# TORTURE

1

2020

*Journal on Rehabilitation of Torture Victims and Prevention of Torture*

VOLUME 30, NO 1, 2020, ISSN 1018-8185

**TORTURE**

**Journal on Rehabilitation of Torture Victims and Prevention of Torture**

Published by the International Rehabilitation Council for Torture Victims (IRCT), Copenhagen, Denmark.
TORTURE is indexed and included in MEDLINE. Citations from the articles indexed, the indexing terms and the English abstracts printed in the journal will be included in the databases.

**Volume 30, No 1, 2020**
**ISBN 1018-8185**

The Journal has been published since 1991 as Torture – Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture, and was relaunched as Torture from 2004, as an international scientific core field journal on torture.



**Correspondence to**
IRCT
Vesterbrogade 149, building 4, 3rd floor,
1620 Copenhagen V, Denmark
Telephone: +45 44 40 18 30
Email: publications@irct.org

**Subscription**
http://irct.org/media-and-resources/publications#torture-journal
The Journal is free of charge.


Front page: Mogens Andersen, Denmark
Layout by Pedro López Andradas
Printed in Lithuania by KOPA.

# Content

# COVID-19 and Torture

**Pau Pérez-Sales***

Over the past few weeks, and with the Editorial already at completion, the COVID-19 pandemic has invaded our lives. Its systemic impact has affected, and continues to affect in equal measure the provision of rehabilitation to victims of torture.

Amongst the many areas in which COVID-19 has impacted the field of prevention and rehabilitation of torture survivors, at least 8 areas of concern can be highlighted.

1. Attacks on basic fundamental rights and unnecessary increase in social control measures (Human Rights Watch, 2020a)
2. Increases in cases of ill-treatment or torture linked to the pandemic itself. For instance, various media sources have reported cases related to the dissemination of information in countries where this was considered to be against the interest of the state (Wang, 2020; Human Rights Watch, 2020b; Amnesty International, 2020a)
3. Respect for the rights of detainees and COVID preventive measures in detention settings that are compliant with human rights (Council of Europe, 2020; OHCHR, 2020; Council of Europe, 2010) and especially amnesty processes for political prisoners or the use non-custodial measures (Comninos, 2020; Amnesty International, 2020b).
4. Increases in cases of gender-based violence (Ford, 2020; UNFPA, 2020; UN Women, 2020) and assaults on homeless populations (Phasuk, 2020; Hartley, 2019), both related to fear and isolation.
5. Relapse of symptoms, especially nightmares, flashbacks and somatic symptoms, in survivors that were ill-treated or tortured while in custody, due to COVID-related self-confinement or measures of medical isolation.
6. The reshaping of society: Will there be a change in values towards more egalitarian, empathetic and supportive societies? Or an evolution towards a more fearful society with an increasing lack of solidarity as fear instils?
7. The use of warlike metaphors (the "war" on the Coronavirus) as a prelude to restrictions in freedoms, censorship or authoritarianism in the name of the collective good (Human Rights Watch, 2020a).
8. Cutting budget allocations for the most disadvantaged, vulnerable groups in general and survivors of torture specifically, in favour of security policies or market-based post-COVID decisions (UNDP, 2020; European Council, 2020).

These are some of the many areas of reflection on COVID-19 as a global crisis in the field of human rights and the prevention of torture and rehabilitation of torture victims.

Torture Journal invites our readers to share your experiences, reflections, research and data in the form of a Letter to the Editor, News or Research Report for inclusion in future issues of the Journal. This is a global crisis which may, in turn, foster a shared learning opportunity for all.

*) Editor-in-Chief.
Correspondence to: pauperez@runbox.com

*References*

China: Free Covid-19 Activists, '*Citizen Journalists*'. (2020b, April 27). Human Rights Watch. https://www.hrw.org/news/2020/04/27/china-free-covid-19-activists-citizen-journalists

Coalition Against Torture: *Government officials should be accountable for excessive use of force, ill-treatment during COVID-19 lockdown.* (2020a, April 23). Amnesty International. https://amnesty.org.in/news-update/coalitionagainst-torture-government-officials-shouldbe-accountable-for-excessive-use-of-force-illtreatment-during-covid-19-lockdown/

Comninos, A. (2020, March 12). *COVID-19 in prison.* APT. https://apt.ch/en/blog/covid-19-in-prison/

Council of Europe. (2020, March 20). COVID-19: Council of Europe anti-torture Committee issues "Statement of principles relating to the treatment of persons deprived of their liberty". https://www.coe.int/en/web/cpt/-/covid-19-council-of-europe-anti-torture-committee-issues-statement-of-principles-relating-to-the-treatment-of-persons-deprived-of-their-liberty-

*Covid-19 and Ending Violence Against Women and Girls*. (2020). UN Women. https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/issue-brief-covid-19-and-ending-violence-against-women-and-girls-en.pdf?la=en&vs=5006

*COVID-19: Measures needed to protect people deprived of liberty, UN torture prevention body says.* (2020, March 30). OCHR. https://www.ohchr.org/EN/NewsEvents/Pages/ DisplayNews.aspx?NewsID=25756&LangID=E

Ford, L. (2020, April 28). *'Calamitous': domestic violence set to soar by 20% during global lockdown.* The Guardian. https://www. theguardian.com/global-development/2020/apr/28/calamitous-domestic-violence-set-to-soarby-20-during-global-lockdown-coronavirus

Hartley, L. (2019, January 31). *Anger at 'torture' of city homeless man set on fire*. Coventry Telegraph. https://www.coventrytelegraph.net/news/coventrynews/coventry-homeless-man-set-fire-15748697

*Human Rights Dimensions of COVID-19 Response*. (2020a, March 19). Human Rights Watch. https://www.hrw.org/news/2020/03/19/human-rightsdimensions-covid-19-response

*Millions more cases of violence, child marriage, female genital mutilation, unintended pregnancy expected due to the COVID-19 pandemic.* (2020, April 28). United Nations Population Fund. https://www.unfpa.org/news/millions-more-cases-violence-child-marriage-female-genital-mutilation-unintended-pregnancies

Phasuk, S. (2020, April 24). *Covid-19 Curfew Arrests of Thailand's Homeless.* Human Rights Watch. https://www.hrw.org/news/2020/04/24/covid-19-curfewarrests-thailands-homeless

*Position Note on the Social and Economic Impacts of Covid-19 in Asia-Pacific*. (2020). UNDP. https://www.undp.org/content/undp/en/home/librarypage/crisis-prevention-and-recovery/the-social-and-economic-impact-of-covid-19-in-asia-pacific.html

*Report on the comprehensive economic policy response to the COVID-19 pandemic.* (2020, April 9). European Union. https://www.consilium.europa.eu/en/press/press-releases/2020/04/vvvvv09/report-on-the-comprehensive-economicpolicy-response-to-the-covid-19-pandemic/

*Syria: Vulnerable prisoners should be released to prevent spread of COVID-19.* (2020b, March 31). Amnesty International. https://www.amnesty.org/en/ latest/news/2020/03/syria-vulnerable-prisonersshould-be-released-to-prevent-spread-of-covid19/

The prohibition of torture is absolute and no exceptions allowed, ever. (2010, October 30). Council of Europe. https://www.coe.int/en/web/commissioner/blog/-/asset_publisher/xZ32OPEoxOkq/content/the-prohibition-oftorture-is-absolute-and-no-exceptions-allowedever?_101_INSTANCE_xZ32OPEoxOkq_languageId=en_GB

Wang, M. (2020, April 1). *China: Fighting COVID-19 With Automated Tyranny*. Human Rights Watch. https://www.hrw.org/news/2020/04/01/china-fighting-covid-19-automated-tyranny

# Internet and Communications as elements for CIDT and Torture. Initial reflections in an unexplored field*

**Pau Pérez-Sales**, Laia Serra*****

The internet was once seen as a new and definitive window to freedom and a world without torture. There is however, another less obvious but perhaps more notorious side: torturous environments can also be created through the internet; a place where individuals may be targeted for discrimination, coercion or control. There is a dearth of academic research and theoretical developments in this very new area of knowledge and this Editorial will review and reflect on various aspects, thereby suggesting possible lines of research.

## Searching for definitions

A recent theoretical review in the field of online violence (Harris & Woodlock, 2019) with its focus on gender, proposed the use of the term *technology-facilitated coercive control* when referring to abuse using social networks or the internet. The authors propose that similar denominations are sought for other kinds of digital violence and suggest that any denomination of these new phenomena include the terms perpetrator and purpose. Other expressions found in the literature include *digital coercive control* (DCC), *technology-facilitated violence* (TFV), or *technology-related violence* (Douglas, Harris, & Dragiewicz, 2019).

The Council of Europe's Cybercrime Convention Committee has recently defined cyberviolence[1] as: "*the use of computer systems to cause, facilitate, or threaten violence against individuals that results in, or is likely to result in, physical, sexual, psychological or economic harm or suffering and may include the exploitation of the individual's circumstances, characteristics or vulnerabilities"* (T-CY, 2018), a definition also adopted by the European Parliament (Van Der Wilk, 2018).

This definition, however, focuses on the internet and leaves aside other forms of communication. For the purposes of this editorial, we will consider a wider perspective and, mirroring the conditions of the UNCAT definition, consider Internet and Communications Ill-Treatment and Torture (ICIT) as *those acts of violence intentionally committed, instigated or aggravated, in part or whole, by the use of information and communication technologies that cause psychological and emotional pain or suffering, for such purposes as obtaining informa-*

*) The Editor-in-Chief takes full responsibility for the content of the Editorial. The opinions expressed are his own and do not necessarily reflect the view of the Publisher.
A draft version of this Editorial was used and mentioned in the UN Special Rapporteur on Torture Report (2020) A/HRC/43/49 on Psychological Torture, as entitled "Internet and Torture".

**) Editor-in-Chief.
Correspondence to: pauperez@runbox.com

***) Criminal lawyer specialising in gender, digital violence and freedom of expression.
Correspondence to: laiaserra@icab.cat

1 https://www.coe.int/en/web/cybercrime/cyberviolence#{%2250020850%22:[0]}

https://doi.org/10.7146/torture.v30i1.120593

*tion, punishment, intimidation, coercion or for any reason based on discrimination of any kind when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.*

This is achieved, among other methods, by inducing emotional suffering through threats and fear, breaking bonds of confidence in the targeted person, inducing shame, embarrassment, humiliation or guilt, promoting and fostering prejudices and discrimination, damaging reputation, creating conflict with peers, fellows, relatives or loved ones or breaking community ties. The ultimate objective, as in classical torture, would be to change the identity, attitudes or behaviours of the targeted person and break their will. These are working definitions that need to mature further, as research and knowledge develops.

A particular challenge relates to the role of the state in ICIT. Indeed, a state's passivity or lack of due diligence, when acting against recurring and known patterns of digital violence, especially those affecting socially discriminated groups such as women or social or politically-motivated activists, facilitates ICIT's alignment with the classic definition of torture or ill-treatment. In her 2018 report, the United Nations Special Rapporteur on the issue of violence, its causes and consequences, stated that the duty of due diligence to prevent, investigate and punish sexist violence, extends to the digital world (UN Human Rights Council, 2018).

**Medical and Psychological Impacts.**

Although there are no studies on the level of psychological pain that ICIT can entail, future studies in this new field must consider at least three sources of suffering: (a) direct effects: fear, shame, guilt, helplessness or rage, leading to anxiety, depressive or somatisation disorders (b) indirect effects: the cognitive and emotional burden of being forced to devote time and energy to prevent and counteract such acts (i.e. to defend reputation publicly, assess danger and implement eventual security measures or to try to circumvent surveillance and control) (c) psychosocial effects: impact on family, interpersonal relationships, workplace and social networks (i.e fear, detachment, polarisation, rumour spreading…).

The closest reference in academia is cyberbullying[2], and digital dating abuse[3], although the severity of threats, danger and degradation is not comparable to that of ICIT and there is no consensus on the role of the state. A recent European Transnational Study with more than 5000 respondents found three profiles of emotional consequences: 5% of teenagers showed severe emotional damage to cyberbullying including suicidal tendencies; for 75% of teenagers, there were moderate symptoms of anxiety or depression that disappeared with time and 20% cyberbullying had no major impact on them (Ortega et al., 2012). A review of the specific relationship between suicide attitudes and cyberbullying using studies from 1997 to 2018, found that those who experience cyber victimisation are at two to three times more risk of committing suicide[4] depending on personal and social vulnerability factors that themselves would necessitate further exploration (John et al., 2018). Although these are

2 There is no consensual definition of bullying and cyberbullying. For a review of definitions see Gleeson (2014). Bullying is defined as *ongoing harmful behaviour in relationships with power disparities*. Cyberbullying is referred to the use of communication technologies for bullying.

3 Digital dating abuse is defined as *the use of verbal, physical and sexual aggression by an intimate partner*.

4 OR 2.35 (95% CI 1.65-3.34) times as likely to self-harm, OR 2.10 (95% CI 1.73-2.55) times as likely to exhibit suicidal behaviors and OR 2.57 (95% CI 1.69-3.90) times more likely to attempt suicide

indirect data obtained from a population comprising different ages and in different contexts, it highlights the immense mental suffering that Internet and Communications Ill-treatment and Torture can entail.

Certain organisations track internet-related violence specifically as a form of gender-based violence (Barrera & Rodríguez, 2017; Serra, 2018; Van Der Wilk, 2018). Especially relevant is the work of Colectivo Luchadoras ("Fighters Collective") from Mexico (Barrera & Rodríguez, 2017); a feminist group that has collected and analysed hundreds of internet incidents and propose 13 categories that could serve as a good point of departure for the academic study of ICIT (table 1).

There is also a similar classification developed by the Internet Governance Forum (IGF, 2015).

Summarising table 1, the Internet Governance Forum and the Council of Europe documents, we can consider four main situations: (a) Coercion, threats, and intimidation; (b) Surveillance, monitoring, and control in real-time; (c) Theft of sensitive information; (d) Defamation and public degradation.

In terms of analysis, and from a psychological perspective, conditions (a) and (b) are fear-producing actions, and (c) and (d) target identity.

**Essential elements to understand Internet and Communications related-violence as ill-treatment or torture.**

We have defined internet related violence. Now, we turn to the subject that suffers this violence and to a new phenomen: the difficult to define new identities.

**Internet-based identities.**

ICIT has peculiar characteristics that derive from attacks on new forms of identity created through the internet, the exact definition of which is still subject to debate. *Digital identity* is defined as that which a person creates on the internet by constructing a way of presenting him or herself in the virtual community (Gonzales & Hancock, 2011). A related concept is *Information Technology (IT) identity*, as the extent to which an individual views IT as integral of a person's sense of self -as both a new type of material identity and an integral part of the self (Carter & Grover, 2015). There is however, an even more under-researched identity: the identity that others (including the state) create of us. When others (including the state) create and spread information about us, inaccuracies blend seamlessly with the truth, the totality of these elements making up the image others have of us (our "digital identity"). Anyone carrying out a web search will be unable to distinguish true elements from those that may be defamatory and will likely make conclusions based on the totality of what is found. Our digital identity is, as a result, almost impossible to control. The higher the levels of exposure, the higher the risks of losing control. It is not surprising that those growing up in the era of new technologies, who are much more conscious of their new digital identity, devote time to carefully construct their *digital self.*

Furthermore, amongst consistent users of social networks (as is the case with many human rights activists), there is a dialogical effect: the internet constitutes a distinctive "looking glass" that modifies one's identity (Zhao, 2005) and research shows that the more it is used, the more vulnerable a person is to what others say about them (Manago, 2014). Stigma in the form of a permanent digital footprint is arguably more difficult than ever to escape. The internet has become a digital prison (Lageson & Maruna, 2018) by producing a lasting mark of shame through messages, comments, videos and/or pictures. That is very difficult to delete.

**Table 1.** *Mapping Internet and Communications attacks*

1. **Unauthorised access (tapping) and monitoring access.** Password theft, spyware; intervention/ tapping devices; equipment theft; locking user access; phishing[1], virus infection; key loggers[2].
2. **Control and manipulation of personal information.** Deleting, changing or falsifying personal data (photo or video); taking photos or video without consent (not necessarily with sexual content); controlling accounts on digital platforms.
3. **Spoofing and Identity Theft.** Creation of false profiles or accounts; usurpation of a personal website with name or data referring to the individual; impersonating an individual , including using your account to communicate; theft of identity, money or property.
4. **Monitoring and Cyberstalking.** Surveillance or hidden cameras, location identification employing images; geolocation on equipment /cellular or notifications; cyberfollowing; cyberstalking[3].
5. **Discriminatory statements.** Abusive comments; discrimination against various groups, electronic insults; discriminatory media coverage.
6. **Harassment.** Stalking; waves of group insults; messages from strangers; repeated messages; sending unsolicited sexual pictures.
7. **Threats.** Messages, images or videos with threats of physical or sexual violence
8. **Dissemination of personal or intimate information without consent.** Sharing private information (doxxing[4]); exposure of sexual identity or preference that generates risk (outing); dissemination of intimate or sexual content without consent; disclosure of privacy.
9. **Blackmail.** Sextorsion[5].
10. **Discrediting.** Dissemination of content; smear campaigns; defamation; disqualification.
11. **Technology-related sexual abuse and exploitation.** Deceiving for purposes of trafficking; sexual abuse; grooming[6].
12. **Attacks to channels of expression.** Removal of profiles or pages on social networks; DDOS attacks[7]; restrictions of use domain; domain theft; blackouts (from the state or company) during a meeting or protest or from a provider
13. **Omissions by actors with regulatory power.** Lack of regulation or implementation of protection measures related to messages, images or videos with threats of physical or sexual violence.

1 A technique that seeks to trick people into infecting and/or stealing information from a digital device.
2 Keylogg: Software or hardware that can intercept and save keystrokes on the keyboard of an infected computer.
3 The use of digital technology devices, or online activity, to monitor a person and to use the information harvested to harass or intimidate him or her online, to monitor his or her physical movements, or to capture him or her at a specific geographical location.
4 Doxxing: An abbreviation of the phrase "dropping docs," which refers to the act of sharing someone's personal details with others online, in particular a physical address or personal identification documents, such as a form of bullying or harassment.
5 Sextorsion: The use of intimate images or personal information as a form of coercion for sexual exploitation or blackmail
6 Grooming: The use of social networks to deliberately cultivate an emotional connection with minors for the purpose of sexual abuse or exploitation
7 DDOS attack: DDoS- Distributed Denial of Service – a malicious attempt to create massive traffic, resulting in temporarily or indefinitely disrupting service of a host connected to the internet

Internet and Communications Ill-treatment and Torture aims to provoke silence (Basak et al., 2019), but psychological and psychosocial mechanisms that operate between victims and perpetrators and between both and the wider digital community is also a field of academic research in its infancy. Anonymity and the search for popularity play a hitherto mediational role in these mechanisms. As an example, a recent study showed that a vast majority of shamers on Twitter shamed the victim and not the perpetrator. Shamers' follower counts also were seen to increase faster than that of the non-shamers, showing that shamers could easily be enticed to do so if their actions are validated by others (Basak et al., 2019). The mechanisms operating in the physical world are not the same that operate in the digital world. This was seen in a visionary manner by Guy Debord (1967/1995) in *The Society for Spectacle*, a book written before the digital era but essential to understanding some of the paradoxical destructive dynamics of the digital world.

