judges in its light, despite recommendations by governmental commissions to do so (The Turkel Commission, 2010; The Ciechanover Commission, 2015). This fact has not gone unnoticed by the UN Committee Against Torture, which recommended that “all relevant staff, including medical personnel, are specifically trained to identify and document cases of torture and ill-treatment in accordance with the Istanbul Protocol” (UN Committee Against Torture, 2016, para 50). IP reports previously submitted by PCATI have been dismissed by the state body responsible for examining complaints of torture as redundant, or have simply been ignored, though no opposing expert opinions were presented. The state's decision to dismiss Mr Tbeish's complaint, from September 2016 states:

“There is no evidence in the case documents that the complainant lost consciousness, or that the complainant incurred any physiological or psychological harm as a result of his arrest or interrogation by the ISA. There is nothing in the medical records presented to us, nor in the medical opinion of Dr F.A., to alter this conclusion.”

The Court and the Istanbul Protocol — Take II

This disparaging view of the IP has been advanced by the High Court of Justice

before, notably, in its decision in the case of Mr As'ad Abu Gosh, from December 2017 (As'ad Abu Gosh et al. v the Attorney General et al.). This PCATI petition was supported by an IP report written by two physicians and a clinical psychologist who twice interviewed the petitioner—who was interrogated by the ISA in 2007. Though the opinion found consistency between the severe physiological and psychological findings and the account of the harsh and prolonged interrogation, and although no counter-opinion was presented, the court dismissed its evidentiary weight, again noting:

*“One must deduct from the evidential weight of the expert opinion also in view of the time which had passed since the Petitioner’s interrogation until his examination by the experts. **More than 5 years had elapsed, which is significant.** This is all the truer when one notes the **lack of medical records** in the Petitioner’s case.”* [paras 27-28, emphasis added]

This stated lack of medical records from the time of the interrogation, a frequent occurrence in PCATI’s experience, was the primary ground for dismissing the physiological findings of the experts, which included findings of neurological damage attributed to the interrogation. The psychological findings were ignored by the court—a reoccurring phenomenon in a system that overtly views torture as physical and expects visible damage—and unfortunately, no mention of these can be found in the decision.

The court went further:

*“One does not dispute the claim that **the expert opinion is based on the Petitioner’s statements at that point**, close to his release from prison, and even the representative of the Petitioners*

has agreed that it is not identical to the first complaint submitted... This gap faults the weight of the expert opinion to a large extent. This holds even if some of the Petitioner’s complaints to the writers of the expert opinion had been put forward by him earlier, and even if the writers were aware of this gap and gave an explanation for it...” [para 25, emphasis added]

And, though the IP opinion was discussed at length during a court hearing—the link between the narrative and findings considering the time passed between the interrogation and the evaluation, the more detailed descriptions in the medico-legal opinion, and the IP’s international standing—this was not reflected in the decision:

“According to the experts, “the torture” which the Petitioner recounted “may” be a cause for the medical diagnosis, while the existence of a causal connection between the two is “reasonable to a large extent”. In reference to this conclusion of theirs, one should note that the experts cannot determine whether the interrogative means used in the Petitioner’s interrogation amounted to torture by the Convention, in spite of their training in the field of documentation of torture.”

And so, the question remains and continues to be avoided: If an IP assessment is not significant, how can claims that interrogational methods cause great pain and suffering be established?

The Istanbul Protocol in Israel— Concluding remarks

An attitude of suspicion of the unfamiliar was visible in the justices’ facial expressions when Mr Tbeish’s IP report was introduced in the hearing. Indeed, following the High Court of Justice decisions, PCATI finds

itself at a professional crossroads. On one side is the IP, a tool we believe in and struggle to introduce into Israel. On the other is a legal system that discredits the IP's potential while digging deeper into its own conception of torture. In the current context, should we continue advocating for the IP and its medico-legal reports, even though a legal brick wall awaits us?

Mr Tbeish was not surprised when the High Court of Justice decision in his case was made public. He too knew that of over 1,200 complaints of torture that have been submitted over nearly two decades, no ISA interrogator has ever been indicted. Yet, he was content that his story was documented, heard and asserted, even though not believed in court. And so, while we are debating internally—and on these pages—the most effective and appropriate IP strategies, this principle remains: There is great value in hearing a victim's story; there is worth in facilitating its broadcast to the wider world, beyond the walls of the interrogation room, regardless of the interrogatee's identity.

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A problematic Israeli High Court dismissal of a torture complaint. A commentary by Hans Draminsky Petersen, MD*

In her description of the case of Firas Tbeish (FT), Efrat Shir highlights some crucial weaknesses in the protection of detainees against torture and ill-treatment, inter alia, that the court does not deal, neither with ill-treatment, nor with psychological aspects of torture and ill-treatment; and proper medical documentation does not exist. A key issue is that Israeli authorities do not use the UN Istanbul Protocol (IP) for documentation of torture and ill-treatment and results of such examinations produced by external and independent experts are rejected.

FT was convicted of terrorist acts and was given a relatively mild sentence after a plea agreement. The court held that “particularly in view of the exceptional interrogation that the defendant experienced” the arrangement was found reasonable (para 13).¹

On April 2, 2013, FT filed a complaint through his attorneys requesting a criminal

investigation against his interrogators due to “a brutal course of psychological and physical torture” (para 14). He further requested the investigation of the members of the medical staff that allegedly were physically present in the interrogation room in order to provide medical treatment, but who did nothing to “stop the torture” (para 14).