## Physical world

Outside of the context of the internet, the challenges are also vast. We live in what has been labelled a "post-privacy" world (Busch, 2019). Human beings are permanently exposed to scrutiny. Computers record personal interests, searches, purchases, sexual perversions or political ideology; gadgets capable of playing music and informing us of the weather are also capable of informing others of our preferences and conversations; phone applications access our photographs and videos; GPS and cameras inform on who we are and where we are; surveillance cameras in streets, banks and buildings can trace our paths and who we talk to or even what we say; credit cards and shopping apps record our steps and our tastes, while aerial cameras and drones allow tracking of individuals even in the middle of crowds. No news or event takes place, even in the most remote of places that is not recorded on smartphones, uploaded and viewed worldwide within a few hours, while Periscope, Instagram or Facebook also broadcast our lives. This is part of what big data analytics will provide to governments and private companies. It can however, also be used against individuals.

The power of big data analytics for social control is exemplified by the recent scandal involving the use of millions of Facebook profiles by Cambridge Analytica in London, to create psychological clusters of voters that were latterly used to further Donald Trump campaign[1]. Linked to this is the new academic branch of neuro-politics that studies how to control and direct voters by studying public and private brain responses to political stimuli (Rose & Abi-Rached, 2014; Schreiber, 2017).

## Torture and ICIT

From a moral and ethical point of view, torture is defined relationally. It is grounded in concepts of *autonomy, control, and free will*. For philosophers and specialists in ethics, torture is a relationship between two human beings characterised by a violation of dignity and understood as a lack of recognition and respect, and a violation of autonomy, expressed by the absolute power, control and imposition of the will of the perpetrator, and the lack of control, powerlessness and suppression of the free will of the victim (Koenig, 2013; Luban, 2009; Maier, 2011; Parry, 2003; Pollmann, 2011; Scarry, 1985; Sussman, 2006).

When developing the idea of torture as related to dignity and humiliation, and the absolute repression of free will, most philosophers conceive of a one-to-one relationship between

1 https://www.nytimes.com/2018/04/04/us/politics/cambridge-analytica-scandal-fallout.html

perpetrator and victim. The torturer aims to break the victim by, among other elements, attacking the victim's identity through fear and humiliation, which in turn produces emotional pain and suffering. In psychiatry however, humiliation is conceptualised as an interpersonal emotion. Torture survivors often have long-lasting feelings of humiliation and can perfectly recall the event or series of events when this humiliation was provoked by the perpetrator(s) and indelibly engraved in their memory.

Internet and communications-related violence acts exactly on these same two essential points, but with very particular distinctions.

1. *Fear is unspecific*. For the psychological study of fear as an emotion, there are two very distinct phenomena. Fears that are related to concrete and visible threats (i.e. an animal attacking the person) and fears related to invisible, unpredictable or unknown threats (i.e being confined in a dark place). While visible and predictable threats allow for some sense of control, invisible and unknown threats induce helplessness and despair (Hopper & Hidalgo, 2006; Phillips, 2011). ICIT is a modality of torture that (a) does not require the physical presence of a perpetrator, and in which (b) the perpetrator is quite often anonymous or behind a hidden or false identity[2]. Furthermore, both elements make it more difficult to demonstrate the link of the perpetrator with state actors or to make evident the political or discriminatory purpose of the threat.
2. *Shame instead of humiliation.* While humiliation happens in a private space between two persons or between a person and a small group of perpetrators, broadcasting through social networks means that the attack on an individual's identity happens in the public sphere, and is thus amplified and prolonged endlessly by the almost infinite memory of internet search engines (Hodalska, 2019). It is this condition of *public debasement* that makes *shame,* and not humiliation, the core emotion. From a psychological point of view, shame is more damaging and produces more pain and suffering than humiliation. While humiliation drives to action towards the perpetrator (rage, pursue of justice, sometimes desire of revenge), shame is usually linked to inhibition, paralysis, powerlessness, helplessness, avoidance of exposure and the desire to hide and disappear (Leary & Tangney, 2012).
3. *Cruelty.* Studies in social psychology show that the two most accurate predictors of cruelty in perpetrators are anonymity and impunity (Anderson & Carnegey, 2004). Experimental models show that when perpetrators are able to act without revealing their identity, they choose the most cruel actions possible. The same occurs when perpetrators can act with impunity and where retaliation is impossible. Cruelty is also further facilitated by the way that interaction takes place on social media and by the design and format of communication, such as limitations to the number of characters in posts that tends to provoke brief insulting messages.
4. *Mediated interaction.* If the purpose of torture is to control and break will, it is

2 As a side note, according to Douglas, Harris, & Dragiewicz (2019), to understand the emotional suffering of internet-related violence, the most essential variable is Spatiality. In their view the experiences of, risk and mental health consequences faced by victim/survivors in regional, rural and remote locations or where the perpetrator might physically reach the person are entirely different from pure on-line threats and must be studied separately.

essential to be able to see the impact of torture on the victim directly. In ICIT, quite often, there is an inability to see a victim's reaction (i.e. regarding threats to life). This can either protect the victim or trigger escalation. But there are also contexts in which visibility is clear and immediate; the victim's reaction is especially visible on the internet either through the violence that the victim explicitly shows as a reaction, or because the Internet community can perceive that the person attacked reduces online presence, maintains a "low profile", avoids interacting with certain profiles, loses followers or begins to be targeted by more and more parties.

5. *Permanent stress.* In ICIT, the perpetrator often has 24 hours uninterrupted access to the victim. The victim may engage in frequent checking behaviours with exponential anxiety and feelings of fear. Furthermore, each time violent or controversial content is reactivated, the trauma is also reactivated. Not knowing when the controversy may be revived generates a great deal of helplessness and a sense of vulnerability. It may also occur at a time when the victim is ill, emotionally fragile or facing other personal challenges, or equally at a time of professional growth that may suffer detriment as a result.
6. *Multiplicity of aggressors*. The impact of digital violence often does not originate from a single source. Instead, we witness either a snowball phenomenon with the multiplication of an initial violent content, or an organised collective attack in which the victim is confronted with the ripple effect of being violently targeted from different online profiles, at the same time and for the same reason. These two dynamics increase the feeling of helplessness, the inability to activate personal resources and the loss of self-esteem to the extent that it may irreversibly damage self-perception and identity.

These are six very specific and peculiar elements that make ICIT a condition liable to produce very severe pain or suffering, deserving specific studies from academia that have, at the time of writing, not yet been explored.

## From theory to practice: ICIT cases

### Threats and punishment

A nurse works in the health center of a rural community or a peripheral neighborhood. She provides clinical care to everybody in her community, including injured demonstrators who are participating in protests against the government. Some of her neighbours whose ideology aligns with the government inform the authorities, and she is, sometime in the future, made redundant by her employer. The government - like most current governments - has an agency that specialises in network monitoring and control. They soon find her presence on Facebook and in WhatsApp groups that disseminate, among other things, news they deem to be anti-government. She is thus put on a blacklist and considered an enemy of the state. Using false or anonymous IP addresses, the government agency floods other social networks connected to her (in particular her Twitter and Facebook family contacts), and networks akin to the government with messages that present her as a terrorist, as an anti-patriot and a danger to the community. They also reveal information to the media of an intimate or deeply humiliating nature from her time at university; something she thought that belonged to the past. The message is widely distributed and includes photos in which she is easily recognisable. A photo collage makes her appear to be holding a small weapon – which

she is not. As a consequence, pro-government groups begin to harass her, both inside and out of her new workplace through threats, insults or paintings on walls reproducing Twitter messages. She is terrorised, and despite her initial resistance and her efforts to delete all her social media accounts, the campaign becomes widespread and all her family and peers circles take positions on what they understand to be her ideological and personal viewpoints. She soon begins to think that there is a risk of direct physical aggression by organised groups, and eventual arrest by authorities. She is recognised by some patients in her new workplace, and internet messages spread information about the place where she is now employed. There are letters of complaint and finally the private institution where she works, decides to avoid public image problems and eventual problems with the government and makes her redundant. Emotionally exhausted, she does not know what do, and enters into a depressive state with a mixture of real and overvalued symptoms of persecution: it is impossible to distinguish, for her, true and imaginary danger. Countering the social media campaign is extremely complex. She first decides to restrict her movements to a minimum and stay at home except for essential trips outside. After some time, she moves to a different town. Shortly after, when she also receives death threats through phone messages in her new location, she takes the painful decision to go into exile.

This case is not fictitious. She is "H," a nurse working in Nicaragua. Many more cases of a similar nature are reported in other countries, especially concerning journalists[3] and human rights defenders, but quite often also normal citizens who are not even involved in political activities and are simply carrying out their jobs. H never saw her aggressor and never knew the true nature of the danger she faced. She was publicly accused, mocked and debased and was unable to identify the origin of the violence. There was effectively no need even to detain her, to produce severe psychological pain or suffering and to intimidate and coerce her.

A recent case study in Indonesia, Colombia, and Kenya (NDI, 2019) identified the widespread practice of hate speech, embarrassment and reputational risk, physical threats, and sexualised distortion of content targeting women activists, as dominant forms of threats and punishment.

Between December 2016 and March 2018, Amnesty International (AI) conducted qualitative and quantitative research on women's experiences of threats, violence, and abuse on Twitter. Their poll in 8 countries interviewed women and non-gender binary individuals (Dhrodia, 2018). The research highlighted the particular experiences of women of colour, women from ethnic or religious minorities, lesbian, bisexual or transgender women, non-binary individuals, and women with disabilities, to demonstrate the intersectional nature of threats, debasement, and abuse (Amnesty International, 2018). The research found that women, more often than men, were the target of threats of murder, rape, physical violence and graphic imagery via email, comment sections of newspapers and across all social media. As of 16 March 2018, Amnesty International had met with the Twitter CEO on three separate occasions to obtain a clear policy from the site, and, at the time of publishing the report, had not re-

3 https://www.elsalvador.com/eldiariodehoy/periodistas-instan-a-gobierno-no-ignorar-acoso-en-redes-sociales/625770/2019/

ceiving a satisfactory answer. There has been some progress since then[4].

On 27 January 2017, Ugandan human rights activist, Dr. Stella Nyanzi, wrote a post on Facebook in which she dubbed the Ugandan president 'a pair of buttocks' (Rukundo, 2018). The message was widely reproduced and as a consequence, she was then subjected to various forms of public internet threats by state agents that limited her activity. In spite of that, the threats culminated in her arrest on 7 April 2017. She was charged with cyber harassment and offensive communication contrary to sections 24 and 25 of the Ugandan Computer Misuse Act (CMA), which is vague legislation developed to restrict freedom of expression and political dissidence in the country. She was sentenced and jailed.

### ICIT: Shame

Nelson Julio Alvarez, known as Nexy J. Show, a Cuban LGBTIQ activist and YouTuber, was detained by the Cuban Security Services, who seized his digital devices including his computer and mobile phone. During the weeks that followed, they replaced his identity on social networks for the purpose of public denigration[5]. Ezequiel Fuentes, another Cuban LGBTIQ cyber activist on Facebook was also the target of a widespread defamation campaign in which alleged members of, or collaborators with, the Ministry of the Interior publicly revealed private information including his relationships, as well as his health records[6]. Alvarez was targeted through identity theft and humiliation and Fuentes through defamation. Both were painfully forced to reduce their online presence.

In an interview, UK journalist Nosheen Iqbal, often the target of internet attacks, emphasised the role of "followers" in internet violence; an uncritical mass of people who are ready to denigrate a person and reproduce the attitude of very aggressive ideological opinion makers. After writing opinion pieces, Iqbal experienced systematically that after certain individuals made deeply offensive comments in the mass media, swaths of others followed in what seemed to be a well-orchestrated strategy (Mijatovic, 2018).

### Threats, shame and post-truth environments

Freedom on the Net is an international database that collates and analyses situations of manipulation of news fora, opinion groups, harassment and online attacks on human rights defenders. Their reports include a long list of countries that infiltrate so-called *trolls*[7] in discussion forums to manipulate and direct their content. Venezuela, the Philippines and Turkey are relevant examples among 30 countries where governments were found to employ armies of "opinion shapers" to create hegemony for government-supported viewpoints, drive particular agendas, and counter government critics on social media (Freedom House, 2017). In Turkey, for instance, the report describes *AK Troller*, or *White Trolls*, a group pertaining to the ruling Justice and

4 https://blog.twitter.com/en_us/topics/company/2019/hatefulconductupdate.html

5 https://www.washingtonblade.com/2019/10/24/policia-detiene-al-yutuber-cubano-nexy-j-show/

6 https://adncuba.com/noticias-de-cuba-derechos-humanos/lgbtiq/ciberbullying-contra-comunidad-lgbtiq-cubana-homofobia.

7 On the Internet a 'troll' or 'hater' is a user who intentionally seeks to provoke, offend or impoverish the conversation within an online community, such as a blog, forum or social network profile. See also the discussion on *Corporate, political, and special-interest sponsored trolls* in https://en.wikipedia.org/wiki/Internet_troll

Development Party and which is government funded. Some 6,000 people have allegedly been recruited by the party to monitor and manipulate discussions, drive specific agendas, and counter government opponents on social media (Freedom House, 2017).

These organised groups create *fake news* that are accepted in an uncontested way by an often uncritical mass of the population (Lazer et al., 2018). Such widespread situations of creating *parallel worlds* have given rise to a new field of knowledge in social psychology and sociology: *post-truth environments* or a *post-truth society*. These are defined as contexts in which people are more likely to accept arguments based on emotions and beliefs rather than those based on facts (Bunce, 2019; Harsin & Harsin, 2018). Lies and falsehoods or manipulated statistics are easily accepted by public opinion in as much as they support the desired emotions. A person or an organisation can be the target of a post-truth emotional environment. Internet followers can, in the same way, react to emotional slogans in environments of political polarisation without further reflection.

### On the peripheries of torture: controlling human beings through the net

Until this point, we have described elements of the psychological foundations of internet and communications ill-treatment or torture, with various examples. The internet is about empowering individuals by providing access to information. At the same time however, it is becoming more and more a place where both state and private companies alike gather personal information that can potentially be used for intimidation and control, including surveillance of movements, acts and opinions. This can be linked, as far as the individual is aware, to the production of emotional suffering or pain for the purposes suggested by the Convention against Torture. We will review some of these additional facets in the second part of the paper.

### Surveillance and control of human right groups and political activists

The European Court of Human Rights recently published a Fact Sheet on Mass Surveillance[8] with case law from Germany, UK, Russia and Hungary among other countries (ECtHR, 2019). They were selected relevant cases that violated Article 8 (right to respect for private and family life, home and correspondence) of the European Convention, including the *Big Brother Watch and Others v. the United Kingdom* (nos. 58170/13, 62322/14 and 24960/15) after the revelations by Edward Snowden regarding programmes of surveillance and intelligence sharing between the USA and the United Kingdom. The case concerned three types of surveillance conducted by the Government Communications Headquarters, or GCHQ, Britain's signals-intelligence agency: (a) bulk interception of communications under the TEMPORA program; (b) intelligence sharing and receipt in collaboration with the PRISM and Upstream programs run by the National Security Agency (NSA) and (c) the obtaining of communications data from service providers. It was the first ruling against Britain's mass-surveillance programmes since Edward Snowden's 2013 revelations[9].

Russia is an example of a country where internet usage is under full control by the state and surveillance is widespread. All cryptographic systems except those licensed by the Federal Security Service of the Russian Federation (FSB) are forbidden. All internet provid-

8 https://www.echr.coe.int/Documents/FS_Mass_surveillance_ENG.pdf

9 For a full discussion of the hearing see https://www.lawfareblog.com/summary-big-brother-watch-and-others-v-united-kingdom

ers must install a software named SORM that allows filtering and remote control of internet traffic[10]. A special unit of the Secret Services is devoted to surveillance and internet control (HRW, 2017). In September 2017, WikiLeaks released "Spy Files Russia," confirming how state entities had full access to detailed data on Russian internet and cellphone users by its citizens as part of SORM[11]. Amongst many examples, when the Crimean journalist Mykola Semena was detained and sentenced for crimes against the state, the Russian Secret Service had full control over his computer.[12]

The British organisation Privacy International maintains a database and updated information on the systems of surveillance and control of groups and activists in different countries of the world[13] including persons from the anti-torture movement. It also maintains a Surveillance Industry Index[14] with detailed information of hundreds of companies offering internet monitoring and surveillance services to governments, armies, military institutions, and private companies. Many of their activities are manifestly illegal and target the control of and threat to citizens, and especially political dissidents and human rights activists.

The United States Federal Bureau of Investigations (FBI) uses control and monitoring mass surveillance systems. A report by Privacy International (2018) has documented infiltration and troll activities in the Facebook anti-torture group Mass Action Against Police Brutality. Privacy International also revealed the existence of an FBI document mapping social networks of peaceful climate change activists which includes both names and other personal data[15].

A recently leaked document published in US newspapers showed the existence of a secret database shared by different US security agencies to track activists, lawyers and human rights defenders travelling to the Mexico-USA border to help migrants[16]. Furthermore, LookingGlass Cyber Solutions, a private company hired by US Homeland Security gathered personal information on the internet of around 600 persons who had participated in demonstrations against Trump's migrant family separation process in 2018[17], a US practice that is considered by some scholars as torture (Gray, 2019).

The Israel based company Cellebrite offers the Universal Forensic Extraction Device (UFED) designed to retrieve chat logs, texts, and other data from phones, in some cases bypassing PIN codes or passwords[18]. A recent report[19] showed, for instance, its use in extracting information from Mohammed al-Singace, a Bahraini political activist who was later detained and tortured in custody. Cellebrite offers, among other services to governments, the tracking of phone cells of asylum seekers to obtain information, through their GPS records, regarding which countries they have visited since leaving their countries of origin and challenge asylum claims as non-credible

10 https://en.wikipedia.org/wiki/SORM
11 https://wikileaks.org/spyfiles/russia/
12 https://www.bbg.gov/wp-content/media/2017/02/Mykola-Semena%E2%80%94Fact-Sheet-2017.03.16.pdf
13 www.privacyinternational.org
14 https://sii.transparencytoolkit.org/
15 https://www.theguardian.com/us-news/2018/dec/13/fbi-climate-change-protesters-iowa-files-monitoring-surveillance-
16 https://www.nbcsandiego.com/news/local/Source-Leaked-Documents-Show-the-US-Government-Tracking-Journalists-and-Advocates-Through-a-Secret-Database-506783231.html
17 https://theintercept.com/2019/04/29/family-separation-protests-surveillance/
18 https://www.cellebrite.com/en/product/
19 https://bahrainwatch.org/amanatech/en/investigations/cellebrite

based on this data. According to journalist research, many European countries, including Germany, the UK and Austria use Cellebrite services as evidence to deport migrants[20].

A well-known case of surveillance software usage is that of Pegasus[21], the programme that came to light when R3D, a Mexican human rights organisation protecting freedom of expression discovered its systematic use by the government to spy on journalists and activists who were later targeted, some of them suffering threats, defamation, kidnapping or torture (R3D, 2017). The software consists of malware that infects Apple iPhones through a WhatsApp message or a failed phone call. The attacker has access to everything in the victim's device: email, messaging services, camera, and microphone. The software is manufactured by the Israeli company, NSO Group. On its website[22] the company claims to sell the tool exclusively to governments on the condition that it is only used "to combat terrorists" and notes that the software has saved "thousands of lives." The software is sold also to private companies and contractors through reseller companies such as Hacking Team. According to R3D, the government is billed around 75,000 euros per successfully controlled telephone. A report by the *Red en Defensa de los Derechos Digitales* (Network for the Defense of Digital Rights) evidenced that the software was acquired by the Mexican Army in 2012 and by the office of the Attorney General (PGR) in 2014. An impressive series of studies show how the use of Pegasus has been an essential element in the murdering of journalists and for targeting politicians, lawyers and opponents in Mexico.[23]

A research center, Citizen Lab[24] based at the University of Toronto, produces regular reports and provides advice against such practices. It has detected the use of Pegasus in 45 countries and other similar software in almost all countries[25].

### Social control of population

Although beyond the scope of this review, we would also at least mention the three most well- known methods of social control of the population amongst those of which civil society groups are aware.

- *International Mobile Subscriber Identity (IMSI) Catchers*. This is a device that connects to mobile phones in a particular area and can, among other things, provide the exact location of the user, build a network of all the numbers with which the person makes contact, as well as the successive contacts of those contacts; block or intercept data; access the content of calls, text messages and web sites visited or send intimidating anonymous messages to other mobile phones[26]. As a counter-response effort, there

20 https://www.wired.co.uk/article/europe-immigration-refugees-smartphone-metadata-deportations
21 https://en.wikipedia.org/wiki/Pegasus_(spyware)
22 https://www.nsogroup.com/
23 https://citizenlab.ca/2018/11/mexican-journalists-investigating-cartels-targeted-nso-spyware-following-assassination-colleague/
24 https://citizenlab.ca/
25 Hacking Team owns another malware, also allegedly to detect terrorists, that, according to an exhaustive report by Derechos Digitales is employed by almost all governments in Latin America to control political opponents, journalists and human right defenders (Perez de Acha, 2016). The report considers that such software has spread rapidly because secret services from governments in the region have cooperation programs and share both technologies and databases.
26 https://www.eff.org/wp/gotta-catch-em-all-understanding-how-imsi-catchers-exploit-cell-networks

are different free mobile apps that allegedly detect IMSI catchers.

- *Facial recognition systems*. These capture detailed images of the participants in meetings or demonstrations with high-resolution cameras located in very distant places or inside drones. These are compared by the police with photographs of citizens and cross-referenced with databases to identify individuals of concern. Its use is being questioned by civil society organisations (Ruhrmann, 2019) and it seems there are plans for a European Union strict regulation[27]. In a counter-response effort, the Center for Human Rights Science at Carnegie Mellon University has developed a tool that can collate video recordings made with smartphones by demonstrators to produce an account of police brutality (Aronson, Cole, Hauptmann, Miller, & Samuels, 2018). Different governments have counter-reacted with legislation that forbids the use of smartphones during demonstrations and imposes severe fines if police are recorded, including confiscation of the phone[28].
- *Social media intelligence* - often shortened to SOCMINT - refers to the massive monitoring and gathering of information posted on social media platforms. These are software systems that are capable of downloading an entire website, forum or communications within a group, monitoring a citizen's social networks and accumulating evidence against them.

In June 2019, in Egypt, amid the most repressive period for decades, the government-linked El Watan newspaper published a leaked Interior Ministry tender document inviting software companies to contribute to the development of an open-source intelligence system called the "Social Networks Security Hazard Monitoring System." It would monitor Facebook, Twitter, WhatsApp and Viber in real-time for usage that might "*harm public security or incite terrorism*." It would also screen content for "*vocabulary which is contrary to law and public morality.*" According to Wikithawra[29], an independent monitoring group, at least 76 people have been detained so far this year in Egypt for offenses related to "online publishing."[30]

Such great interest in controlling users via the internet is not surprising. For certain authors, the so-called Arab Spring is an internet-based movement lead by a new young generation (Cole, 2014). Egypt, Tunisia and Libya were, amongst others, examples of countries where new technologies harnessed the internet to organise nationwide protests on designated days and to delegitimise the regime with videos of police torture and exposing government corruption[31]. The murder of Khaled Said in Alexandria, after he was beaten to death in public, by plain-clothes police officers, in front of witnesses, is a good example. Autopsy photographs of his badly battered face were circulated immediately on the internet, provoking both widespread demonstrations and vigils – many of which were organised and announced on Facebook and Twitter. The Facebook group "We are all Khalid Said" later became a hub for activists and a source of information for the population[32].

27 https://euobserver.com/science/145707
28 https://blog.witness.org/2015/07/film-the-police-not-in-spain/
29 https://wikithawra.wordpress.com/
30 https://www.csmonitor.com/World/Middle-East/2014/0630/Citing-terrorism-Egypt-to-step-up-surveillance-of-social-media
31 http://misrdigital.blogspirit.com/
32 There is there a complex double-sword: internet can help in the fight for freedom, but it is at cost of enormous risks for those involved. Egypt's 2011 uprising early demonstrations

### Broadcasting torture to produce collective fear and terror

*Occupy Paedophilia* is the name given to groups of ultra-nationalist Russian neo-Nazi youths who have made a name for themselves by publishing videos in which they torture young members of the LGBTI community. The groups use targeted dating apps to organise meetings with individuals under the pretense of a "date," who are then filmed while being humiliated and beaten. At least in one case, the torture ended in death. In mid-2013, the first videos and photos began to appear on YouTube and the social network VK.com, a Russian equivalent to Facebook. The members use VK to create cells. At its highest peak, there were around 500 cells of 8 to 10 members, distributed in cities all around Russia. Although their stated goal is to locate paedophiles, the videos of the victims are of LGBTI teenagers or young adults, who are tortured and beaten, and during which their sexual orientation or gender identity is revealed to family, friends and their wider communities. For several years, the Russian state, which had enacted several laws against so-called "gay propaganda," did not act against them despite having their members identified and appearing in newspapers and TV, providing relative impunity for these acts (Wilkinson, 2014). It was also coincident with Russia's actions at the Human Rights Council in pushing for a wide margin of appreciation when dealing with "traditional values." A group that imitated Occupy Paedophilia was created in Barcelona in 2013. In December 2019, its members were convicted of a crime against moral integrity and disclosure of secrets with aggravating circumstances of superiority and homophobia, after they had orchestrated meetings with gay men through dating apps with pretenses of romance or sexual intentions. Instead, the group collectively ambushed their targets in order to humiliate them, record their actions and spread videos publicly. In 2018, Sudan's security services tried to undermine growing popular protests by apprehending a group of students in Darfur, torturing them brutally until some "admitted" to producing bombs to pursue violent intent in the name of militia groups in Darfur, and spreading false confession video-recordings on Facebook and state television (Carmichael & Pinnell, 2019). Contrary to what was expected, however, this attempt to create a post-truth situation lead to a popular reaction. Facebook comments disputing the validity of the confessions went viral and fuelled protests. Social media posts bearing the hashtag #WeAreAllDarfur were shared thousands of times (Carmichael & Pinnell, 2019).

### Legal initiatives to prevent and act against ICIT

In July 2018, the United Nations Human Rights Council approved a resolution on *The promotion, protection and enjoyment of human rights on the Internet* through which it encouraged State Parties to legislate on how to protect freedom in the net while at the same responding to global threats[33]. Two years prior, in 2016, the European Union institutions succeeded in forcing internet giants Facebook, YouTube, Twitter, Microsoft, and more recently Instagram, to adopt internal Codes of Conduct[34].

were organized via a Facebook page. All the organizers were detained just three days later and all followers were tracked, and many of them detained or interrogated. Not being part of these groups means not having access to information on when and where actions would take place, but accessing them presented high risk for detention, interrogation and torture (Tufekci, 2014).

33 A/HRC/38/L.10/Rev.1.

34 https://ec.europa.eu/info/policies/justice-and-

These provide for various commitments, and require companies to implement clear and effective procedures for examining complaints regarding hate speech, so that access to such content can be withdrawn or disabled within 24 hours. According to the fourth evaluation of the application of this code in February 2019, its implementation had succeeded in eliminating 70% of content identified as being hate speech. Google has allegedly tried to control the manipulation of forums and the use of hate speech through Perspective[35], an app that detects such practices and which can also be used by social organisations. There are not many examples of case law. Quite noticeably, on 14 January 2020, in the case of Beizaras and Levickas v. Lithuania, the European Court of Human Rights ruled against the State on the basis of discrimination, violation of family and private life, and lack of access to effective remedies, for failure to properly act or investigate homophobic hate speech on Facebook against an LGTBI activist.

### Forensic and legal considerations

We have described situations in which a state causes or does not prevent nor put a stop to the intentional infliction of severe psychological suffering of a citizen to achieve coercion, humiliation or punishment without the need to resort to physical violence. How this suffering is distinct from those of traditional torture is a largely unexplored field. Medical and psychological research must support legal efforts to regulate these complex and multifaceted situations.

Online ill-treatment and torture must be recognised and acknowledged. The revelations by Snowden and others of the widespread practice of surveillance of citizens led to no consequences for the authorities implicated other than scandal for and prosecution of the whistleblower. According to some scholars, paradoxically, competition for citizen surveillance has in fact increased (Richards, 2019). The letters to the governments of the United States, United Kingdom, Ecuador and Sweden by Special Rapporteur Nils Meltzer regarding Julian Assange in 2019, showing forensic evidence of torture, was a landmark document that opened a path for recognition of ICIT[36].

There is a delicate line between freedom of expression and hate conduct, and public harassment that needs legal clarification. International legislation related to ICIT should consider protection measures, removal of harmful content in internet, as well as forms of restoration, rehabilitation, satisfaction assurances of non-recurrence, combining measures that are symbolic, material, individual and collective.

There is also a need for international regulations that force internet intermediary companies to guarantee data security and privacy, regulate and control companies selling spyware and hardware and software aimed to infiltration, surveillance and massive control of population. Similar to support for the control of international trade of weapons potentially usable as torture devices, comparable legislation related to the trade of software and hardware of ICIT-capable devices is also necessary.

There is additionally a need for clear regulations on government access to private information, including cloud storage systems and infiltration of personal devices without a judicial order. Anonymity or encryption is a right and it should not be suppressed, controlled or

fundamental-rights/combatting-discrimination/racism-and-xenophobia/eu-code-conduct-countering-illegal-hate-speech-online_en

35 https://www.perspectiveapi.com/#/home

36 https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=24642

restricted by any state. Humanitarian organisations must also seek greater understanding of how data and metadata collected or generated by their programs for social, political or humanitarian purposes, can be accessed and used by other parties for social control (Pirlot de Corbion et al., 2018). Organisations working with survivors have an ethical duty through the do-no-harm principle to avoid involuntarily putting people at risk of internet and communications-based torture.

Finally, a complex challenge for the medical field is how to address the specific needs of rehabilitation of survivors of ICIT, combining, as with other situations, therapeutic work in individual and collective domains, with a special focus on symbolic elements.

**In this issue**

Megan Berthold, Peter Polatin, James Lavelle, Craig Higson-Smith, Frederick Streets, Caitrin Kelly and Richard Mollica develop a Complex Care Approach (CCA) for treatment of torture victims that integrates medical, psychological, psychosocial and existential elements from a holistic perspective, and apply it to an hypothetical paradigmatic case. Rouf Khawaja and collaborators present a series of 40 cases of male victims of sexual torture in India with severe urological sequelae in defining the concept of *parrilla torture* and showing the interplay between medical and psychological sequels. Carme Vivancos and Iñaki Rivera present data from an early analysis of the safeguards in the medical examination of people detained in Catalonia (Spain) in the framework of civic protests. The analysis serves as a reminder that the ethical principles of the Istanbul Protocol must be respected in all circumstances. Their data evidences a request for more thorough investigation by the Spanish authorities. Sexual conversion therapies are still common practice in many countries around the world as a recent IRCT report has shown. The Independent Forensic Expert Group has been working over the past two years on an analysis of these practices as a form of ill-treatment or torture. The reader will find a landmark document: the group's latest Statement with the conclusions and recommendations to the international legal and medical communities.

Johan Lansen, one of the great European figures of the 20th century in the work with torture survivors, from his own experience as a Holocaust survivor, passed away in November 2019. Torture Journal reprints, as a posthumous tribute, the article that he published in the Journal of Medical Ethics more than 15 years ago with personal reflections on the ethical dilemmas of working with perpetrators. This is a brief but extraordinary contribution that we are honoured to rescue.

We are living in times of a global crisis of unknown magnitude. The world has had much experience of wars in which humans have fought against each other. It is the first time however in the contemporary age in which the world defends itself from a common enemy, and when the element that should unite humanity, that difficult to define concept that we call the human condition, is globally challenged. From the Journal we are compiling initiatives or situations to provide perspectives on the current pandemic and the work with torture survivors. You can send us contributions (papers, reflections, reviews or news). In addition, continuing with the regular work of the journal throughout this year, three specific Special Sections are planned: Physiotherapy in the rehabilitation of torture victims, work with victims in contexts of active and continuous violence, and forced disappearance as a form of torture. The Calls for Papers can be found on the Journal's website. We look forward to your contributions.

*References*

Amnesty International. (2018). *#ToxicTwitter: Violence and abuse against women online*. https://www.amnestyusa.org/wp-content/uploads/2018/03/Toxic-Twitter.pdf

Anderson, C., & Carnegey, N. (2004). Violent evil and the General Agression Model. In A. G. Miller (Ed.), *The social psychology of good and evil*. Guilford. New York.

Aronson, J. D., Cole, M., Hauptmann, A., Miller, D., & Samuels, B. (2018). Reconstructing human rights violations using large eyewitness video collections: The case of euromaidan protester deaths. *Journal of Human Rights Practice*, *10*(1), 159–178. https://doi.org/10.1093/jhuman/huy005

Barrera, L., & Rodríguez, C. (2017). *La violencia en línea contra las mujeres en México. Informe para la Relatora sobre la Violencia contra las Mujeres MS. Dubravka Simonovic*. Internet Es Nuestra. www.Internetesnuestra.mx

Basak, R., Sural, S., Ganguly, N., & Ghosh, S. K. (2019). Online Public Shaming on Twitter: Detection, Analysis, and Mitigation. *IEEE Transactions on Computational Social Systems*, *6*(2), 208–220. https://doi.org/10.1109/TCSS.2019.2895734

Bunce, M. (2019). Humanitarian Communication in a Post-Truth World. *Journal of Humanitarian Affairs*, *1*(1), 49–55. https://doi.org/10.7227/jha.007

Carmichael, F., & Pinnell, O. (2019). How fake news from Sudan's regime backfired. *BBC News*, pp. 1–10.

Cole, J. (2014). *The New Arabs: How the Millennial Generation is Changing the Middle East*. Simon & Schuster.

Debord, G. (1995). The Society of the Spectacle. *Society*, p. 154. https://library.brown.edu/pdfs/1124975246668078.pdf

Dhrodia, A. (2018). Unsocial media: A toxic place for women. *IPPR Progressive Review*, *24*(4), 380–387. https://doi.org/10.1111/newe.12078

Douglas, H., Harris, B. A., & Dragiewicz, M. (2019). Technology-facilitated domestic and family violence: Women's experiences. *British Journal of Criminology*, *59*(3), 551–570. https://doi.org/10.1093/bjc/azy068

ECHRT. (2019). *Mass surveillance* (Vol. 8). https://www.echr.coe.int/Documents/FS_Mass_surveillance_ENG.pdf

Freedom House. (2017). *Manipulating Social Media to Undermine Democracy*. https://doi.org/10.1080/00224545.1975.9923293

Gleeson, H. (2014). *The prevalence and impact of bullying linked to social media on the mental heath and suicidal behaviour among young people*. Dublin. https://assets.gov.ie/25088/59fb1e4948fc43028f931a6c1e0c8790.pdf

Gonzales, A. L., & Hancock, J. T. (2011). Mirror, mirror on my Facebook wall: Effects of exposure to Facebook on self-esteem. *Cyberpsychology, Behavior, and Social Networking*, *14*(1–2), 79–83. https://doi.org/10.1089/cyber.2009.0411

Gray, G. (2019). Disappearing refugees inside the United States. *Torture Journal*, *29*(1), 144–146. https://doi.org/10.7146/torture.v29i1.113206

Harris, B. A., & Woodlock, D. (2019). Digital coercive control: Insights from two landmark domestic violence studies. *British Journal of Criminology*, *59*(3), 530–550. https://doi.org/10.1093/bjc/azy052

Harsin, J., & Harsin, J. (2018). Post-Truth and Critical Communication Studies. In *Oxford Research Encyclopedia of Communication*. https://doi.org/10.1093/acrefore/9780190228613.013.757

Hodalska, M. (2019). Cyberbullying, Fear and Silence: From Bystanders to Cyber-Samaritans. *Perils of the Web: Cyber Security and Internet Safety*, (May). https://doi.org/10.1163/9781848885011_004

Hopper, E., & Hidalgo, J. (2006). Invisible_Chains: Psychological coercion of human trafficking victims. *Intercultural Human Rights Law Review*, *1*, 185/209.

HRC. (2018). *Report of the Special Rapporteur on violence against women, its causes and consequences on online violence against women and girls from a human rights perspective - A/HRC/38/47*.

HRW. (2017). *Online and on All Fronts. Russia's assault on freedom of expression.* Human Rights Watch. https://www.hrw.org/sites/default/files/report_pdf/russiafoe0717_web_2.pdf

IGF. (2015). *Best Practice Forum (BPF) on Online Abuse and Gender-Based Violence Against Women*. Internet Governance Forum.

John, A., Glendenning, A. C., Marchant, A., Montgomery, P., Stewart, A., Wood, S., … Hawton, K. (2018). Self-harm, suicidal behaviours, and cyberbullying in children and young people: Systematic review. *Journal of Medical Internet Research*, *20*(4). https://doi.org/10.2196/jmir.9044

Koenig, K. A. (2013). *The "Worst". A Closer Look at Cruel, Inhuman and Degrading Treatment*. University of California, Berkeley - School of Law; University of San Francisco. Doctoral Dissertation.