The court ruled on November 26, 2018 that FT was not tortured. The following reflections on several aspects in this ruling develop further the arguments of Shir. There are two main challenges: How does Israel in practice define torture and how should torture be documented and appraised?

Medical evidence produced during the period of interrogations

In the period when “*special means*” were employed, FT was examined four times by a prison service physician; three of the examinations were done in the interrogation room and the medical notes are quoted as follows in the ruling (para 6).

1. September 19, 2012 the medical examination found “pain and swelling in the upper right molar area” and noted “Buccal swelling. Pain upon palpation. Periodontal abscess”.
2. On Sept. 21, 2012 at 5:37 AM [the physician] found “his general condition is reasonable”, his skin is “pale”, and he suffers from diarrhea.
3. The same day at 6:03 AM, he was examined following complaints of pain in his knees, and it was noted that “in the examination—he appeared agitated. Red eyes. Did not sleep tonight—interrogation”. The examination did not find reason for new treatment.
4. The same day at 6:42 PM, the petitioner was examined again, this time for complaints of pain in his left knee.

¹ “para” refers to the respective paragraphs in the ruling.

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The examination found “his general condition is reasonable”, and he was given medication for swelling, pain and restricted movement of his knee.

The role of the doctor in a detention facility is to safeguard the detainee’s health and to identify, document and report torture and ill-treatment (UN Mandela Rules). The reproduced documents are grossly insufficient in both respects. For example, none of them indicate the reason for the examination and where it took place, nor contain any history of symptoms and signs.

In the context of detention and application of “*special means*” the doctor should have in mind the possibility that the swelling of the mouth and the pathology of the knee could have had a traumatic cause. If swellings of the mouth on both the jaw (“periodontal”) and the cheek (“buccal”) arise acutely and are thought to be of infectious origin (“abscess”) there is ground for further examinations, primarily by a dentist who has access to X-ray examinations, or at least measurement of temperature and administration of penicillin. A description of the general health status of the teeth would have been useful to substantiate the likelihood of the diagnosis “abscess”/infection. On the other hand negative findings such as absence of hematomas are also highly relevant in the context of interrogations using “*special means*” where application of physical violence may take place or may be alleged. “Diarrhea” is not described (onset, appearance, frequency and concomitant pain vomiting and fever) and an examination of the abdomen is absent. “General condition” is not explained (e.g. blood pressure, pulse rate and temperature). Pain swelling and restricted movement of a knee are described perfunctorily and no diagnoses is suggested,

notwithstanding that the most likely cause in a healthy young man is trauma.

The insufficiency of the medical notes concerning findings in the mouth and the absence of actions taken by the doctor could make the reader think that an obviously possible diagnosis of a traumatic lesion was disregarded in favour of the—for the authorities—more acceptable diagnosis of infection (given implicitly).

To fulfill the demands of the Mandela Rules the doctor should—in accordance with the IP—keep meticulous record on the relevant A) *history*, which should include physical and psychological traumas, B) the onset, nature, duration and gravity of *symptoms* and the C) results /*findings* of an objective examination. When assessing the veracity of allegations of torture and ill-treatment those three elements should be considered together appraising whether the history is consistent with the other elements, which constitutes D) a *conclusion*. Likely differential diagnosis should be mentioned and further actions (e.g. specialist examinations or treatment) may be required.

The quoted medical records fail in all of these: A and D are absent and B and C are insufficient.

It is remarkable that the Inspector of Interrogees’ Complaints from the Department of Complaints against the ISA (in the following: “the Inspector”) seems to rely on the prison medical service’s description of the deceased medical doctor who carried out the four examinations of FT as “very meticulous” without assessing for him or herself the quality of the documents. The allegations of loss of consciousness during interrogations were rejected based on the fact that they were not mentioned in the medical records.

The inspector disregarded the knee and mouth pathologies described by the

prison doctor, and FT's allegation that he lost a tooth as a consequence of torture is not commented. It is stated that "it would be expected that if there were substance to the claims, the medical records would show objective findings" (para 19). By disregarding documented lesions, it is implicitly concluded that there was no substance in FT's allegations. Moreover, the inspector disregarded the common knowledge that absence of marks does not prove that torture was not committed as underlined repeatedly in the IP.

The inspector's interviews with prison staff, including the medical service took place up until 3½ years after the event.

FT described that at some point he had a black spot in the eye that was hit during interrogation. He further alleged that he was shaken. An examination by an ophthalmologist with a CT scan could have revealed or ruled out a whip-lash maculopathy, which causes disturbances of the vision lasting for weeks or months. Neither these alleged abuses nor the symptoms were mentioned in the doctor's notes quoted in the ruling. The reader of the ruling could think that this reflects that either the doctor disregarded symptoms described by the detainee or that he was far from being proactive in his gathering of information from the detainee—an impression that is reinforced by the general extreme brevity of the notes.

Medical complicity in ill-treatment and torture

Whether or not the doctor was present during the interrogations cannot be deduced from the ruling, but notably three of the examinations were carried out in the interrogation room "although there was no particular medical urgency" (para 19). FT requested an investigation of the medical

staff (para 19). The investigator's remarks mentioned in the ruling cannot constitute such an investigation.

The doctor's possible presence for the "*special means*" raises serious concerns about medical complicity in torture /ill-treatment. The relevant questions here: Why were the medical examinations conducted in the interrogation room? Did the interrogators call the doctor because they were worried about the health of FT as a result of the application of "*special means*"? Or was the doctor present during the interrogations as indicated by FT?