Lageson, S. E., & Maruna, S. (2018). Digital degradation: Stigma management in the internet age. *Punishment and Society*, *20*(1), 113–133.

https://doi.org/10.1177/1462474517737050

Lazer, D. M. J., Baum, M. A., Benkler, Y., Berinsky, A. J., Greenhill, K. M., Menczer, F., … Zittrain, J. L. (2018). The science of fake news. *Science*, *359*(6380), 1094–1096. https://doi.org/10.1126/science.aao2998

Leary, M. R., & Tangney, J. P. (2012). *Handbook of Self and Identity*. Guilford Press.

Luban, D. (2009). Human Dignity, Humiliation, and Torture. *Kennedy Institute of Ethics Journal*, *19*, 211–230. https://doi.org/10.1353/ken.0.0292

Maier, A. (2011). Torture. How Denying Moral Standing Violates Human Dignity. In E. Kaufmann, P., Kuch, H., Neuhäuser, C., & Webster (Ed.), *Humiliation, Degradation, Dehumanization* (pp. 101–118). Springer Netherlands.

Manago, A. (2014). *Identity Development in the Digital Age: The Case of Social Networking Sites.* Oxford Handbooks On-line.

Mijatovic, D. (2018). *New Challenges to Freedom of Expression: Countering Online Abuse of Female Journalists*. https://www.osce.org/files/f/documents/c/3/220411.pdf

NDI. (2019). *Tweets That Chill : Analyzing Online Violence Against Women in Politics*. www.ndi.org/tweets-that-chill

Ortega, R., Elipe, P., Mora-Merchán, J. A., Genta, M. L., Brighi, A., Guarini, A., … Tippett, N. (2012). The Emotional Impact of Bullying and Cyberbullying on Victims: A European Cross-National Study. *Aggressive Behavior*, *38*(5), 342–356. https://doi.org/10.1002/ab.21440

Parry, J. T. (2003). What Is Torture, Are We Doing It, and What if We Are. *Pitt. Law Review*, *64*, 237–249.

Perez de Acha, G. (2016). *Hacking team malware para la vigilancia en América Latina*. Santiago de Chile.

Phillips, E. M. (2011). Pain, Suffering, and Humiliation: The Systemization of Violence in Kidnapping for Ransom. *Journal of Aggression, Maltreatment & Trauma*, *20*(8), 845–869. https://doi.org/10.1080/10926771.2011.626512

Pirlot de Corbion, A., Hosein, G., Nyst, C., Fisher, T., Gerathy, E., Callander, A., & Bouffet, T. (2018). *The Humanitarian Metadata Problem: 'Doing No Harm' in the Digital Era*. (October), 130. Privacy International. https://privacyinternational.org/sites/default/files/2018-12/The HumanitarianMetadata Problem - Doing No Harm in the Digital Era.pdf

Pollmann, A. (2011). *Humiliation, Degradation, Dehumanization* (P. Kaufmann, H. Kuch, C. Neuhaeuser, & E. Webster, Eds.). https://doi.org/10.1007/978-90-481-9661-6

Privacy International. (2018). *Secret Global Surveillance Networks: Intelligence Sharing Between Governments and the Need for Safeguards*. (April), 173. https://privacyinternational.org/sites/default/files/2018-04/Secret%20Global%20Surveillance%20Networks%20report%20web%20%28200%29.pdf

R3D. (2017). *Gobierno espía. Vigilancia sistemática a periodistas y defensores de derechos humanos en Mexico*. Mexico. https://r3d.mx/2017/06/19/gobierno-espia/

Richards, J. (2019). Intelligence gathering, issues of accountability, and Snowden. In *Terrorism and State Surveillance of Communications.* (pp. 19–37). Routledge.

Ruhrmann, H. (2019). *Facing the future. Protecting Human Rights in Policy Strategies for Facial Recognition Technology in Law Enforcement.*

Rukundo, S. (2018). My President is a Pair of Buttocks': The limits of online freedom of expression in Uganda. *International Journal of Law and Information Technology*, *26*(3), 252–271. https://doi.org/10.1093/ijlit/eay009

Scarry, E. (1985). *The body in Pain*. Oxford University Press.

Serra, L. (2018). On-line gender based violence. *Pikara - Online Magazine.*, *2*(December), 227–249. Pikara Magazine. http://lab.pikaramagazine.com/wp-content/uploads/2019/06/VIOLENCIAS_EN.pdf

Sussman, D. (2006). Defining Torture. *Case Western Reserve Journal of International Law*, *37*, 225.

T-CY. (2018). *Mapping study on cyberviolence*. Council of Europe. www.coe.int/cybercrime

Tufekci, Z. (2014). Social Movements and Governments in the Digital Age: Evaluating a Complex Landscape. *Journal of International Affairs, 68*(1), 1–18. http://blogs.cuit.columbia.edu/jia/files/2014/12/xvii-18_Tufekci_Article.pdf

Van der Wilk, A. (2018). *Cyber violence and hate speech online against women* (PE 604.979). https://www.europarl.europa.eu/RegData/etudes/STUD/2018/604979/IPOL_STU(2018)604979_EN.pdf

Wilkinson, C. (2014). Putting "Traditional Values" Into Practice: The Rise and Contestation of Anti-Homopropaganda Laws in Russia. *Journal of Human Rights*, *13*(3), 363–379. https://doi.org/10.1080/14754835.2014.919218

Zhao, S. (2005). The Digital Self: Through the Looking Glass of Telecopresent Others. *Symbolic Interaction*, *28*(3), 387–405. https://doi.org/10.1525/si.2005.28.3.387

# The complex care of a torture survivor in the United States: The case of "Joshua"

**S. Megan Berthold[1], Peter Polatin[2], Richard Mollica[3], Craig Higson-Smith[4], Frederick J. Streets[5], Caitrin M. Kelly[6], and James Lavelle[7]**

**Key points of interest**

- To effectively treat torture survivors, providers must understand and address multiple and complexly related factors.
- A Complex Care Approach (CCA), an adaptation of the Chronic Care Model, is presented. The CCA includes five-domains, including the Trauma Story, Bio-medical, Psychological, Social, and Spiritual domains.

**Abstract**

*Introduction:* Torture is an assault on the physical and mental health of an individual, impacting the lives of survivors and their families. The survivor's interpersonal relationships, social life, and vocational functioning may be affected, and spiritual and other existential questions may intrude. Cultural and historical context will shape the meaning of torture experiences and the aftermath. To effectively treat torture survivors, providers must understand and address these factors. The Complex Care Model (CCM) aims to transform daily care for those with chronic illnesses and improve health outcomes through effective team care.

*Methods:* We conduct a literature review of the CCM and present an adapted Complex Care Approach (CCA) that draws on the Harvard Program in Refugee Trauma's five-domain model covering the Trauma Story, Bio-medical, Psychological, Social, and Spiritual domains. We apply the CCA to the case of "Joshua," a former tortured child soldier, and

1) S. Megan Berthold, PhD, LCSW, Associate Professor and Director of Field Education, University of Connecticut School of Social Work (and Co-Chair of the NCTTP Research and Data Project)
Correspondence to: megan.berthold@uconn.edu
2) Peter Polatin, M.D., MPH, Faculty, HPRT; Psychiatric consultant, IRC/Dallas; Adjunct Associate Professor of Global Mental Health, George Washington University; Associate Professor of Anesthesia/Pain and Psychiatry (retired) UTSW; Health Program Consultant, DIGNITY - Danish Institute Against Torture (retired)
Correspondence to: peter.polatin@gmail.com
3) Richard Mollica, MD, MAR, Director of Harvard Program in Refugee Trauma, Massachusetts General Hospital Professor of Psychiatry, Harvard Medical School
Correspondence to: rmollica@partners.org
4) Craig Higson-Smith, MA, Director of Research, Center for Victims of Torture
Correspondence to: chigsonsmith@cvt.org
5) Frederick J. Streets, M.Div., DSW, LCSW, Associate Professor (Adjunct) Pastoral Theology, Yale University Divinity School
6) Caitrin M. Kelly, MD, Massachusetts General Hospital
7) James Lavelle, LICSW, Co-Founder of Harvard Program in Refugee Trauma (HPRT)

https://doi.org/10.7146/torture.v30i1.113063

discuss the diagnosis and treatment across the five domains of care.

*Findings:* The CCA is described as an effective approach for working with torture survivors. We articulate how a CCA can be adapted to the unique historical and cultural contexts experienced by torture survivors and how its five domains serve to integrate the approach to diagnosis and treatment. The benefits of communication and coordination of care among treatment providers is emphasized.

*Discussion / Conclusions:* Torture survivors' needs are well suited to the application of a CCA delivered by a team of providers who effectively communicate and integrate care holistically across all domains of the survivor's life.

*Keywords:* complex care approach, five-domain model, torture survivors.

## Introduction

Torture is an assault on the physical and mental health of an individual, typically having an impact on multiple domains of the lives of survivors and their families. The survivor's interpersonal relationships, social life, and vocational functioning may be affected, and spiritual and other existential questions may intrude. His or her cultural and historical context will shape the meaning of their torture experiences and the aftermath. Furthermore, torture impacts larger social and/or political networks and the community (Mollica, 2006; National Partnership for Community Training, 2011).

To effectively treat torture survivors, providers must understand and address these multiple and complexly related factors. Treatment approaches developed in Western countries to attend to the psychological domain of care typically focus on post-traumatic stress disorder (PTSD), failing to address the full range of impacts of torture (Bandeira, 2013). Interdisciplinary care can be expensive and many treatment centers are doing what they can with limited resources, recognizing that rehabilitation services are very often incomplete (Jorgensen et al., 2015; Quiroga & Jaranson, 2005).

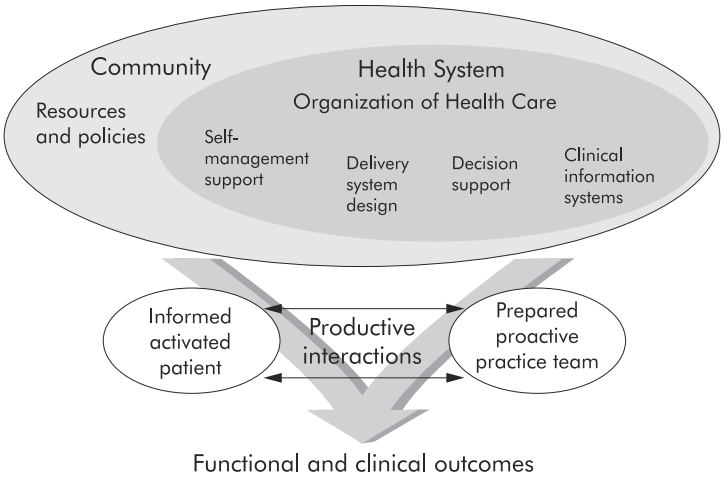
## Methods

The Complex Care Approach (CCA) with five domains (i.e., trauma story, bio-medical, psychological, social, and spiritual) is described as an adaptation to the Chronic Care Model (CCM) that has been used in many countries to treat individuals with chronic health conditions. The CCA is an effective approach to treat torture survivors with complex presentations in contexts that are rich in resources. In other contexts that do not have access to such services as primary care and extensive psychological and social services, a different approach is needed. A de-identified fictional composite case is presented of "Joshua," a former child soldier who has experienced torture, adapted from real life experiences of multiple survivors in order to protect their confidentiality and identities. The CCA is applied to discuss the diagnosis and treatment of Joshua across each of the five domains of care. The severity of Joshua's depression and post-traumatic stress symptoms are assessed using the Hopkins Symptom Checklist-25 and Harvard Trauma Questionnaire (Mollica, McDonald, Massagli & Silove, 2004). Emphasis is given to the need to prioritize interventions, establishing safety first, and to the importance of integration across all domains of care.

### *The Chronic Care Model (CCM)*

Practitioners and researchers in the United States have been among the leaders in the field of complex care of chronic health con-

**Figure 1.** *The Chronic Care Model (CCM)*




Reproduced from Epping-Jordan, Pruitt, Bengoa & Wagner, 2004, *with permission from BMJ Publishing Group Ltd.*

ditions, perhaps in part due to an influential report issued by the Institute of Medicine (IOM) in 2001 that called for far reaching changes to the U.S. health system (Institute of Medicine Committee on Quality of Health Care in America, 2001). This IOM (2001) report noted, in part, major shortcomings in care coordination and problems when treatment focuses narrowly on only one disorder in those who have multiple diagnostic conditions. Despite advances in the effectiveness of treatment, a random survey of patients with chronic conditions in the United States found that only 56.1% received the recommended care (McGlynn et al., 2003). Less than half of U.S. patients with asthma, depression, hypertension, or diabetes were receiving appropriate medical care (Clark et al., 2000; Joint National Committee on Prevention, 1997; Legoretta et al., 2000; Young et al., 2001). Given the additional barriers that refugees and torture survivors often face in accessing treatment (e.g., language and cultural barriers, trauma history, provider knowledge gaps, lack of health insurance [Esala et al., 2018]), it is likely that these populations are even less likely to receive appropriate care in the United States.

The Chronic Care Model (CCM) was developed to improve health outcomes and promote effective delivery of evidence-based and patient-centered care. Its aim is to transform daily care for patients with chronic illnesses from acute and reactive to proactive, planned, and population-based. It is designed to accomplish these goals through a combination of effective team care and planned interactions; self-management support bolstered by more effective use of community resources; integrated decision support; and patient registries and other supportive information technology (see Figure 1). These elements are designed to work together to strengthen the provider-patient relationship and improve health outcomes (Coleman et al., 2009, p. 75).

Practitioners have applied the CCM to a wide range of chronic health and mental health conditions and diverse populations in high-income and low and middle-income countries (LMICs). Successful implementation of integrated care models require that health systems are strengthened (Thornicroft et al., 2018). Budget constraints and increased volumes of referrals of refugees or other traditionally underserved individuals pose challenges to care in high-income countries. Innovations made in LMICs such as task-sharing and the growth in services provided by non-specialists may be beneficially applied in these high-income settings (Thornicroft et al., 2018).

*Adaptation of the CCM for treatment of refugees and torture survivors: A complex care approach*

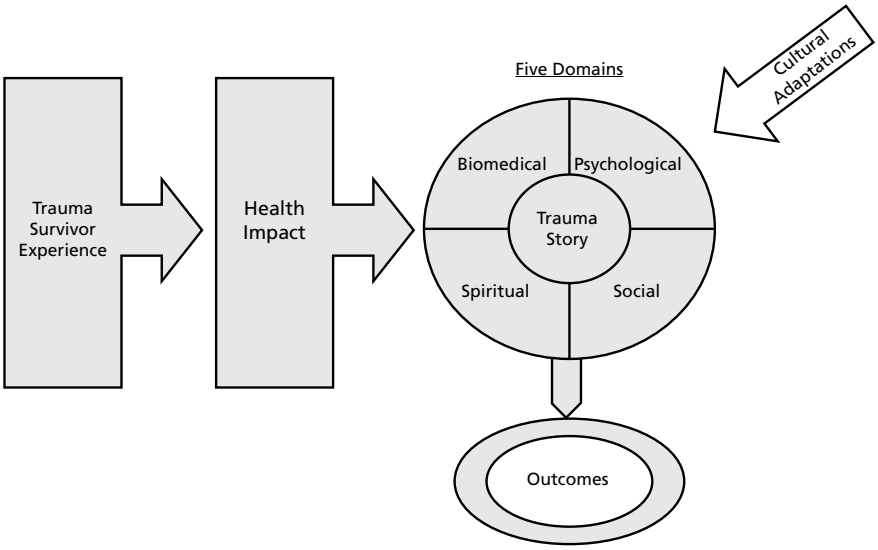
Refugees and torture survivors commonly experience multiple traumas that add complexity to their treatment. Psychiatric practitioners working transculturally and in war zones with refugee families have long recognized that the appropriate care of refugees requires complex care approaches and systems that address not only individual, family, and interactional psychological factors, but also attend to culture, social, and political domains (Rezzoug et al., 2008). Many torture treatment specialty clinics provide interdisciplinary care (Vukovich & Esala, 2016). Research on collaborative care for complex conditions experienced by refugees and torture survivors is sparse but promising, warranting further study (Esala et al., 2018).

Torture survivors differ from other patients in some key respects that have implications for the adaptation of the CCM. Torture survivors as a group have been victims of serious violent crime that is intentional, targeted, human-perpetrated, and planned. These crimes are often implemented by institutions and systems of the state including, in some cases, health care institutions and personnel (Boyd, 2016; McCarthy, 2013). Therefore, establishing trust and addressing perceived issues of impotence and helplessness are often more critical when working with torture survivors compared to other patients. Some torture survivors are dislocated from their communities of origin and separated from traditional family and communal systems of support and affiliation. Therefore, for these survivors, establishing new systems of support and connection can be vital. Survivors often come from cultures with which providers in countries of exile are less familiar and cultural competency is essential so that these providers have a better understanding of these patients and do not react with xenophobia and bias. For those who flee to other countries from very different societies and cultures, the health care system may be very unfamiliar and even frightening. Certain procedures used in medical assessment or treatment for various conditions such as phlebotomy, the use of electrical stimulation, or even noises or close confinement in enclosed spaces for MRI or CT imaging may serve as retraumatizing triggers.

*Five domains of the complex care approach (CCA)*

The CCM is quite biomedical in nature. Therefore, four additional domains that emerged out of work at the Harvard Program in Refugee Trauma (Mollica et al., 2017) have been added to compliment the biomedical domain. These five domains of care (i.e., trauma story, bio-medical, psychological, social, and spiritual) comprise a Complex Care Approach (CCA) to the care of torture survivors. Of particular note, the trauma story was added as an important domain for assessment and treatment with torture survivors. A key emphasis of the approach is that interdisciplinary treatment team members must work

**Figure 1.** *Complex Care Approach with Torture Survivors*




collaboratively, such that the assessment and intervention plan must be integrated in nature across all domains of care (Mollica, 2006; Mollica et al., 2017). In addition, the approach is participatory, with the survivor fully engaged in and driving treatment directions and decisions. Cultural adaptations must be made to the CCA in all domains to match the culture and worldview of each torture survivor. All of these components work together to shape the approach with torture survivors (National Partnership for Community Training, 2011), and influence the outcomes and quality of life of survivors.

Practitioners should begin with establishing intervention priorities, foremost of which is stabilizing and attending to safety and other survivor-identified concerns first, an approach common to many trauma-specific treatments (Mollica, 2006; National Partnership for Community Training, 2011). We recommend starting with the social domain, identifying and building on existing social support in a manner that is non-stigmatizing and promotes the establishment of an empathic and trusting relationship with the treatment team. In the early phase of treatment, coping and affect-regulation skills training will likely be a focus (Mollica, 2006). Only after the survivor is stabilized and if it is determined that they can tolerate it (e.g., they have sufficient affect regulation strategies), an in-depth trauma history (Mollica, 2006) can be conducted to fully assess the impact of the trauma(s) on the physical and mental health of the survivor across five key domains, making cultural adaptations as appropriate (see Figure 2).