In other words: Was the doctor complicit in application of "*special means*" / ill-treatment or torture while monitoring the health of FT and guiding interrogators in preventing mishaps?

Apparently the inspector posed no such questions.

The suspicion that the doctor transgressed medical ethics² is reinforced by

2 According to the UN standard for medical ethics in prisons:

It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment.

According to the WMA Tokyo Declaration:

1. The physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures (...) in all situations, including armed conflict and civil strife.

4. physicians have the ethical obligation to report abuses...

6. The physician shall not be present during any procedure during which torture or any other forms of cruel, inhuman or degrading treatment is used or threatened.

the gross insufficiency of the medical reports that could be taken as a cover-up, rather than reflecting mere incompetency.

It appears that both the UN and the World Medical Association (WMA) standards were violated by the doctor. The ruling did not at all treat the complaint about medical complicity in torture and ill-treatment.

Israel's medical association (IMA)—a member of the WMA—should have regulations and guidance to protect doctors working in places of detention from situations where they may violate provisions of the international standards and IMA ought to look into cases where information indicates that violations have taken place. IMA should work for the introduction in Israel of the Istanbul Protocol. It should advocate for the appointment or establishment of an independent institution where such examinations can take place and should facilitate trainings of doctors and psychologists in its use and trainings for legal professionals in the implications of the IP examination results. This is in line with the UN Committee against Torture's recommendations to Israel (2016) and the IMA would be a natural partner in the process.

Non-institutional medical and psychological examinations of FT

FT was examined by a medical doctor some five months after the interrogations applying “*special means*”. A medical record is not reproduced in the ruling. It is criticized for lacking description of medical findings and diagnosis and that the opinion—that FT's symptoms from the eye and leg match his story—relies primarily on FT's complaints (para 55).

First, while it is correct that lack of diagnosis or assessment of the origin of

symptoms and signs is a problem in medico-legal documents, a reader of the ruling could wonder why the same criticism was not applied against the documents written in the prison. Second, when a medico-legal examination is done it will have to rely on information from the person /patient and other available medical evidence. Apart from the low quality documents quoted above, sufficient medical evidence was not produced in a timely fashion by the authorities, the only actors who were empowered to do so.

FT was further thoroughly examined in December 2017 by a clinical psychologist and a psychiatrist internationally recognized for his extensive experience with the IP: Their report was not “granted real weight,” because

- a. it was only made available for review by the Inspector shortly before the court hearing.
 - b. It was prepared more than five years after the interrogation.
 - c. It was almost entirely based on FT's version (para 56).
- Cs. a. If information important for establishing facts emerges it would be in the interest of the court to include it.
- Cs. b. IP examinations may be carried out even after a long delay, but particularly physical marks after torture will disappear with time. Psychological symptoms may be long-lasting, even lifelong, e.g. the PTSD, (cf. Pérez-Sales, 2017). It is interesting that 5 1/4 years delay is determined to be invalidating for the value of the report, while the value of the interviews by the inspector with the prison staff, some of which were conducted 3 1/2 years after the event,

was not questioned. Where is the time limit for acceptability?

Cs. c. The medical-psychological IP examination of a person who alleges exposure to torture is the UN standard for an assessment of the credibility /consistency of a statement about torture.

It is a very meticulous interview where specialists most often spend 5-10 hours with the examinee, sufficient to approach the history of torture /ill-treatment and symptoms from various angles, to assess the examinee's psychological and physical reactions to the examination and to assess the level of consistency between the elements of the examination, i.e. the credibility of the allegations.

It is not a police investigation and including witnesses' statements in the medical examination is rarely relevant, and then only to clarify health related issues, i.e. ailments and sequelae in the period after interrogation, detention and imprisonment. The medical examiners will not be mandated, empowered nor qualified to interview appropriately, e.g. police investigators as to their participation in a possible crime.

The interests of the officers and the doctor

An officer who has participated in torture or other potentially prohibited actions during interrogations will not have the slightest interest in shedding light on facts so as to avoid sanctions and to avoid implicating colleagues, which could make him a pariah in his institution. This lack of motivation would include record keeping that may not always be complete, particularly as to information about "*special means*".

Is it at all thinkable that interrogators who transgress the limit for the permissible would put that on record? Nevertheless,

the logic of the Inspector seems to be that when something is not on record it did not happen. There are serious incentives for not putting all parts of the acts committed or medical evidence on record. Nevertheless, the Inspector and the judges regarded the records and the testimonies of officers and the doctor as the final truth.

The ruling and the CAT

As party to the CAT Israel has the obligation to perform prompt, and impartial examinations of complaints of torture (CAT §§ 12, 13). The investigation by the authorities was far from prompt and the medical aspects far from sufficient; it was close to being non-existent and the sparse information quoted in the ruling was of very poor quality.

The UN Committee against Torture (2016) has recommended that "[Israel] urgently take the measures necessary to guarantee in practice that physicians and other medical staff dealing with persons deprived of liberty duly document all signs and allegations of torture or ill-treatment and report them without delay to the appropriate authorities."

The authorities should have referred FT for a full IP medical-psychological examination at the time when the first torture complaint was lodged. Such examinations could further have clarified FT's right to compensation, (cf. CAT § 14). Moreover, FT should have been referred to a dentist and an ophthalmologist.