A deidentified fictitious composite case of torture survivor "Joshua" is presented below, followed by application of the CCA, used to design an assessment and treatment plan.

**Joshua: Clinical case of a torture survivor**

Joshua is a 32-year-old Liberian male, unmarried, who lives with his mother, sister, niece and nephew in Dallas, Texas in the United States.

*Referral:* by a Dallas refugee agency case worker because of perceived difficulties functioning and inability to hold a job.

*Source of information:* personal interview as well as collateral information from family and case worker.

*Chief complaint:* "I am hot over my body and I feel weak a lot. It feels like ants crawling over me. My head hurts so, so much. There is a soft spot in my head, and I am afraid that it will get worse."

*Present illness:* Joshua arrived in Dallas 12 years ago in 2006 after his mother, herself an asylee, successfully petitioned for him to join her. Joshua's mother had come to the United States before he did. She had applied for and been granted asylum, therefore becoming an "asylee." A year later, she petitioned for Joshua to join her in the United States as a derivative asylee. Joshua later adjusted his status and became a Lawful Permanent Resident. At the time that Joshua's mother submitted her petition, asylees were eligible to sponsor unmarried children who were under the age of 21 at the time of their own original asylum application as derivative asylees. Joshua did not disclose his history as a former child soldier in his application. He fears that his legal status in the United States as a Lawful Permanent Resident may be in jeopardy as a result.

His family reports that he secludes himself in his room and at times talks to himself or shouts. His sister says that she has heard him crying and praying to die. He hardly sleeps and has disturbing nightmares when he does. Joshua expresses suspicion of others, including his family, suggesting that people are spying on him or following him. When he does go out, he often becomes extremely agitated, demanding to return home. He is fearful of utilizing public transportation. His family says that when he first arrived in Dallas, he seemed normal. But, over a six-month period, his symptoms worsened. The family has no idea what triggered his symptoms. Joshua complains of intermittent severe headaches but refuses to see a doctor. He also complains of some discomfort when moving his bowels and pain in his lower back, neck, and shoulders. He has mild systolic hypertension and smokes 2 packs a day.

He has made several attempts to seek employment, but because of his extreme discomfort and limited education, he is limited in his job skills. He has made no attempt to reach out to anyone for support, either within his family or to others in the Liberian community. His family attends a United Methodist church with a number of Liberian refugees in the congregation. At the request of his family, the local pastor visited him at home and tried to engage him, but Joshua became agitated, accused the pastor of spying on him, and asked him to leave the house, much to the embarrassment of his family. In spite of a number of invitations, he has refused to attend services at this church.

**Psychosocial history**

Joshua is functionally illiterate with almost no formal education. He was born during the war years in Liberia, in a small village outside of Gbargna, a large town about 100 miles from the capital, Monrovia. His family are members of the Kpelle tribe. He did not attend school, because there were no teachers available during the war years of his youth. When he was 7 years old,

Charles Taylor's rebels, who had been active for several years in this part of the country, destroyed his village. He witnessed the rape of his mother and sister. He was captured by a warlord, given a gun and was forced to shoot and kill his father. He remembers that he was unfamiliar with the gun, and was shaking so much that he took multiple shots, and watched as his father slowly died. That memory has stayed with him. Thereafter, he fought for Taylor as a child soldier. During this time, he was given "brown" (heroin), cocaine, marijuana, and sleeping pills, while he and the group of child soldiers to whom he had been assigned systematically attacked villages, torturing, killing, and raping the population. He suffered two gunshot wounds, but fortunately they were superficial and were treated with herbal poultices, with which he healed uneventfully. During one occasion, toward the end of this period and just before Taylor was elected president, Joshua was captured by a rival group. He was beaten severely, tortured with cigarette burns, and knocked out. He was rescued after a few days by his compatriots.

After the war, he lived on the streets of Monrovia. He did not know whether his mother and sister were alive, or where to look for them. He was arrested several times, but released each time after a few months. Finally, however, he was given a longer sentence in a prison where many of the other prisoners came from opposing sides of the war. He had been using opioids, and went through opioid withdrawal "cold turkey" during each of his imprisonments. Although it was available, "for a price" in prison, he finally decided not to use it anymore, even though he continued to sell it.

There was much conflict within the prison and the guards did not do much to control the violence. Joshua allied himself with others of his tribe, and had no choice but to participate in the fights which occurred daily. Joshua was placed on the list for family reunification to the United States although he remained in prison initially to finish the last few months of his sentence. Eighteen months later he was granted a visa and joined his family in Dallas. At that time, he was 20.

Joshua lives with his mother, sister, niece, and nephew. His mother and sister are both working as nurses in a local health center. His sister is divorced with two teenage children. Before Joshua joined the family, his mother and sister had many friends, including people in the Liberian-American community. Now that Joshua is with them, many friends avoid contact with them knowing his history as a child soldier and expressing anger towards him. Joshua is alienated in the United States because of his history as a perpetrator. He does not understand why his family remains distant from him and blames him for his past. Overall, Joshua's quality of life is poor.

*Screening Instruments:*

1. Hopkins Symptom Checklist 25 (HSCL-25)
   Depression Score 3.2; 1.75 = Cut off point; possible range 1-4
2. Harvard Trauma Questionnaire (HTQ)
   Score 3.48; 2.5 = Cut off point; possible range 1-4

## Findings

*Five domains of the CCA applied to the case of Joshua*

The work with Joshua is discussed from the perspective of each of the five domains of the CCA. Clinical teams may want to start with the social domain to facilitate engagement with Joshua and establish a foundation of support and safety to promote his health and wellbeing across the realms of his life. Throughout, emphasis is placed on evidence-based treatment options. While psychiatric diagnoses are utilized in this case example, it is understood that there may be limitations to this in the care of survivors. Team members are encouraged to interact with Joshua from a person-centered approach, avoiding medical jargon and labels and framing his condition and situation in a non-stigmatizing manner. It would be vital for the treatment team members, in consultation with Joshua, to make an integrated treatment plan that accounts for the timing and sequencing of each component.

*1. Trauma story:* The trauma story domain is envisioned as the central domain that affects all others, although it is generally not recommended to begin treatment by gathering a detailed trauma history until the person is stabilized and safety has been established. The enormity of the horror and scale of Joshua's abuse over time is almost unimaginable. It is clear that his personality, including trust in others and his ability to form relationships with loved ones, was severely disturbed due to the extreme forms of interpersonal violence he has experienced. The therapist must consider that the major research on child soldiers reveals that the developmental trajectories of child soldiers are severely and chronically impacted, leading to inappropriate social and defensive behaviors (D'Alessandra, n.d.; Umiltà et al., 2013). Trust must be built with Joshua over multiple sessions so that he becomes more comfortable talking about his trauma story.

Before working with Joshua, it is important that his therapist understands that storytelling plays an important role in Liberian society and culture. The therapist must be very careful that the repetition by Joshua of his dehumanizing early traumatic life experiences (e.g., being made to kill his father), which by their very nature are difficult to share, do not lead to his increased lack of social connection and that he is able to tolerate engaging in this work. Prior to initiating work with his trauma story, Joshua may benefit from psychotropic medication to diminish his dissociation and hyperarousal and better regulate his affects, thus enabling him to talk about his traumatic narrative. In addition, if there is cognitive impairment from a TBI, it should be determined to what extent this may interfere, if at all, with being able to cognitively process his trauma story. Justice and potentially, forgiveness may play a role in the therapy. While the therapist cannot bring the rebels to justice, the need for justice can be discussed fully in therapy. In some cases, a survivor may have the opportunity to engage in a court or other formal process that seeks to bring the truth of their torture to light and pursue forms of redress. In these situations, the team may refer the survivor to an attorney and work closely with the survivor (and sometimes their legal team) to provide psychosocial support before, during, and after the proceedings.

*2. Biomedical:* Torture survivors frequently present with multiple medical complaints or conditions which must be carefully assessed (Mollica, 2011). Joshua has several medical issues that are chronic and non-urgent (i.e., mildly elevated blood pressure, active or

past Hepatitis C infection, mildly elevated liver enzymes, current smoking, and chronic pain). It is recommended to address these in a time appropriate manner in conjunction with his psychiatric treatment plan and in a patient-centered approach.

Joshua's chronic pain complaints, including headaches, cervical and lumbar pain, and bilateral shoulder pain, are consistent with those seen in many survivors of torture (Quiroga & Jaranson, 2005), and it cannot be assumed that the etiology is psychological. Although there is a certain amount of comorbidity between physical and psychological symptoms of pain (Defrin et al., 2017), Williams and colleagues (2010) found a physical etiology to the pain complaints in 78% of a random sample of survivors of torture. Regardless of whether the etiology of the pain is primarily physical or psychological, it is beneficial to address it within the context of a holistic, interdisciplinary program. This would ideally include education ("pain school"), physiotherapy, and a cognitive behavioral restructuring of the patient's pain perception.

*3. Psychological:* There are five broad areas of psychological concern in Joshua's case, including Complex PTSD with dissociation, depression with paranoid delusions, suicidal ideation, substance use, and the need to rule out a possible Traumatic Brain Injury (TBI). It is recommended that the therapist utilize a consultative approach with Joshua and, given his agitated state of presentation, an initial priority would be to stabilize Joshua. Engaging familial and other supports would be vital to this effort. While some mental health teams may seek to admit Joshua to a psychiatric inpatient unit where he can be fully evaluated within an atmosphere of relative safety, this is not initially recommended given how stigmatizing, frightening, potentially re-traumatizing, and culturally dystonic a psychiatric hospitalization would likely be for him. Instead, efforts to engage Joshua in treatment might begin with home visits from a social worker or visiting nurse. Such an approach would be more likely, compared to hospitalization, to reduce the chance of Joshua's experiencing stigma or ostracization. Suicidality should be assessed and, if he becomes at high risk for attempting or completing suicide, despite the implementation of prevention efforts including a safety plan (Stanley & Brown, 2012), then a psychiatric hospitalization would be indicated.

An introduction to a therapist and a Kreyol[1] interpreter for further assessment and treatment are recommended to address his extreme fear and paranoia, and to establish, for him, a safe and trusting therapeutic relationship. Many clinicians avoid trauma-focused treatment for patients with psychosis for fear of symptom exacerbation and relapse. However, this has not been found to be the case, and it is recommended that trauma-focused therapies be initiated early on (van den Berg et al., 2016). There is significant evidence that the reprocessing of traumatic memories is fundamental to treatment for PTSD (Schnyder et al., 2015). A number of studies as well as systematic reviews and meta-analyses have concluded that both Trauma-Focused Cognitive Behavior Therapy (TF-CBT) and Narrative Exposure Therapy (NET) are most efficacious in treating PTSD in adult survivors of war and torture (McPherson, 2012; Robjant & Fazel, 2010; Weiss et al., 2016), including former child soldiers (Onyut et al., 2005; McMullen et al., 2013). Eye Movement Desensitization

1 Liberian English is a derivative of English, but has its own idiosyncratic expressions and words.

and Reprocessing (EMDR) may also be valuable (Schnyder et al., 2015).

The process of re-exposing Joshua to his traumatic memories should be titrated as he is helped to differentiate his experiences in time and space. The therapist may strive to locate Joshua's traumas in a Liberia of the past, thereby releasing him to live more confidently in his adopted country in the present. In order to learn how to control his emotional reactions to his traumatic experiences, Joshua would likely benefit from understanding where they are coming from (through psychoeducation) and how to control them (through relaxation training, cognitive restructuring). Using approaches aligned with Joshua's own body-oriented description of his suffering, the therapist may assist Joshua to increase his awareness of his physiological arousal and affective state from moment to moment, and to increase his ability to modulate his baseline arousal and his reactivity to distressing triggers. The inclusion of body-oriented approaches to arousal regulation (including muscle relaxation, stretching, and diaphragmatic breathing) in CBT have been shown to be effective for the management of persistent arousal related symptoms with people from various cultural backgrounds (Hinton et al., 2012). Joshua's therapist can also start to tackle some of his more delusional and paranoid beliefs and attributions, determining whether they are rational fears given his torture experiences. Research in multiple contexts has demonstrated the benefits of assisting war survivors to dispute unhealthy thought beliefs and thought patterns (Schulz et al., 2006; Kaysen et al., 2013).

Many torture survivors are resistant to the use of medications in treatment, particularly if this was used as part of the torture as in the case of Joshua (e.g., Joshua was often drugged as a child soldier). Psychiatric consultation may be considered to assess whether Joshua would benefit from pharmacotherapy aimed at reducing his most debilitating symptoms in consultation with him. This may allow Joshua to more easily engage in evaluation and therapy earlier on and with less disruptive anxiety. Further medication might be indicated at a later stage if Joshua's progress in psychotherapy is modest because of disruptive symptoms of emotional traumatization.

A neuropsychological assessment may be beneficial due to Joshua's history of concussions and loss of consciousness, as well as his difficulties with memory and emotional lability. This assessment would identify the likelihood of Joshua having suffered a TBI. Symptoms of even minor TBI may be long lasting and are easily confused with those of PTSD and depression. The presence of comorbid TBI is typically associated with poorer therapeutic outcomes (Iverson, 2005) but may benefit from cognitive therapy.

As Joshua gains greater control over his symptoms through symptom management and through the integration of traumatic memories, and as he replaces the defensive schemas that kept him alive as a child soldier with beliefs and thought patterns that allow him to thrive as an adult in a more peaceful world, his relationships at home and in the community will hopefully improve.

*4. Social:* The team's social worker or related staff might initially engage Joshua through the social domain, identifying and building on his existing social supports in a manner that is non-stigmatizing and promotes the establishment of an empathic and trusting relationship. The most pressing immediate intervention recommended in the social domain is to assist Joshua and his family members in the United States to collaborate in formulating a viable therapeutic plan, one that is person-centered and prioritizes Joshua's concerns and goals.

Engaging the support of Joshua's mother and sister in encouraging him to seek treatment may be valuable and would provide an opportunity for them to express care and concern for him and strengthen their relationship. If Joshua begins to experience a reduction of symptoms, he may be more receptive to psychotherapy, a healing modality which is probably quite foreign to him.

It is likely that his mother decided to sponsor Joshua as a derivative asylee to promote family reconnection and healing. His case is complex. Although his experiences meet the U.S. definition for torture (18 U.S.C. § 2340[1]), he would also be considered a perpetrator, which led him to not disclose his history as a former child soldier. He has experienced stigma as a former child soldier from most fellow-Liberians. His main problem in this domain is one of tension and strained relationships within his family as a result of him being forced to murder his father and other experiences as a child soldier, exacerbated by his own internal world that is full of feelings of suspicion, anxiety, guilt, and fear. Joshua is particularly fearful that he will be harmed because of his past perpetrator behavior, either by losing his legal status in the United States or by other Liberians seeking retaliation.

Joshua's treatment should extend beyond individual therapy to include family therapy as "[d]uring post-conflict reintegration, child soldiers with self-reports of supportive families and communities endorse better mental health and psycho-social functioning than those reporting discrimination" (Kohrt, 2013, p. 165). Family therapy should start at a point at which Joshua feels ready (in individual therapy) to include his family in his recovery, and from that point individual and family work should continue in parallel. Using a narrative/trauma story approach with the family will help both Joshua and his immediate family to fill in the blanks regarding what happened to each of their family members during the war and their years of disconnection and disrupted attachment. After some stability is achieved by Joshua and his family, a larger engagement plan might explore how to connect him with the Liberian-American community in Dallas.

It remains to be seen if his current struggle to trust others will be more complicated as a result of his legal concerns, including fear of possible deportation. Referral to an immigration attorney is recommended. It may be valuable for Joshua to consider longer-term skill-based education for his future and a referral for vocational training could be made. Gaining acceptance from his family and community may, if successful, take time and eventually may benefit from participating in a community support group. A first step may be for Joshua to forgive himself. The work in the social domain would build on the work Joshua does in psychotherapy.

Some former child soldiers from Liberia have engaged in altruistic or other communal healing endeavors through which to demonstrate to themselves and the community a commitment and desire to redress the effects of their violent actions in the past. Joshua may or may not choose to (or be psychologically prepared to) engage in such actions now or in the future.

*5. Spiritual:* A person's religious or spiritual life is often significantly disrupted and sometimes completely destroyed by torture. A survivor's core beliefs, values, and sense of self may be greatly damaged whether or not they were ever part of a religion. Religion, spirituality, and faith may provide context and meaning to suffering, serve as a framework for many forms of traditional healing, and be significant factors in one's physical and mental health. These factors may not be central or even present for everyone and it is important to not assume that they are.

Some survivors may reject spirituality and/or any religious or faith tradition. Spirituality for some may well encompass much more than organized religion, and could include such things as the survivor's customary beliefs, their core beliefs about the self, and their understanding of what it means to take a life and suffer the consequences of such actions. For those torture survivors who are religious or spiritual, the cultural role of religion and spirituality, the resources of religious institutions, and an understanding of their spiritual worldview is crucial to consider when planning and providing them with mental health services (McKinney, 2011; Piwowarczyk, 2005).

A spiritual needs assessment will enable the care team to better evaluate Joshua's views and feelings about religion and spirituality (Tuskin et al., 2011) and whether being a part of a faith community may be a source of strength for him or not. The symbolic representation of religion in the person of a clergy may be too provocative for him at this time, stimulating in him thoughts and feelings of guilt and shame.

If Joshua does have a religious or spiritual orientation to life, whether he shares his family's Methodist faith or not, this may make a positive contribution toward his feeling that his life is worth living and has a purpose, and possibly enhance his self-esteem, sustain him and give him hope. Joshua may find it helpful to participate in religious or spiritual rituals such as a traditional cleansing ritual. Such rituals have been found to be healing for some Liberian, Burundian, Northern Ugandan, and Sierra Leonean former child soldiers in dealing with their symptoms of posttraumatic stress (Babatunde, 2014; Schultz & Weisaeth, 2015; Stark, 2006).

## Conclusion

The Complex Care Approach is well suited for the assessment and treatment of torture survivors such as Joshua who present with multiple and complex needs in the United States or another high-resourced country. It is not feasible, however, to implement the CCA in lower resourced settings, particularly where there is limited or no access to primary care, psychological, or social services. This is a key limitation of the CCA. Another limitation is that outcome data using the CCA has not yet been collected.

The CCA is closely related to the biopsychosocial model of health and illness developed by George Engel (1977), adding additional components such as the trauma story and spirituality that are highly relevant for torture survivors. Like with the biopsychosocial model before it, care team members should be aware of the potential strengths and weaknesses of the CCA. Key strengths of both include: emphasis on a person-centered and empathic approach to care; the benefits of psychoeducation; and collaboration between multiple providers, patients and family members (Papadimitriou, 2017; Hong et al. 2014; Koponen et al., 2017). These characteristics are vital when serving individuals who have experienced human-perpetrated trauma such as torture, and who often have great difficulty initially trusting others and engaging in a therapeutic process.