The issue of compensation for exposure to non-permitted means is not dealt with directly. However, the mild sentence (as quoted above) could be seen as the judge apparently recognizing that the interrogation procedures were unfair or reprehensible and leniency was used as a form of compensation without admitting openly

what had happened to FT.

It appears that the establishment of FT's actions as terrorist activities is used as a justification for the means used against him, which violates the CAT § 2.2.

The ruling does not mention *Other Cruel, Inhuman and Degrading Treatment or Punishment* ["ill-treatment"] in spite of the fact that ill-treatment is prohibited in the CAT. Since the "special means" used in the FT case is classified material it is impossible to see how the court distinguishes between "special means", (in principle unlawful, but subject to impunity at the discretion of the Attorney General) and ill-treatment / torture, which is prohibited. The lack of transparency in the administration of "special means" and the system of administrative impunity violates the obligation under the CAT for states to prevent torture and ill-treatment (§ 2.1 and 16.1). The points (a-h) in the following section can be seen as an illustration of a lack of will to prevent torture and ill-treatment.

The ruling and its questionable foundation

The court ruled that FT's claims were thoroughly and carefully investigated and that FT was not tortured (para 67) and that "there were no support for the claim that he had lost consciousness or that he suffered any physiological or psychological harm as a result of his arrest or interrogation (para 19)." The conclusion, *inter alia*, builds on

- a. The very poor quality medical documentation from examinations in the period of "special means" usage.
- b. Disregard of medical findings described in a).
- c. Failure to conduct appropriate medical-psychological examinations immediately after allegations of torture and ill-treatment.
- d. The absence of consideration in the ruling of an IP examination made by an international and a local expert.
- e. Misinterpretation of the concept of torture. One individual element (sleep deprivation) of the allegations was assessed as not constituting torture (para 51). Instead, the whole of the interrogating environment should have been assessed taking into consideration that the individual methods may not always amount to torture, but the application of them simultaneously will most likely constitute torture. Likewise, an individual symptom (vomiting) was assessed as not being a proof of torture (para 52). Instead, the entirety of FT's physical and psychological health should have been assessed through a full examination in accordance with the IP.
- f. Institutional records (classified) and statements from interrogating officers and prison guards collected some 3½ years after the events were valued as the truth in spite of the obvious interest that officers have in not shedding light on potentially punishable actions, de facto approved or not approved beforehand by a superior.
- g. Labeling FT as untrustworthy was, *inter alia*, based on FT's unwillingness to have a polygraph examination, the results of which are controversial. Polygraph tests, like any imperfect diagnostic tests, yield both false positive and false negative results and test performance is far below perfection and highly variable across situations ((National Research Council 2003, p.106).
- h. The untrustworthiness of FT was further based on inconsistencies in his accounts over time. It should be considered that torture is designed to impair the cognitive functions of the victim through

the application simultaneously of e.g. sleep deprivation, lengthy interrogations, physical exhaustion procedures and psychological pressure. Details may have been misperceived and on later occasions interpreted or just worded in different manners. Impaired memory and ability to concentrate are common symptoms experienced by victims of torture. It is not to be expected that a torture victim can recall all details in the same wording. The strength of the IP is that such differences are explored and assessed while taking the necessary time approaching such issues from various angles.

Conclusion

1. It is not for the documenting medical experts (Shir, 2019), but for the court to decide whether the level of pain and suffering inflicted reaches the threshold of torture [while disregarding ill-treatment], i.e., the court upholds the prerogative to apply its own interpretation of the definition of torture, despite existing medical evidence and disregarding the Istanbul Protocol. The criteria used to determine the level of FT's pain and suffering does not appear in the ruling.
2. The ruling states that the burden of proof—that the “means” were not reasonable [constituting torture]—falls upon the petitioner (para 36). In the light of the above (1, a-h) this is in practice impossible for the petitioner to establish. This aligns with Shir's statement that no ISA interrogator has been indicted in 1200 torture complaints.

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Institutionalizing torture in Israel: The Firas Tbeish decision.

A commentary by John W. Schiemann, PhD*

Efrat Shir's article in this volume, "How do you say IP in Hebrew? The case of Mr. Firas Tbeish," provides a valuable service by documenting the difficulties surrounding the recognition of the Istanbul Protocol by the Israeli Supreme Court, in a discussion of the court's 2018 ruling in *Firas Tbeish v. The Attorney General (FT)*. Shir rightly notes that the court's "reasoning behind the decision was ... disturbing." In the course of her analysis she raises two important questions:

1. "How does one prove ... [having been tortured when] ... interrogations are not recorded, medical files are lacking and interrogees' rights frequently ignored?"
2. "If an IP assessment is not significant, how can claims that interrogational methods cause great pain and suffering be established?"

The implicit answers to these questions from the state of Israel are: 1. "one can't" and 2. "they can't" respectively.

Shir's examination explains the background to these responses by revealing the systematic efforts by both the government

of Israel and its highest judicial body to institutionalize torture. On the one hand, the government, Shir notes, "has neither outlawed nor defined torture in domestic legislation" yet has crafted secret guidelines to regularize its use. On the other hand, the Supreme Court pursues its own three-pronged strategy that effectively institutionalizes torture, something Shir shows in part by referring briefly to another case brought by The Public Committee Against Torture in Israel (PCATI), *As'ad Abu Gosh et al. v the Attorney General et al.* (2017).