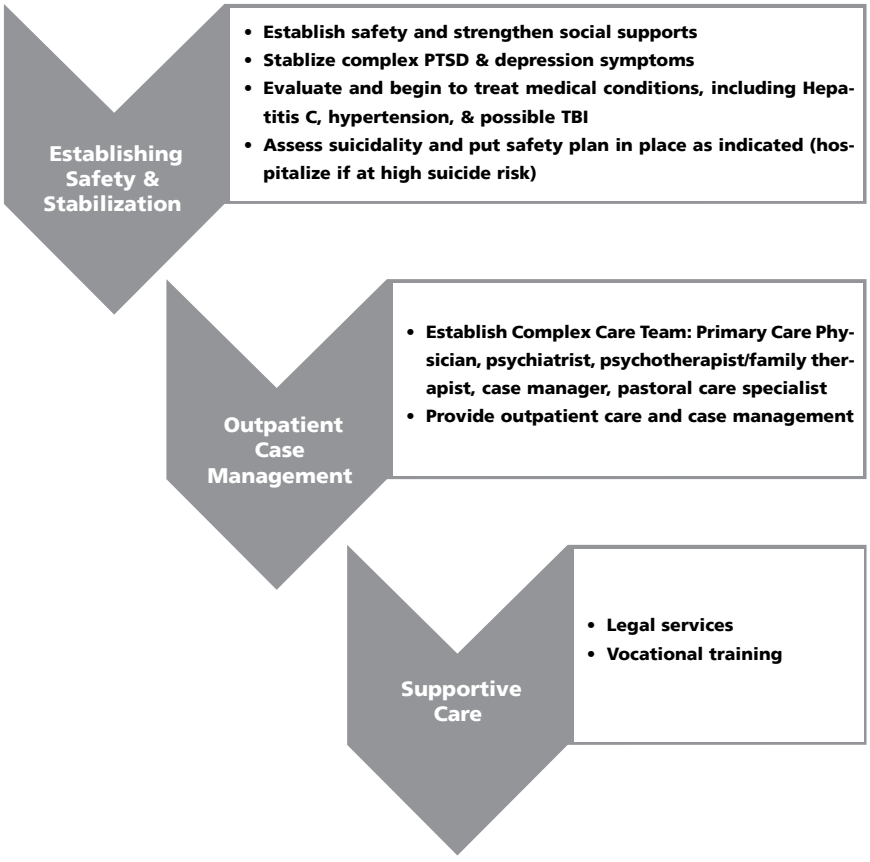
Key weaknesses identified with the biopsychosocial approach include: challenges with coordinating the responsibilities and work of multiple providers; it is often not implemented in a fully integrated fashion; lack of guidance regarding how the various domains interact in the manifestation of the condition or health of the patient; and lack of clarity regarding when various interventions should be applied and in what order (Papadimitriou, 2017). Additional criticism from some includes, in part, promotion of eclecticism without ensuring balance across the different domains, as well as insuf-

ficient attention and weight given to the subjective experience of patients (Benning, 2015).

When applying the CCA to the treatment of torture survivors, conscious attention to the risks of these weaknesses and implementation of strategies to prevent them from occurring are recommended. Establishing a team leader at the outset and regular team meetings held at least once per month would be important for coordinating and ensuring integration of care. In the absence of this, members of the complex care team may easily become overwhelmed, duplicate efforts, and work at cross purposes with one another to the detriment of the torture survivor and their family. Figure 3 outlines a three-phased process of care for Joshua.

Establishing safety and stabilization at the outset are important foundational steps in the CCA. Ideally, once a therapeutic relationship is formed and Joshua has built some trust in his care team members and feels ready, referrals for additional adjunctive services (e.g., legal services and vocational training) would provide the opportunity to assess his legal options that may contribute to increased safety and to prepare him for vocational opportuni-

**Figure 3.** *Phased Process of Care for Joshua*



ties. Given his negative experiences with others who know about his history as a child solider and his concerns about the possible impact of his past history as a child soldier on his legal status, Joshua may be reluctant or anxious about consulting with an immigration attorney. Joshua's derivative asylee status may be in jeopardy given the bar to asylum in the United States for those who perpetrate serious harm on others (with limited exceptions for acting under duress) (Board of Immigration Appeals, 2018). Support from his care team, as well as gaining understanding that his communication with an attorney would be privileged, may facilitate his seeking legal consultation. Care team members could also work with the attorney, as needed, to ensure that he or she is trauma-informed.

Providers require specialized knowledge of the history and culture of the survivor's country of origin, the impact of his or her torture experience(s), and his or her experiences before and after arrival in the new country of resettlement, including during transit. Assessment must be multi-dimensional and holistic, as well as ongoing. Treatment planning is informed by the specifics of client's historical and cultural background and intentional strategies are utilized to overcome barriers to entering and completing treatment. Given the impact of their human perpetrated traumas, torture survivors typically benefit from overt transparency and predictability in their relationships with providers (Mollica, 2006). Care should be given to the prioritizing, ordering, and spacing of interventions and efforts to secure early wins, no matter how small, and in multiple domains can promote continued motivation for engaging in treatment as well as opportunities to reinforce interventions across domains. Throughout, the CAA supports the mobilization of existing strengths and resources, including family and community support, and the development of new ones.

It is important to recognize that not all torture treatment programs have access to an in-house primary care physician, psychiatrist, social worker, or other care team members and do not have existing linkages to a full range of services. In the case presented here, Joshua cannot be successfully treated without access to primary care and holistic services covered by the five domains. If a treatment program does not have access to essential resources within their center, linkages to primary care and other collaborative services are recommended given the promising outcomes of such care on health and mental health outcomes relevant to torture survivors from studies with other populations (Esala et al., 2018). The complex multiple trauma experiences and associated effects found in Joshua and other torture survivors requires an interdisciplinary and holistic approach such as that of the CCA. With holistic complex care it is likely that Joshua will experience significant and sustained relief from his distress and regain a positive quality of life.

For those torture survivors in the United States or other settings with major medical, social, and psychological problems, the CCA is a promising approach. Of course, the traumatic life experiences of the survivor affects all domains. In a resource poor setting where a multidisciplinary team is not available, the clinician can establish the diagnosis and treatment implication of each of the domains and set treatment priorities based upon the availability of resources.

*References*

Babatunde, O. A. (2014). Harnessing traditional practices for use in the reintegration of child soldiers in Africa: Examples from Liberia and Burundi. *Intervention, 12*(3), 379-392. https://doi.org/10.1097/wtf.0000000000000057

Bandeira, M. (2013). *Developing an African torture rehabilitation model: A contextually-informed,*

*evidence-based psychosocial model for the rehabilitation of victims of torture.* Johannesburg, South Africa: The Centre for the Study of Violence and Reconciliation. http://www.csvr.org.za/images/docs/Other/developing_african_rehabilitation_model_part1_setting_foundations.pdf

Berthold, S.M., Mollica, R.F., Silove, D., Tay, A.K., Lavelle, J., Lindert, J. (2019). The HTQ-5: revision of the Harvard Trauma Questionnaire for measuring torture, trauma and DSM-5 PTSD symptoms in refugee populations. *Eur J Public Health, 29(*3), 468-474. https://doi.org/10.1093/eurpub/cky256.

Benning, T. B. (2015). Limitations of the biopsychosocial model in psychiatry. *Adv Med Educ Pract, 6*, 347-352. Doi: 10.2147/AMEP.S82937

Board of Immigration Appeals (2018). 27 I&N Dec. 347. Interim Decision #3930. Retrieved from https://www.justice.gov/eoir/page/file/1075801/download

Boyd, K. (2016). Medical involvement in torture today? *Journal of Medical Ethics, 42*(7), 411-412. https://doi.org/10.1136/medethics-2016-103737

Clark, C. M., Fradkin, J. E., Hiss, R. G., Lorenz, R. A., Vinicor, F., & Warren-Boulton, E. (2000). Promoting early diagnosis and treatment of Type 2 diabetes. *JAMA, 284*(3), 363–365. https://doi.org/10.1001/jama.284.3.363

Coleman, K., Austin, B. T., Brach, C., & Wagner, E. H. (2009). Evidence on the chronic care model in the new millennium. *Health Aff (Millwood), 28*(1), 75–85. https://doi.org/10.1377/hlthaff.28.1.75

D'Alessandra, F. (n.d.). The psychological consequences of becoming a child soldiers: Post-traumatic stress disorder, major depression, and other forms of impairment. Harvard Carr Center. https://carrcenter.hks.harvard.edu/files/cchr/files/dalessandra_pshychol_cons_of_childsoldiers.pdf

Defrin, R., Lahav, Y., & Solomon, Z. (2017). Dysfunctional pain modulation in torture survivors: The mediating effect of PTSD. *Journal of Pain, 18*(1), 1-10. https://doi.org/10.1016/j.jpain.2016.09.005

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*, 129-136.

Epping-Jordan, J. E., Pruitt, S. D., Bengoa, R., & Wagner, E. H. (2004). Improving the quality of health care for chronic conditions. *Qual Saf Health Care, 13*(4), 299-305. https://doi.org/10.1136/qshc.2004.010744

Esala, J. J., Vukovich, M. M., Hanbury, A., Kashyap, S., & Joscelyne A. (2018). Collaborative care for refugees and torture survivors: Key findings from the literature. *Traumatology, 24*(3), 168-185. https://doi.org/10.1037/trm0000143

Hinton, D. E., Rivera, E. I., Hofmann, S. G., Barlow, D. H., & Otto, M. W. (2012). Adapting CBT for traumatized refugees and ethnic minority patients: Examples from culturally adapted CBT (CA-CBT). *Transcultural Psychiatry, 49*(2), 340–365. https://doi.org/10.1177/1363461512441595

Hong, C. S., Siegel, A. L., & Ferris, T. G. (2014). *Caring for high-need, high-cost patients: What makes for a successful care management program?* Commonwealth Fund pub. 1764, Vol. 19. The Commonwealth Fund.

Institute of Medicine Committee on Quality of Health Care in America (Eds.). [IOM] (2001). *Crossing the quality chasm: A new health system for the 21st century.* National Academies Press.

Iverson, G. L. (2005). Outcome from mild traumatic brain injury. *Current Opinion in Psychiatry, 18*(3), 301-317. https://doi.org/10.1097/01.yco.0000165601.29047.ae

Joint National Committee on Prevention (1997). Detection, evaluation, and treatment of high blood pressure, Sixth Report. *Archives of Internal Medicine, 157*(21), 2413–2446. https://doi.org/10.1001/archinte.157.21.2413

Jorgensen, M. M., Modvig, J., Agger, I., Raghuvansh, L., Shabana Khan, S., & Polatin, P. (2015). Testimonial therapy: Impact on social participation and emotional wellbeing among Indian survivors of torture and organized violence. *Torture, 25*(2), 22-33.

Kaysen, D., Lindgren, K., Zangana, G. A. S., Murray, L., Bass, J., & Bolton, P. (2013). Adaptation of cognitive processing therapy for treatment of torture victims: Experience in Kurdistan, Iraq. *Psychological Trauma: Theory, Research, Practice, and Policy, 5*(2), 184-192. https://doi.org/10.1037/a0026053

Kohrt, B. (2013). Social ecology interventions for post-traumatic stress disorder: What can we learn from child soldiers? *The British Journal of Psychiatry*, *203*, 165-167. https://doi.org/10.1192/bjp.bp.112.124958

Koponen, A. M., Simonsen, N., & Suominen, S. (2017). Quality of primary health care and autonomous motivation for effective diabetes self-management among patients with type 2 diabetes. *Health Psychology Open, 4*(1), 1-7. https://doi.org/10.1177/2055102917707181

Legoretta, A. P., Liu, X., Zaher, C. A., & Jatulis, D. E. (2000). Variation in managing asthma: Experience at the medical group level in California. *American Journal of Managed Care,*

*6*(4), 445–453.

McCarthy, M. (2013). US health professionals aided detainees' torture. *BMJ, 347*(7932), 1. https://doi.org/10.1136/bmj.f6680

McGlynn, E. A., Asch, S. M., Adams, J., Keesey, J., Hicks, J., DeCristofaro, A., & Kerr, E. A. (2003). The quality of health care delivered to adults in the United States. *New England Journal of Medicine, 348*(26), 2635–2645. https://doi.org/10.1056/NEJMsa022615

McKinney, M. M. (2011). Treatment of survivors of torture: spiritual domain. *Torture,* 21(1), 61–66.

McMullen, J., O'Callaghan, P., Shannon, C., Black, A., & Eakin, J. (2013). Group trauma-focused cognitive-behavioural therapy with former child soldiers and other war-affected boys in the DR Congo: A randomised controlled trial. *Journal of Child Psychology & Psychiatry, 54*(11), 1231–1241. https://doi.org/10.1111/jcpp.12094

McPherson, J. (2012). Does narrative exposure therapy reduce PTSD in survivors of mass violence? *Research on Social Work Practice, 22*(1), 29–42. Doi: 10.1177/1049731511414147

Mollica, R. F. (2006). *Healing invisible wounds: Paths to hope and recovery in a violent world.* Harcourt.

Mollica, R. F. (2011). Medical best practices for the treatment of torture survivors. *Torture, 21*(1), 8-17.

Mollica, R., Lavelle, J., Fors, U., Ekblad, S., & Wadler, B. (2017). Using the virtual patient to improve the primary care of traumatized refugees. *Journal of Medical Education,16*(1), 2-16.

Mollica, R. F., McDonald, L. S., Massagli, M. P., & Silove, D. M. (2004). *Measuring trauma, measuring torture: Instructions and guidance on the utilization of the Harvard Program in Refugee Trauma's versions of the Hopkins Symptom Checklist-25 (HSCL-25) & the Harvard Trauma Questionnaire (HTQ) [Manual]*. Harvard Program in Refugee Trauma.

National Partnership for Community Training (2011). Best, promising, and emerging practices: A compendium for providers working with survivors of torture. Thematic Issue of *Torture Journal, 21*(1), 1-66.

Onyut, L. P., Neuner, F., Schauer, E., Ertl, V., Odenwald, M., Schauer, M., & Elbert, T. (2005). Narrative Exposure Therapy as a treatment for child war survivors with posttraumatic stress disorder: Two case reports and a pilot study in an African refugee settlement. *BMC Psychiatry, 5*(7), 1–9. https://doi.org/10.1186/1471-244X-5-7

Papadimitriou, G. (2017). The "Biopsychosocial Model": 40 years of application in psychiatry. *Psychiatriki, 28*(2), 107-110. https://doi.org/10.22365/jpsych.2017.282.107

Piwowarczyk, L. (2005). Torture and spirituality: Engaging the sacred in treatment. *Torture, 15*(1), 1-8.

Quiroga, J., & Jaranson, J. (2005). Politically motivated torture and its survivors, *Torture, 16*(2-3), 1-111.

Rezzoug, D., Baubet, T., Broder, G., Taïeb, O., & Moro, M. R. (2008). Addressing the motherinfant relationship in displaced communities. *Child and Adolescent Psychiatric Clinics of North America, 17*(3), 551-568. https://doi.org/10.1016/j.chc.2008.02.008

Robjant, K., & Fazel, M. (2010). The emerging evidence for Narrative Exposure Therapy: A review. *Clinical Psychology Review, 30*(8), 1030–1039. https://doi.org/10.1016/j.cpr.2010.07.004

Schnyder, U., Ehlers, A., Elbert, T., Foa, E. B., Gersons, B. P. R., Resick, P. A., … Cloitre, M. (2015). Psychotherapies for PTSD: What do they have in common? *European Journal of Psychotraumatology, 6*(1), 28186. https://doi.org/10.3402/ejpt.v6.28186

Schulz, P. M., Resick, P. A., Huber, L. C., & Griffin, M. G. (2006). The effectiveness of Cognitive Processing Therapy for PTSD with refugees in a community setting. *Cognitive & Behavioral Practice, 13*(4), 322–331. https://doi.org/10.1016/j.cbpra.2006.04.011

Schultz, J.-H., & Weisaeth, L. (2015). The power of rituals in dealing with traumatic stress symptoms: cleansing rituals for former child soldiers in Northern Uganda. *Mental Health, Religion & Culture, 18*(10), 822-837. https://doi.org/10.1080/13674676.2015.1094780

Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19*(2), 256-264. https://doi.org/10.1016/j.cbpra.2011.01.001

Stark, L. (2006). Cleansing the wounds of war: An examination of traditional healing, psychosocial health and reintegration in Sierra Leone. *Intervention, 4*(3), 206–218. https://doi.org/10.1097/WTF.0b013e328011a7d2

Thornicroft, G., Ahuja, S., Barber, S., Chisholm, D., Collins, P. Y., Docrat, S., . . . Zhang, S. (2018). Integrated care for people with longterm mental and physical health conditions in low-income and middle-income countries. *Lancet Psychiatry, 6*(2),174-186. https://doi.org/10.1016/S2215-0366(18)30298-0

Tuskin, J. J., Streets, F. J., & Basit, A. (2011). Religion, spirituality and faith. In R. F. Mollica (Ed.), *Textbook of global mental health: Trauma and recovery, a companion guide for field and clinical care of traumatized people worldwide* (pp. 285-300). Harvard Program in Refugee Trauma.

Umiltà, M. A., Wood, R., Loffredo, F., Ravera, R., & Gallese, V. (2013). Impact of civil war on emotion recognition: The denial of sadness in Sierra Leone. *Frontiers in Psychology*, *4*, 523. https://doi.org/10.3389/fpsyg.2013.00523

Van den Berg, D. P., de Bont, P. A., van der Bleugel, B. M., de Roos, C., de Jongh, A., van Minnen, A., & van der Gaag, M. (2016). Trauma-Focused Treatment in PTSD Patients With Psychosis: Symptom Exacerbation, Adverse Events, and Revictimization. *Schizophrenia Bulletin, 42*(3), 693-702. https://doi.org/10.1093/schbul/sbv172

Vukovich, M., & Esala, J. (2016, September 12). *Integrated behavioral health care with survivors of torture: Learning from the data and from each other.* Measured Impact Webinar. Heal Torture. http://www.healtorture.org/webinar/integratedbehavioral-health-care-survivors-torture-learningdata-and-each-other

Weiss, W. M., Ugueto, A. M., Mahmooth, Z., Murray, K., Hall, B. J., Nadison, M., … Bass, J. (2016). Mental health interventions and priorities for research for adult survivors of torture and systematic violence: A review of the literature. *Torture, 26*(1), 17–44.

Williams, A. C., Peña, C. R., & Rice, A. S. (2010). Persistent pain in survivors of torture: A cohort study. *J Pain and Symptom Management, 40*(5), 715-722. https://doi.org/10.1016/j.jpainsymman.2010.02.018

Young, A. S., Klap, R., Sherbourne, C. D., & Wells, K. B. (2001). The quality of care for depressive and anxiety disorders in the United States. *Arch Genl Psychiatry, 58*(1), 55–61. https://doi.org/10.1001/archpsyc.58.1.55

**Acknowledgements**

The authors wish to thank the Bellevue/NYU Program for Survivors of Torture.