First, the court simply ignores certain claims (e.g. cruel, inhuman or degrading treatment) and evidence (e.g. psychological trauma) entirely. Second, it treats the absence of evidence of torture in the form of ISA medical records as evidence of the absence of torture. Such rulings sustain a system that "overtly views torture as physical and expects visible damage" and so provides further incentive to ISA officials to simply not record any injuries from abuse. Third, the court not only fails to "train its own investigators and judges" in the IP, but also actively "disparage[s]" and dismisses its evidentiary weight by referencing the (necessary) lapse of time between torture and IP examination on the one hand, and discounting statements by the victim on the other hand.

Several additional aspects of the court's decision weaken existing minimal restraints on torture in Israel and are certain to encourage its continued use and likely expansion: attempts at legal and normative justifications for torture, further bureaucratization of torture, and providing ex ante legal cover.

Attempts at legal and normative justifications for torture

The FT decision raises profound concerns

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about the legal and normative justification for torture by the Israeli state. There are two issues with the legal justification. First, the decision equates the successful elicitation of information under torture with its lawfulness. In several places the decision states very explicitly that the abuse was legally justified by the successful elicitation of information (*FT*, paras 9,26,59). On this view any torture can be justified if it results in information. The court avoided addressing whether torture is justified if it *fails* to generate information, but there are two possibilities: either torture is justified despite the failure or it is not. The former position would “give a green light” to torturing under any conditions because it is justified even if little or no information is elicited. If, on the other hand, the court holds that the failure to elicit information means the torture was unjustified, it has the perverse effect of directly contradicting the court’s own rationale and justification for torture where the detainee actually had information but refused to divulge the known information despite the torture.

The second problem as concerns legal justification is the court’s finding that the torture was lawful because the means “were proportionate relative to the serious threat” (*FT*, para 59; also Justice I. Amit concurring, para 2). Here, the court creates new law without factual grounding. Israel is party to the Convention against Torture, which thus has binding legal force. Paragraph two of Article two explicitly states that “[n]o exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture.” There is nothing in this provision, nor anywhere else in the treaty, that comes close to mentioning, let

alone providing, exculpatory exceptions related to proportionality.

Nor can the court find support in its own 1999 landmark decision outlawing torture in *Public Committee against Torture v. State of Israel (PCATT)*. That decision refers to proportionality but only in the context of the possibility for an investigator to claim a necessity defense after the fact, whilst very explicitly not making the abuse itself lawful.

Moreover, even here, the language of the 1999 decision respects the non-derogable character of the prohibition by explicitly noting that the proportionality must never rise to the level of torture. In the court’s 1999 language, “an investigator who, in the face of such danger, applies a degree of physical pressure, which does not constitute abuse or torture of the suspect, but is proportionate to the danger to human life can, in the face of criminal liability, avail himself of the ‘necessity defense’” (*PCATI*, para 16). The decision goes on (*PCATI*, para 23) to reaffirm that “[t]hese prohibitions are “absolute.” There are no exceptions to them and there is no room for balancing.”

In addition to ignoring the treaty to which it is a party and making up its own law, the court’s decision also begs the question as to whether a bigger perceived threat would justify measures even the Israeli court would deem torture. Indeed, at least one justice -- D. Mintz -- already seems to think so, given a passing remark in his concurring opinion “that torture is prohibited, apart from extremely exceptional cases,” despite the fact that torture is absolutely prohibited in Israeli law (*FT*, para 3). A follow up ruling on the same case (HCJ 9105/18) by the Chief Justice noting that Mintz’s comment was “inaccurate” does little to assuage such fears.

With respect to the broader normative justification, according to this decision

not only does the bomb not really need to tick, but it may not even be likely to go off. Shir correctly notes that the ticking bomb hypothetical has been the paradigmatic justification—the “necessity defense” in Israeli legal terms—for Israeli (and other countries’) interrogational torture. The Firas Tbeish decision broadens the scope of the necessity defense beyond *PCATI*—which already allowed the requirement to be met even when the danger may be realized “in a few days, or even in a few weeks”—by now weakening the requirement that the threat be certain (*PCATI*, para 34). In the words of the court, the threat is now “might ... cost human lives” (*FT*, para 60) rather than the 1999 decision language requiring that “the danger is certain to materialize” (*PCATI*, para 34). In sum, both the legal and normative justifications in the decision weaken the prohibition on torture and increase its likelihood.

Bureaucratization of torture

The court’s approval of the ISA’s three internal torture guidelines discussed in the decision effectively serve to further bureaucratize torture in Israel. The first guideline sets out a consultation system permitting superiors to opine to subordinates that torture (“special measures”) is “immediately required” but “who cannot authorize” the torture (*FT*, para 28). In a security agency with a quasi-military chain of command, the scholastic exercise of differentiating between an opinion and an order by a superior is artificial, and is a de facto directive to torture. Consistent with this reality and inconsistent with the guideline’s pretense of expressing opinion only, superiors can, however, set limits on the torture employed according to the second guideline. Thus, by setting limits on discretion about when to torture, the ISA effectively defines

the conditions under which it can be employed ex ante and so triggers torture when those conditions are deemed to have been met. The third guideline completes the bureaucratization by outlining how torture should be memorialized for the record. Nothing says bureaucratized like a requirement to fill out the proper forms.

And yet, despite all this, as well as the court’s own 1999 finding in *PCATI* that ‘the necessity defense’ does not constitute a source of authority which would allow ISA investigators to make use of physical means during the course of interrogations (*PCATI*, paras 36–38), in 2018 the court refused to draw the obvious conclusion that such a combined system does indeed constitute “a predetermined, systematic canon” for the use of torture or “general, advance instruction or direction” (*FT*, paras 64, 65). Indeed, the court instead praised the system for “actually serv[ing] to protect the interrogee from an unlawful infringement of his rights” and, in the words of Justice Mintz, “may moderate the very use of” torture and “facilitate its better implementation” (*FT*, para 65; Justice D. Mintz, concurring, para 3). This is part and parcel of what legal scholar David Luban called the “fantasy” of “fastidious” and limited torture central to the view that torture is compatible with liberal democracy because it “can be neatly confined to exceptional ticking-bomb cases and surgically severed from cruelty and tyranny” (Luban 2005, 1452, 1461). The actual result, however, is a “torture culture, a network of institutions and practices that regularize the exception and make it standard operating procedure” (Luban 2005, 1461). In short, together these rules enable torturing with impunity by helping to systematize a practice the 1999 *PCATI* decision prohibited.

Ex ante legal cover

Although the *PCATI* decision criminalized torture, it also left open the possibility for ex post facto exoneration if the criteria for the necessity defense had been met. This exception had already, in Shir's phrasing, "left the door open" to legal torture by permitting "the State Attorney General to establish his or her own guidelines in regard to security interrogations." The current decision throws the door wide open by claiming that the necessity defense is not merely exculpatory but justificatory. Based on a vague reference to "some criminal law theories," "the result of the application of the necessity defense is, therefore, not merely the exoneration of the actor, but also the justification of the act, such that it is not defined as a harmful phenomenon that the criminal law seeks to prohibit" (*FT*, para 61). This again is creating law without grounding in facts and signals ex ante legal cover to ISA officials who decide to torture, thus incentivizing its continued and expanded use.

Turning a blind eye to torture

In sum, Shir's article shows that with this decision the court signaled that it will continue to use the blindfold of justice to keep its eyes closed to torture by the ISA, whatever the evidence and despite the court's explicit reference to the definition of torture in the Convention Against Torture, to which Israel is a party. The court simply takes witness (interrogators, medical personnel, guards) denials of abuse in the government's internal investigations at face value (e.g. *FT*, paras 17,49). The court also deems the absence of evidence in medical records as the evidence of absence (of torture), rather than opening an investigation about problems with the documentation (*FT*, para 52).

Second and in sharp contrast, the court treats statements and evidence submitted by FT very differently, placing great weight on minor inconsistencies in FT's account over time, questioning FT's inability to recall certain details of his torture (a well-known sequel of torture-induced trauma), and his refusal to take a polygraph test at that stage of the process (*FT*, para 49). Third, the court not only takes at face value the claim by ISA interrogators that the "scope and nature" of their "special interrogation means" "differed significantly from" FT's claims of shaking, stress positions like the frog, and sleep deprivation, but also fails to provide any method or test by which they determined that those differences, even if true, were sufficient not to constitute torture. Further, in *FT* (para 47), just prior to finding no suspicion of criminal offense by the ISA in para 48, the court dismissively refers to the stress positions "as improper "torture methods," as a mere claim by FT in scare quotes when in fact, as Shir states, this was the very finding of *PCATI*:

"Consequently, it is decided that the order nisi be made absolute. The [ISA] does not have the authority to "shake" a man, hold him in the "Shabach" position (which includes the combination of various methods, as mentioned in paragraph 30), force him into a "frog crouch" position and deprive him of sleep in a manner other than that which is inherently required by the interrogation (PCATI, para 40)."

Parenthetically, note that it is clear by the court's use of "inherent" elsewhere in the 1999 decision that it means a possible need to question a prisoner when he might otherwise sleep and not that successful interrogation requires depriving a detainee of

sleep in order to “break” him, i.e. deliberate sleep deprivation as an interrogation method. For example, the court notes that seating the prisoner is inherent to the interrogation, but seating him in the *shabach* stress position is *not* inherent to an interrogation and is therefore prohibited (*PCATI*, 1999, para 27).

Lastly, the injuries to Firas Tbeish and his description of the techniques used against him (e.g. the “frog” and “banana”) are consistent with the by now very well-established public knowledge of ISA torture practices, based not just on detainee reports but by human rights groups and even interrogator revelations (*FT*, para 10; *Absolute Prohibition* 2007, 67; *Amnesty International* 2016, 23; Levinson 2017). The court took the ISA’s claims at face value that instances of torture have been sharply reduced to a “tiny percentage” when a 2015 investigative report by Haaretz and the Public Committee Against Torture in Israel found that torture by interrogators was on the rise (*FT*, para 44; Levinson 2015). Despite this, as Shir notes, “of over 1,200 complaints of torture that have been submitted during nearly two decades, no ISA interrogator has ever been indicted.”

In her discussion of the court’s dismissal of the IP, she says there “is a legal system that discredits the IP’s potential while digging deeper into its own conception of torture.” Shir has helped show that this is true more broadly of torture, beyond the IP. Indeed, I suspect the court may not view the IP as a “strange creature” causing “suspicion of the unfamiliar.” Instead, it may be by now a very familiar creature that threatens torture’s impunity in Israel, and what Shir shows is that the court has developed a systematic strategy to counter it. Torture is possible in Israel because the government and courts are complicit in deliberately creating a legal and institutional black

hole where boundaries are ill-defined and obscure, and no light can shine.