**Funding**

This literature review was developed under the National Capacity Building (NCB) technical assistance project funded by the U.S. Office of Refugee Resettlement (ORR) through co-operative agreement number 90ZT0142. The views expressed are those of the National Capacity Building Project and may not reflect the views of ORR.

# "Parrilla urethra": A sequalae of electric shock torture to genitals in men. A 40 case series in Kashmir (India)

**Abdul Rouf Khawaja[1], Manzoor Dar[2], Yasir Dar[3], Javeed Magray[4], Tariq Sheikh[5], Suhail Zahur[6]**

**Abstract**

*Introduction:* Since the 20th century, electric shock torture has become one of the most prevalent methods of torture partly because it produces sequelae that are more challenging to visibly detect, particularly when administered using high voltage and low current. In sexual torture, a wire is wrapped around the head of the penis and a wire electrode is inserted into the urethra. This produces unbearable pain and can lead to urethral strictures with devastating physical and psychological consequences.

*Objective:* To document electric shock torture to genitals as an etiologic agent in urethral stricture and erectile dysfunction amongst survivors of electric torture introducing the term "parrilla urethra" for the electric shock torture urethral stricture.

*Materials and methods:* The study included 40 patients who attended the Department of Urology, Directorate of Health services, Srinagar, Kashmir, India with obstructive lower urinary tract symptoms (LUTS) / obstructive uroflowmetry between March 2010 and November 2014. All cases had an antecedent of electric shock torture to genitals six months to one year prior to examination. Pre-post psychological impact and well-being was used through Global Assessment of Functioning (GAF) scores.

*Results:* The mean age of patients was 35.6 years. Most of the urethral strictures were located in the anterior urethra. Some degree of erectile dysfunction was present in all (100%) of patients. Psychological sequelae including depression, anxiety, acute stress disorder and symptoms of post-traumatic stress disorder were observed. Patients were treated with standard urethroplasty procedures after addressing the urethral stricture. This improved both physical and psychological sequelae of torture.

*Keywords:* electric shock; parrilla; torture; urethral stricture

## Introduction

The Kashmir region is a geographical area split between Indian, Pakistani and Chinese jurisdiction, that has suffered from protracted political conflict and where ill-treatment and torture has been widely documented (Deol & Ganai, 2018; Haq, 2017, 2018; Human Rights

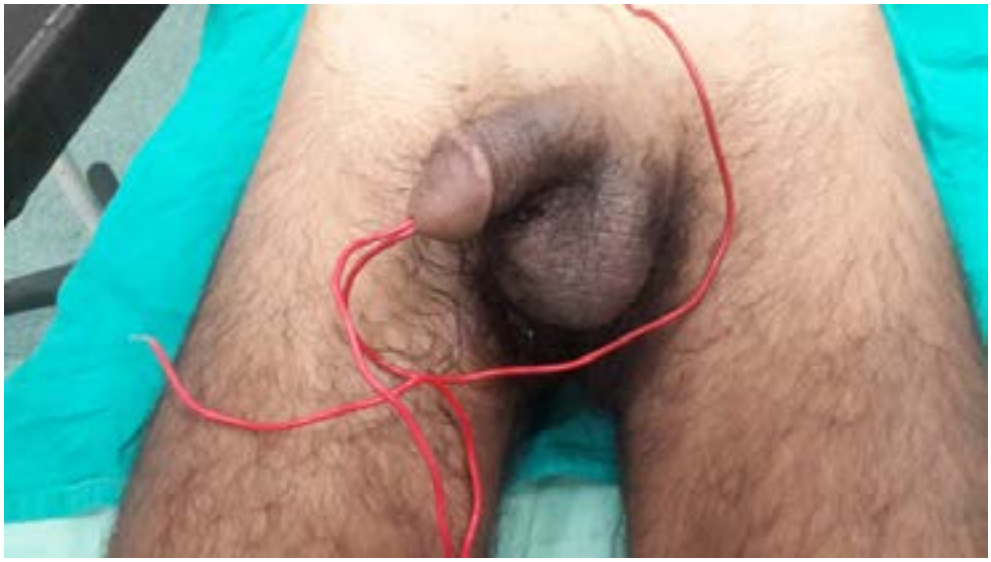
1) Department of Urology. Directorate of Health Services Srinagar, 190011. India.
Correspondence to: roufkhawaja@rediffmail.com
2) Delhi University
Correspondence to: drmanzoor996@gmail.com
3) Institute of Urology Dhule Mumbai.
Correspondence to: yasserahmad009@gmail.com
4) Directorate of Health Services Kashmir.
Correspondence to: drjavaid82@gmail.com
5) Directorate of Health Services Kashmir.
Correspondence to: drtariq.sheikh@gmail.com
6) Directorate of Health Services Kashmir.
Correspondence to: suhaelz@gmail.com

https://doi.org/10.7146/torture.v30i1.105661

Watch, 1993; Institut of Strategic Studies, 2019; JKCCS, 2019). In many of the reports available there have been reports of electric torture (Amnesty International, 1995; Deol & Ganai, 2018; Haq, 2017; Human Rights Watch, 1993; Tahir Tabassum, 2012).

Electrical injury is a physiological reaction caused by electric current passing through the human body (Rybarczyk et al., 2017). Electric shock torture is widespread with Amnesty International (1997) finding that electric shock torture and ill-treatment have been reported in 62 countries in the period 1990-1997, and is commonly used by law enforcement officers with easily concealable, electro-shock weapons (*TASERs* and similar devices) (Amnesty International, 1997). Electric shock torture has become one of the most prevalent methods of torture since the 20th century, partly because it produces sequelae that are more challenging to detect visibly, particularly when administered using high voltage and low current. The method therefore assists perpetrators with circumventing the negative political consequences posed by human rights monitoring mechanisms and from human rights advocates discovering and reporting torture (Amnesty International, 1997). One particular form of electric shock torture is parrilla torture. *Parrilla*, a term that stems from the Spanish word meaning a grill or barbeque for cooking meat, is a method of torture in which a victim is strapped to a metal frame and subjected to electric shock torture (Gómez-Barris, 2009). This torture method produces devastating psychological and physical consequences. The method was used by a number of countries in South America, including during the "dirty war" (1974-1983) in Argentina and in Chile during the Pinochet regime (1973-1990) as an interrogation method (Villani, 2011).

The three major mechanisms of electrical injuries are direct tissue damage, thermal injury and mechanical injury (Dzhokic¨et al., 2008). However, virtually every part of the body can be injured by the electric current and the extent of injury to body tissue is influenced



by a plethora of factors, including the type of body part targeted, the number of torture episodes, the duration of each torture episode, and the strength of the electric current. Alternating current (AC) is three times more dangerous than direct current (DC) of the same voltage. Nerves, muscles, and blood vessels have lower resistance and are better electrical conductors compared to bone, tendon and fat with nerve tissue having the least resistance to current flow, and are thus more susceptible to damage (Dzhokic et al., 2008).

Commonly, bare wire electrodes are applied to or inserted into different sensitive body parts, including genitalia, breasts, buttocks, fingers, toes, tongue, and head. For males, during electric torture to genitals, the fixed wire is wrapped around the head of the penis and a bare wire is inserted into the urethra. This results in mechanical urethral trauma in addition to electric injury to the urethra and other tissues. Some victims may consequently develop obstructive voiding symptoms and erectile dysfunction depending on the severity of the torture episode(s).

The most frequent psychological sequelae include sleep disturbances, being uncomfortable in situations reminding of past torture experiences, stigma and social isolation, ruminations about traumatic events, emotional instability and violence towards family members and suicidal attempts (Araujo et al., 2019; Ba & Bhopal, 2017; Crescenzi et al., 2002; Cunningham & Cunningham, 1997; Masmas et al., 2008; Suhaiban et al., 2019; Tamblyn et al., 2011).

Although electric torture to genitals has been previously described (i.e. Iran Human Rights Documentation Center, 2011;Weishut, 2015), no known research exists that investigates the sequelae and optimum rehabilitation procedures for patients presenting with urethral sequelae. This paper aims to help address this gap with two objectives:

1. To describe electric shock torture as an aetiological factor for urethral strictures and erectile dysfunction.
2. To introduce the term "*parrilla urethra*" into the literature for the urethral stricture disease resulting from electric shock torture to genitals.

## Methods and materials

*Sample*. Survivors of electric shock torture (n=40, age 28-60 years) presenting with urethral strictures at a Directorate of health care centre in Kashmir, India, between March 2010 and November 2014. All the patients included were from Kashmir valley (India) and had suffered torture at the hands of security personnel/armed groups as per narrated in clinical alleged history to our initial examination. We did not assess who was responsible for the violence because it was not relevant for our medical needs assessment.

*Methods.* Patients were self-referred or referred by human rights organizations. There was not a full systematic medical exploration of torture although patients were referred to other services in the hospital when required. Torture was defined using the Convention against Torture (UN General Assembly, 1984). All patients had a history of trauma inflicted upon the urethra via electric shock six months to one year prior to presentation. Patients with earlier lower urinary tract symptoms and any past history of urethral instrumentation were excluded from the study.

Erectile dysfunction was measured using the International Index of Erectile Function (IIEF-5) (Rosen et al., 1999; Rosen et al., 1997). It is a 5-item measure, each one scored from 1 to 5 and giving a composite score of

5-25. The patients were classified as having no ED (22-25), mild ED (17-21), mild to moderate ED (12-16), moderate ED (8-11) and severe ED (5-7).

Retrograde and micturating cystourethrogram testing were obtained in all patients to determine stricture location and length.

Patients were screened for psychological consequences as part of the standard clinical interview and referred to psychiatric assessment when required.

The Global Assessment of Function (GAF) was used as a WHO recommended overall measure of global mental health and functional impact of psychological symptoms. This is a Likert-scale ranked 0 to 100; 100 being optimal functionality (Aas, 2011).

*Ethical elements.* The study was approved by the departmental committee that also looks into ethical aspects of biomedical research conducted in the department. This being a retrospective audit of the anonymised records, the committee did not deem it necessary to refer the study to the main institutional ethics committee (IEC) as there was no ethical issues involved and hence exempt from ethical review.

## Results

*Pre-operative data.* The stricture length ranged from 4 cm to 12 cm with a mean of 6.8 cm affecting the bulbar (n=22), penobulbar (n=7), and penile (n=6) urethra. In 5 cases there was pan-urethral damage (table 1). 28 patients had a history of painful acute urinary retention (AUR). All patients also had erectile dysfunction secondary to electric shock as defined by IIEF-5 Scores 12 patients had severe ED, 21 had moderate ED, and 7 patients had mild to moderate ED. A subsection (n=16) patients also had uncontrollable urine loss which was the result of overflow incontinence from chronic retention or a result of detrusor overactivity. An obstructive pattern was observed on uroflowmetry in all patients.

Psychological sequelae including anxiety, acute stress disorder/post-traumatic stress dis-

**Figure 1.** *Anterior urethral stricture due to electro shock weapon (Parrilla Urethral stricture). Arrow showing stricture.*

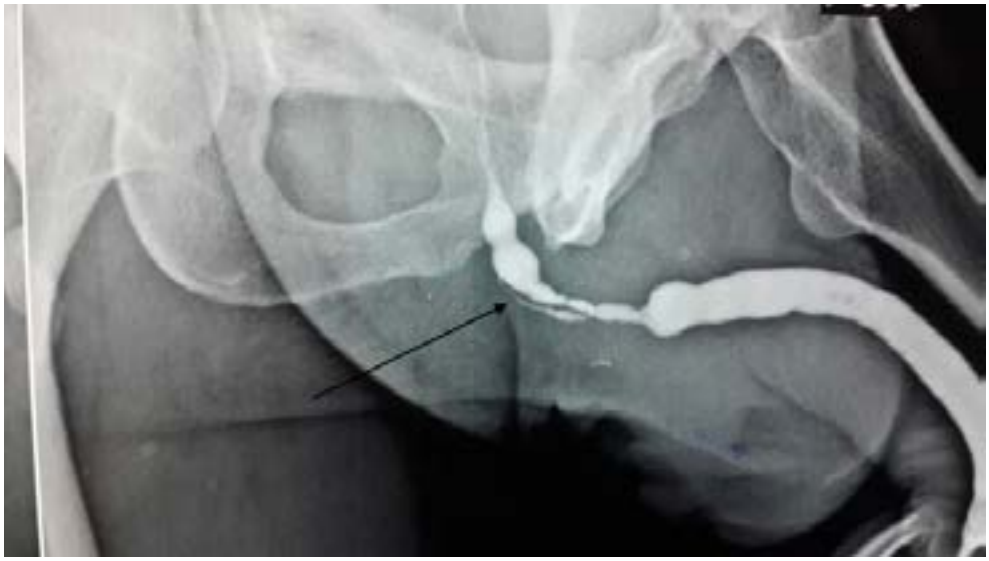


**Figure 2.** *On MCU. Arrow shows post operative one side dorsal onlal buccal mucosal gaft urethroplasty in parrilla urethra*

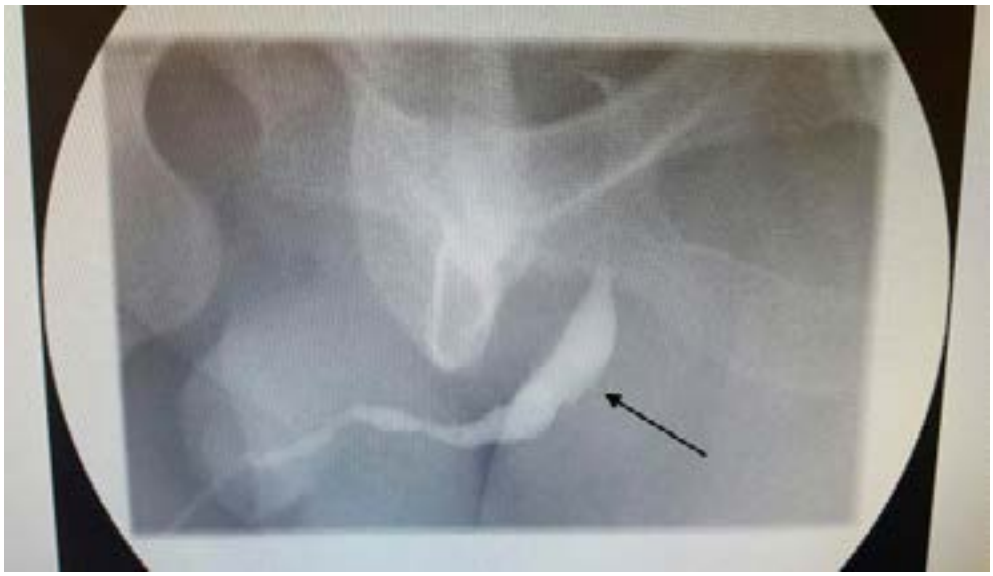


**Table 1.** *Clinical Characteristic of the Patients (n=40 patients)*

| | N=40 |
|---|---|
| Age (years) | 28-60yrs |
| Length of stricture (cm) | 6.8 (4-12) |
| **RGU/MCU-site of stricture** | |
| Bulbar | 22 (55.0) |
| Penobulbar | 7 (17.5) |
| Penile | 6 (15.0) |
| PanUrethral | 5 (12.5) |
| **Before surgery** | |
| Poor Urinary Flow | 40 (100%) |
| Erectile Dysfunction | 40 (100%) |
| - Severe (IIEF 5-7) | 12 (30%) |
| - Moderate (IIEF 8-12) | 20 (50%) |
| - Mild (IIEF 12-16) | 8 (20%) |
| Painful Acute Urinary Retention | 28 (70%) |
| Uncontrollable Urinary Loss | 16 (40%) |

**Table 2.** *GAF-Score*

| | **Pre-Surgery M : 47** | **6-12 m. Post-Surgery M : 68** |
|---|---|---|
| 91-100 | 0 | 7 (17.5%) |
| 81-90 | 0 | 8 (20%) |
| 71-80 | 3 (7.5%) | 20 (50%) |
| 61-70 | 6 (15%) | 5 (12.5%) |
| 51-60 | 11 (27.5%) | 0 |
| 41-50 | 20 (50%) | 0 |

*Chisq: 65.90, p<0.000*

order, and depressive disorder were observed amongst the victims who were referred for psychiatric/psychologist evaluation before management of urethral stricture disease (see table 1). This was in part secondary to torture and in part due to the presence of the suprapubic catheter, social isolation and continuous ammoniac smell of urine.

Patients with acute retention symptoms were initially managed by suprapubic catheterization (SPC) and drainage. All patients were later managed by substitution urethroplasty using oral mucosal graft placed dorsally after mobilization of urethra on one side only (Horiguchi, 2017) decreasing the urinary stream. Its surgical management is a challenging problem, and has changed dramatically in the past several decades. Open surgical repair using grafts or flaps, called substitution urethroplasty, has become the gold standard procedure for anterior urethral strictures that are not amenable to excision and primary anastomosis. Oral mucosa harvested from the inner cheek (buccal mucosa).

GAF scores measure the overall deterioration in functioning (see table 2). After urethroplasty none of the patients had to use a urobag. There were also improvements in erectile function. This is reflected in an overall improvement in GAF scores (Chisq: 65.90, df: 39, $p<0.000$). We could not assess whether the improvement in overall well-being had an impact on primary PTSD and depression symptoms directly related to torture, although this seemed the case in conversations with the psychiatrist and psychologist where the patients were referred.

## Discussion

The "*parrilla urethra*" (electric shock) is a torture method used to cause pain and fear without necessarily causing any immediate visible harm. The patients subjected to such torture complained of erectile dysfunction, dysuria and haematuria, difficulty in micturition as also reported by previous studies (Lunde I, 1992; Petersen et al., 1985). Electric shock torture to genitals is a predominantly physical torture method with both physical and psychological consequences, and with relentless long-term psychological sequelae (Araujo et al., 2019; Ba & Bhopal, 2017; Miles & Garcia-Peltoniemi, 2012). In Kashmir Valley, suicide seems a hidden consequence of the protracted conflict (Wani et al., 2011).

To the urologist, these patients present with predominantly obstructive voiding symptoms with associated poor self-esteem and psychological sequelae. There is, as such, a need for an interdisciplinary approach that is holistic and that addresses both mental and psychological well-being of both mind and body. Most of these patients were on urinary diversion in the form of suprapubic catheter (SPC) with an external urine collection bag (*urobag*) attached to it for collection of urine resulting in change in bodily image and a constant smell of urine. As a result, these patients prefer social isolation which leads to further deterioration of their social, physical and psychological wellbeing. Addressing the urological issues results in freedom from an SPC and consequent improvement in bodily image, which boosts self-esteem and confidence to socialise, thereby having a positive impact on overall wellbeing.