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Unjustifiable Means: The Inside Story of How the CIA, Pentagon, and US Government Conspired to Torture, by Mark Fallon

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(ISBN 978-1-942872-79-5)
BG (Ret) Stephen N. Xenakis, M.D.*

Unjustifiable Means: The Inside Story of How the CIA, Pentagon, and US Government Conspired to Torture is Mark Fallon's detailed account of the tactics, practices, and procedures that he witnessed as a special agent and counterintelligence officer at Guantánamo Bay military prison (Guantánamo) after the terrorist attacks of 11 September 2001 ([9/11] or [the attacks]).¹ Fallon provides a first-hand account of the struggles faced by U.S. government agencies in investigating the planning and execution of the attacks, both behind the scenes and on the front pages. He is a natural storyteller and his reports of the action on the ground make for compelling reading.

The book is written from Fallon's perspective as a seasoned professional with in-depth experience of investigating terrorist operations against the United States of America.

He investigated the first bombing of the World Trade Center in New York City in 1993 and the attack on the *USS Cole* on 12 October 2000. Over the years, Fallon's work has protected the US from threats to national security and brought perpetrators to justice. Fallon reminds us that his story takes place after 9/11, when there was a fervor to react vigorously and when the US government could no longer guarantee safety and security for its citizens.

I disagree with the thesis of the first chapter; that the 9/11 attacks were a "new kind of warfare." The attacks were the failure in preparing for and anticipating the next phase of sophisticated terrorism. For decades, terrorists had threatened the United States. The intelligence agencies had even been tracking Osama bin Laden since the 1990s. Numerous reports by independent journalists over the past few years have criticized the agencies and national security apparatus for not acting to stop him. More than one writer has documented that national intelligence agencies failed to coordinate and share information they had acquired on the planning and activities of bin Laden and other terrorist threats. Labelling the attacks as a new kind of warfare only excuses what followed. Fallon is right however—the US was unprepared and felt it necessary to take drastic action in order to convince its citizens of their safety. With that in mind, senior US government leaders committed to obtaining intelligence that had been missed leading up to the attacks.² Fallon tells the story of how their policies

1 The opinions represented in this review are the author's own, and do not necessarily represent the views of the Journal.

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2 Many Bush Administration leaders continued to defend the use of torture in interrogations long after the official end of the program, and many still defend to this day. (Friedersdorf, 2018; see also Finkelstein & Xenakis, 2018; Open Hearing, Nomination of Gina Haspel to be the Director of the Central Intelligence Agency, 2018; Rizzo & Xenakis, 2018).

and procedures led the US to committing acts recognized by sources including the US Military Commissions as *torture*.

After 9/11, the US Department of Defense launched an aggressive plan to conclude how the attacks had happened. As part of this, Fallon accepted the assignment as deputy commander of a newly created Criminal Investigation Task Force in Guantánamo and was responsible for dealing with the Al Qaeda terrorist network and other suspected perpetrators.

The account opens with Fallon's trip to US Central Command (CENTCOM) headquarters in Tampa, Florida. CENTCOM's military operations include Iraq and Afghanistan and its responsibility extends to managing and interrogating the individuals captured in combat. The Naval Criminal Investigation Service (NCIS) had been delegated to conduct investigations for CENTCOM. Fallon was assigned to lead the efforts and was ordered by the Pentagon to "bring the terrorists to justice." He writes about the participants in the first meetings that included "a plague of lawyers" and a host of psychologists with no experience with interrogations or gathering intelligence. The operations and climate became increasingly chaotic. The already unclear rules and guidelines that applied to the conduct of interrogations became increasingly blurred. The media's explanation was that the attackers were the "worst of the worst" and that innovative tactics were required to protect the country. Fallon explains the details of how this led to cruel, inhuman, and degrading treatment of the prisoners disclosed in the descriptions of the enhanced interrogation tactics that qualify as torture.

The US government justification for this was that the traditional practices and

policies for gathering intelligence had failed. The blame for the failures to protect against the attacks was also implicitly attached to frontline intelligence agents and those conducting interrogations. That, in turn, opened the door for inexperienced and untrained individuals to design ill-conceived practices in Guantánamo, Abu Ghraib prison, Bagram, and a number of other locations. As the chaos unfolded, Fallon tried to sustain proficient operations.

Fallon, to his credit, does not digress to titillating sidebar stories, such as what happened at black sites or during extraordinary rendition. He provides fair and objective impressions of all those involved and does not indulge in psychologizing or unpacking personalities. He is a witness to a trying time in US history and has recorded valuable testimony.

There's a military saying—"...you just have to see this—you can't make up this stuff ..." Fallon's book is a must-read—we all should know about how the US "conspired to torture" and learn from it.

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Paul Broca's clitoridectomy as a cure for "nymphomania": A pseudo-medical mutilation

Philippe Charlier*,**
Saudamini Deo**

Keywords: History of torture, psychiatry,
sexual mutilation

Dear Editor,

Paul Broca (1824-1880) is considered one of the founding fathers of modern neurology, mainly because of his major contribution to the anatomo-clinical method (Figure 1) (Sagan, 1979). He has also distinguished himself by his fascination with cranial measurements at the origin of modern physical anthropology and, unfortunately, racial theories based on cranial indices (facial angle and brain volume, mainly) (Gould, 1981).

But what is less known is that Broca has been illustrated by particularly archaic and mutilating therapeutic practices, such as what is now considered to be female genital mutilation. Clueless in the face

of the therapeutic void, the 19th century neurological physicians sometimes practiced treatments supposedly inherited from ancient Hippocratic and / or Galenic theories (Mota Gomes & Engelhardt, 2014). This was the case for a small patient of Paul Broca (a 5-year-old girl), whom he deemed/diagnosed to be suffered from a severe form of (what was then suffering) nymphomania. In his communication, Broca (1864) reports that he had no choice but infibulation (almost complete suture of the vulva), given the importance of this "vicious habit" resistant to the surveillance of her mother, and despite the prolonged wearing of a chastity belt. The neurologist rejects the possibility of a surgical section of the clitoral nerves, at the risk of a recurrence of symptoms. He also (initially) recuses a clitoridectomy because "amputation of the clitoris meant irreparable destruction of the organ of voluptuousness and an excessive measure in a girl who can recover." Broca (1864) reports that while he performed infibulation, "the child addressed words of tenderness and compassion to her genital organs" which he interprets as evidence of her mental illness and sexual monomania.

It is likely that it was because of his knowledge of anthropology (social and physical) that the neurologist Broca was aware of the practice of infibulation. He also states in his text that the use is common in the East to strengthen female chastity (*sic!*), but "may have never been used against nymphomania" (Broca, 1864). A therapeutic innovation in neurology, in short.

Unfortunately for the patient, given the inefficiency of the surgical treatment, Broca reports that he was forced, several years later, to undo the infibulation, and to perform a radical clitoridectomy. This was also without any success, since the "nymphomania" of the young patient persisted (with the detail that the old and current terms of "nymphomania"

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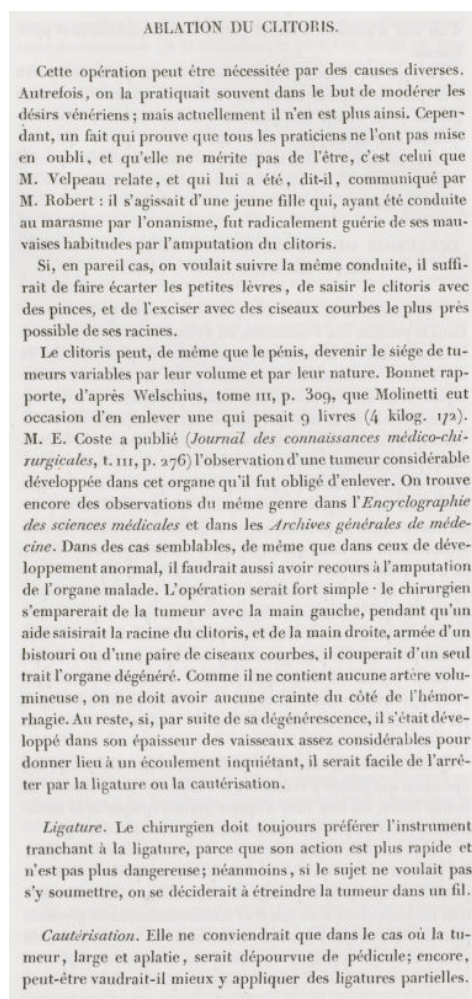
are not exactly superimposable, *a fortiori* on a young child of 5 years, and a modern interpretation would more likely correspond to repeated masturbation, which may or may not have been considered under Other Sexual Dysfunction (DSM-5), and most certainly would be not result in an act of female genital mutilation).

In the context of the west of the late 19th century, one may wonder whether the two surgical acts performed on this girl, consisting anatomically in genital mutilation, cannot be equated with torture injuries. Such gestures were not commonly practiced in this chrono-cultural context. While, in their local use, the classification of these practices of genital mutilation as a torture is still debated by some researchers, it seems more likely that their use out of context, in a Western Victorian society (characterized by the expression of a social authority of the doctor vis-à-vis his patient and his relatives), may be compatible with torture.

Some years later, the practice of clitoridectomy by another contemporary practitioner (Isaac Baker Brown, president of the Medical Society of London, died in 1873 at the age of 61), in contexts of hysteria, catalepsy, mania or epilepsy, sometimes without the consent of the patient, had also triggered an offended reaction by his colleagues who drove him out of the Obstetrical Society (Baker Brown, 1866; Ryan & Jetha, 2010).

Under these circumstances, the question is raised as to whether and how to defend both Broca and/or Baker Brown. Societal practices of the second half of the 19th century were much more mechanical (chastity belt, etc.) than surgical. With a distant glance, clitoridectomy for a neuro-psychiatric reason appears to have been illegitimate mutilation, consistent with torture (Pérez-Sales & Zraly, 2018). In

Figure 1: *Bourgerie, J. M. (1866-1871). Traité complet de l'anatomie de l'homme, par les Drs Bourgerie et Claude Bernard et le professeur-dessinateur-anatomiste N.H. Jacob, avec le concours de Ludovic Hirschfeld. Paris : L. Guérin, tome 7.*



the context of Broca, one may wonder if his Puritanism did not play a role in his decision making him intentionally mutilate this child sexually. Beyond a

cruel or inhuman act, it seems that we should see in this example the expression of a moral and social authority over a vulnerable individual, under cover of a very dubious (or even hypocritical) will of treatment. The “health argument” may well be only a false justification for covering up these facts of genuine torture, as is still practiced now (Mendez, 2013). Research should be developed around clitoridectomy in medicine (particularly in a context of neurology, psychiatry, forensics and hygiene) in the 19th century and the first third of the 20th century, to better understand the extent of this phenomenon and its traumatic consequences.

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The UN Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (CIDTP), Nils Melzer, has decided to focus his next thematic report on "Psychological Torture and Ill-Treatment" The report will be submitted to the Human Rights Council in March 2020.

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