In the literature, the incidence of erectile dysfunction (ED) ranges from 20% to 84% in patients with urethral injury secondary to perineal trauma or pelvic fractures (Blaschko et al., 2015). ED caused by such trauma is due to lesions of the cavernous nerves or branches of the internal pudendal arteries that pass in close proximity to the pelvic bones and posterior urethra. The intimate relationship of the

soft tissues and the bony pelvic ring result in a high risk of concomitant local injury associated with fractures of the pelvis. Even without severe urological injury, damage to the delicate vascular and nervous tissues supplying the genitalia can result in sexual dysfunction (Barratt et al., 2018).

In electric torture ("parrilla urethra") the erectile dysfunction is secondary to electric current injury and adds to the psychological consequences. Penile neurovascular tissue has the least resistance to current flow of all the tissues in the pubic area and is the most susceptible to damage with resultant neurovascular dysfunction and numbness of phallus. The electric current may result in coagulation of small vessels supplying the erectile tissue in addition to causing direct myogenic damage. We thus presume a multifactorial neurovascular and neuro-myogenic basis for erectile dysfunction in our sample of tortured patients.

In the majority of our cases the strictures were in anterior urethra likely due to the difficulty in negotiating bare wire through the anatomical course of bulbar urethra.

The urogenital problems were further compounded and complicated by neuropsychiatric sequalae of torture in our study group and patients were seen by psychiatrist during and after the treatment of urethral stricture. All the patients showed an improvement in GAF score after urethroplasty.

"*Parrilla urethra"* seems to be an appropriate term to define the urethra with sequalae of urethral trauma, particularly urethral stricture resulting from electric shock torture to genitals. The term will help to differentiate it from other aetiologies of urethral stricture.

## Limitations

The sample size is low. We could not use psychometric measures of mental health changes and data is based on overall measures of well-being and clinical information from treating professionals. There is a need for prospective studies that carry out a pre-post measure of mental health impact, whilst distinguishing those impacts related to torture and those related to the psychosocial consequences of urethral stricture.

## Conclusion

Survivors of electric shock torture to genitals often suffer from chronic debilitating urethral strictures with a poor quality of life and psychological distress, necessitating multidisciplinary and individualized treatment. The term "*parrilla urethra"* defines and differentiates these cases of urethral stricture disease from strictures from other aetiologies. Our study shows preliminary evidence that electric shock torture to genitals has devastating consequences on survivors and that addressing the physical consequences can ultimately improve the overall well-being of patients. Future studies need to address whether urethroplasty also has an impact on posttraumatic symptoms derived from torture.

*References*

Aas, I. H. M. (2011). Guidelines for rating Global Assessment of Functioning ( GAF ). *Annals of General Psychiatry*, *10*(1), 2. https://doi.org/10.1186/1744-859X-10-2

Amnesty International. (1995). *India. Torture and deaths in custody in Jammu and Kashmir (ASA 20/01/95)*. https://www.amnesty.org/download/Documents/176000/asa200011995en.pdf

Amnesty International. (1997). *Arming the torturers: electro-shock torture and the spread of stun technology (ACT 40/04/97)*. London.

Araujo, J. de O., Souza, F. M. de, Proença, R., Bastos, M. L., Trajman, A., & Faerstein, E. (2019). Prevalence of sexual violence among refugees: a systematic review. *Revista de Saude Publica*, *53*, 78. https://doi.org/10.11606/s1518-8787.2019053001081

Ba, I., & Bhopal, R. S. (2017). Physical, mental and social consequences in civilians who have experienced war-related sexual violence: a systematic review (1981–2014). *Public Health*,

*142*, 121–135. https://doi.org/10.1016/j.puhe.2016.07.019

Barratt, R. C., Bernard, J., Mundy, A. R., & Greenwell, T. J. (2018). Pelvic fracture urethral injury in males-mechanisms of injury, management options and outcomes. *Translational Andrology and Urology*, *7*(29), S29–S62. https://doi.org/10.21037/tau.2017.12.35

Blaschko, S. D., Sanford, M. T., Schlomer, B. J., Alwaal, A., Yang, G., Villalta, J. D., … Breyer, B. N. (2015). The incidence of erectile dysfunction after pelvic fracture urethral injury: A systematic review and meta-analysis. *Arab Journal of Urology*, *13*(1), 68–74. https://doi.org/10.1016/j.aju.2014.09.004

Crescenzi, A., Ketzer, E., Van Ommeren, M., Phuntsok, K., Komproe, I., & de Jong, J. T. V. M. (2002). Effect of political imprisonment and trauma history on recent Tibetan refugees in India. *Journal of Traumatic Stress*, *15*, 369–375. https://doi.org/10.1023/A:1020129107279

Cunningham, M., & Cunningham, J. D. (1997). Patterns of symptomatology and patterns of torture and trauma experiences in resettled refugees. *Australian and New Zealand Journal of Psychiatry*, *31*, 555–565.

Deol, S. S., & Ganai, R. A. (2018). Custodial violence in Kashmir by the Indian security forces: A spontaneous consequence or a deliberate counter-insurgency policy? *International Journal of Criminal Justice Sciences*, *13*(2), 370–384. https://doi.org/10.5281/zenodo.2657636

Dzhokic, G., Jovchevska, J., & Dika, A. (2008). Electrical injuries: Etiology, pathophysiology and mechanism of injury. *Macedonian Journal of Medical Sciences*, *1*(2), 54–58. https://doi.org/10.3889/MJMS.1857-5773.2008.0019

Gómez-Barris, M. (2009). *Where memory dwells*. Berkeley, Calif.: University of California Press.

Haq, I. (2017). Exploring the Concept of Torture: An Analysis of Kashmir Valley. *SSRN Electronic Journal*, 1–19. https://doi.org/10.2139/ssrn.2954374

Haq, I. (2018). Torture in the Kashmir Valley and Custodial Deaths in India. *Torture Journal*, *27*(3), 109–110. https://doi.org/10.7146/torture.v27i3.103972

Horiguchi, A. (2017). Substitution urethroplasty using oral mucosa graft for male anterior urethral stricture disease: Current topics and reviews. *International Journal of Urology*, *24*(7), 493–503. https://doi.org/10.1111/iju.13356

Human Rights Watch. (1993). *The Human Rights Crisis in Kashmir*. https://www.hrw.org/sites/default/files/reports/INDIA937.PDF

International Institute of Strategic Studies. (2019). *Torture in Indian occupied Kashmir.* http://issi.org.pk/report-roundtable-on-torture-in-indian-occupied-kashmir/

Iran Human Rights Documentation Center. (2011). Surviving rape in Iran's prisons. https://iranhrdc.org/surviving-rape-in-irans-prisons/

JKCCS. (2019). *Torture. Indian state's instrument of control in indian administered Jamnu and Kashmir*. http://jkccs.net/torture-indian-states-instrument-of-control-jammu-kashmir/

Lunde I, O. J. (1992). Sexual torture and the treatment of its consequences. In *Torture and its Consequences- Current Treatment Approaches.* (pp. 310–329). Cambridge University Press.

Masmas TN, Moller E, Buhmann C, Bunch V, Jensen JH, H. T. et al. (2008). Asylum seekers in Denmark- a study of health status and grade of traumatization of newly arrived asylum seekers. *Torture*, *18*(2), 77–86.

Miles, S. H., & Garcia-Peltoniemi, R. E. (2012). Torture survivors: What to ask, how to document. *The Journal of Family Practice*, *61*(4), E1–E5.

Petersen, H. D., Abildgaard, U., Daugaard, G., Jess, P., Marcussen, H., & Wallach, M. (1985). Psychological and physical long-term effects of torture. A follow-up examination of 22 Greek persons exposed to torture 1967-1974. *Scandinavian Journal of Social Medicine*, *13*, 89–93.

Rosen, R., Cappelleri, J., Smith, M. et al. (1999). Development and evaluation of an abridged , 5-item version of the International Index of Erectile Function ( IIEF-5 ) as a diagnostic tool for erectile dysfunction. *International Journal of Impotence Research*, *11*, 319–326. https://doi.org/10.1038/sj.ijir.3900472

Rosen, R. C., Riley, A., Wagner, G., Osterloh, I. H., Kirkpatrick, J., & Mishra, A. (1997). The international index of erectile function (IIEF): a multidimensional scale for assessment of erectile dysfunction. *Urology*, *49*(6), 822–830. https://doi.org/10.1016/S0090-4295(97)00238-0

Rybarczyk, M. M., Schafer, J. M., Elm, C. M., Sarvepalli, S., Vaswani, P. A., Balhara, K. S., … Jacquet, G. A. (2017). A systematic review of burn injuries in low- and middle-income countries: Epidemiology in the WHO-defined African Region. *African Journal of Emergency Medicine*, *7*(1), 30–37. https://doi.org/10.1016/j.afjem.2017.01.006

Suhaiban, H. A., Grasser, L. R., & Javanbakht, A. (2019). Mental health of refugees and torture survivors: A critical review of prevalence, predictors, and integrated care. *International*

*Journal of Environmental Research and Public Health*, *16*(13). https://doi.org/10.3390/ijerph16132309

Tahir Tabassum, M. (2012). Political Situation in Kashmir and Role of the United Nations. *SCS Journal*, *1*(2), 4–28.

Tamblyn, J. M., Calderon, A. J., Combs, S., & O'Brien, M. M. (2011). Patients from abroad becoming patients in everyday practice: Torture survivors in primary care. *Journal of Immigrant and Minority Health*, *13*(4), 798–801. https://doi.org/10.1007/s10903-010-9429-2

UN General Assembly. (1984). *The Convention Against Torture and other forms of cruel, inhuman and degrading treatment or punishment. 10 December 1984.* OHCHR. https://www.ohchr.org/en/professionalinterest/pages/cat.aspx

Villani, M. (2011). *Desaparecido. Memorias de un cautiverio. Club Atlético. El Banco, El Olimpo, Pozo de Quilmes y ESMA*. Biblos.

Wani ZA, Hussain A, Khan AW, et al. (2011). Are health care systems insensitive to needs of suicidal patients in times of conflict? The Kashmir experience. *Mental Illness*, *3*, 11–13.

Weishut, D. J. N. (2015). Sexual torture of Palestinian men by Israeli authorities. *Reproductive Health Matters*, *23*(46), 71–84. https://doi.org/10.1016/j.rhm.2015.11.019

# Medical examination of detainees in Catalonia, Spain, carried out in the presence of police officers

**Carme Vivancos Sánchez*, Iñaki Rivera Beiras****

**Key points of interest**

- Medical examinations of detainees must respect the principles of the Istanbul Protocol, and with no exceptions be carried out of the presence of detention authorities.

## Abstract

*Introduction:* On 14th October 2019, the Supreme Court of Spain issued a court judgment convicting social and political leaders in Catalonia, of crimes of embezzlement, sedition and disobedience. Following this, widespread protests in Catalonia began. During these protests, there were also numerous clashes between protesters and members of different Catalan and Spanish police forces, which ended with more than 600 people suffering injuries to varying degrees.

*Method:* Semi-structured interviews in prison (n=22) with people injured and detained during demonstrations.

*Results: No detainees were informed of their right to a medical examination.* 50% of detainees reported access to medical examinations in police custody. In all cases this was carried out in primary healthcare centres in the presence of police in the examination room. In all cases the report was given to the police instead of the detainee. The whereabouts of this documentation is unknown despite attempts from the detainees and their lawyers to obtain them. 31% of detainees reported being medically examined in the courthouse, with police presence at all examinations. Finally, all detainees reported routine medical examinations at the entrance to prison for pre-trial detention, none of which were carried out in the presence of police forces. Detainees reported good treatment once in the prison.

*Conclusion:* The results show a serious breach of regional, national and international, regulations and in particular the Istanbul Protocol principles relating to the medical examination of detainees.

*Keywords*: Catalan independence movement, medical examinations, police, institutional violence.

## Introduction

The Catalan non-violent independence movement has undoubtedly shaped today's social and political agenda in the Spanish State. For

*) Sistema de Registre i Comunicació de Violència Instituciona (SIRECOVI). Barcelona.
**) Observatorio del Sistema Penal y los Derechos Humanos (OSPDH). Barcelona University
Correspondence to: rivera@ub.edu

https://doi.org/10.7146/torture.v30i1.119257

many years, the operation of the Spanish political, judicial and social system was clearly marked by the existence of the separatist group, Euskadi Ta Askatasuna (hereinafter ETA). Its disarmament in 2011 ETA (Gallego, 2017) characterised a shift of focus to the Catalan pacifist independence movement.

The Catalan self-determination movement has been gaining strength in recent years, and in particular, during the referendum that took place on 1 October 2017. In a civic movement never before seen in Spain, more than 2.3 million people (43% of the Catalan electorate) voted, despite massive police and military intervention in an attempt to deter the electorate. 92% of voters supported independence (Jones & Burgen, 2017). More than 1000 individuals were injured by Spanish police when trying either to vote or to preserve the integrity of the ballot boxes (Generalitat de Catalunya, 2017). This resulted in the beginning of a process of political, economic and civic repression (Palou, 2017).

As part of the country's legal strategy against the pacifist movement, on 14th October 2019, the Supreme Court of Spain issued a judgment convicting the main Catalan social and political leaders to sentences ranging from one year and eight months to thirteen years, for crimes of embezzlement, sedition and disobedience (459/2019, 2019). The weeks that followed the sentencing saw widespread social protests including mass demonstrations and a general strike. There were also numerous clashes between protesters and members of different Catalan and Spanish police forces, which ended with more than 200 people detained and approximately 600 people with varying degrees of injury, which ranged from superficial injuries to loss of eyes due to rubber bullets. Alleged injuries to 289 police officers were also reported (Garcia, 2019).

The SIRECOVI is a Documentation and Communication System for Institutional Violence[1] that collects data of ill-treatment and torture. As part of its activities, SIRECOVI has monitored detention conditions in Catalonia. The results of the research described here are part of a bigger report (SIRECOVI, 2019) that encompasses the entire process of deprivation of liberty, including arrest in public spaces, transportation, conditions in police stations and judicial courts, respect of due process in courts, and the initial days in prisons.

The study focuses on injured detainees that were transferred to Court and sent to pre-trial detention.

## Methods

From 28th October 2019, members of the SIRECOVI travelled to 6 penitentiary centers in the provinces of Barcelona, Tarragona, Lleida and Girona. In-depth interviews were carried out with individuals in pre-trial detention (n=22). Initial contact was facilitated by the prisoners' lawyers. The process was complex and lengthy, requiring 3 weeks to arrange informed consent from all detainees and to plan the agenda of visits.

*Ethical concerns:* Participants signed an informed consent document in advance of the interviews. Special care was taken to ensure that the recollection of episodes of violence or other types of abuse did not add to the nar-

1 SIRECOVI is a Documentation and Communication System for the protection of victims of Institutional Violence. This system is put into operation when someone communicates about a person who has allegedly suffered ill-treatment or torture in places of deprivation of liberty (for example prisons or police stations) or in the public space by an agent of the authority. SIRECOVI's website: https://sirecovi.ub.edu/index_en.html

rators' sense of victimisation. The interviews were recorded as part of the SIRECOVI database which is registered with the Catalan Data Protection Authority.

**Results**

In a sample of young people between 18 and 35 years old, 18 (81%) were men and 4 were(19%) women. 13 (59%) were examined at the police station or in court. 9 (41%) reported not having received any medical examination although their injuries were visually apparent. In all 22 cases, individuals were not informed of their right to a medical examination.

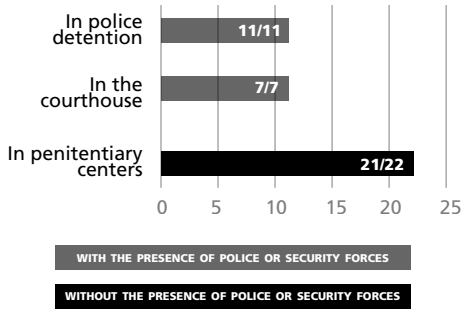
*Police station:* 11 individuals (50%) reported that they were examined by a doctor in police detention, all in the presence of the police or security forces. All detainees were taken to a Primary Healthcare Centre (Centre d'Atenció Primària – CAP) close to their place of detention. In 2 cases (18%) the detainees were handcuffed whilst undergoing an examination. In all 11 cases the report was given to the police instead of the detainee. The whereabouts of this documentation is unknown despite attempts from the detainees and their lawyers to obtain it.

Furthermore, the interviews revealed that the detainees had found the police presence intimidating as that they were unable to speak freely to the doctor. In particular, they were not able to discuss any ill-treatment they had endured, nor the physical and psychological consequences of the treatment. It also transpired that it was impossible to undertake a medical assessment in the two cases where the detainees remained handcuffed, despite the doctors' positive attempt at documentation.

*Courtroom:* 7 (31%) individuals reported being examined by doctors in the courthouse. In all cases the examination was conducted in the presence of police. In 1 (14%) case, the individual was handcuffed during examination. None of the detainees had access to the report.

*Prison:* All detainees reported that they were examined by doctors at the entrance of the prisons where they were to be held in pre-trial detention. Security forces were not present at any point.

The interviews highlighted the good treatment received in the prisons and that the experience was, paradoxically, one of calmness and safety that following two days of suffering, tension, ill-treatment and violence.




**Discussion**

The conduct of medical examinations of detainees is regulated by guidelines and procedures. Of particular relevance are the Istanbul Protocol at the international level and the Catalonian Charter of Citizens' Rights and Responsibilities at the sub-national level.

The **Istanbul Protocol** is the UN Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. It outlines international legal standards and sets out specific guidelines on how to conduct effective legal and medical investigations into allegations of torture and ill-treatment. The relevant paragraphs of the Istanbul Protocol are:

*National codes of medical ethics:* IP56 "[…]to avoid harm, help the sick, protect the vulnerable and not discriminate between pa-

> tients on any basis other than the urgency of their medical needs."
>
> IP61. "[…]doctors must always do what is best for the patient, including detainees and alleged criminals."
>
> *Established standards of medical practice*: IP83 "…Medical experts involved in the investigation of torture or ill-treatment should behave at all times in conformity with the highest ethical standards and, in particular, must obtain informed consent before any examination is undertaken. The examination must conform to established standards of medical practice. In particular, examinations must be conducted in private under the control of the medical expert and outside the presence of security agents and other government officials."
>
> *84. Confidentiality.* "The report should be confidential and communicated to the subject or their nominated representative."

Additionally, the Standard Minimum Rules for the Treatment of Prisoners were revised and adopted as the 'Nelson Mandela' rules. They are often regarded by states as the primary source of standards relating to treatment in detention, and are the key framework used by monitoring and inspection mechanisms in assessing the treatment of prisoners. These rules establish:

> *Rule 24.1.* "The provision of health-care for prisoners is a state responsibility. Prisoners should enjoy the same standards of health-care that are available in the community, and should have access to necessary health-care services free of charge…"
>
> *Rule 34.* "If, in the course of examining a prisoner upon admission or providing medical care to the prisoner thereafter, health-care professionals become aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment, they shall document and report such cases to the competent medical, administrative or judicial authority…'

The European Committee for the Prevention of Torture (CPT) expressed concern following its visit to Spain which took place between 6-13 September 2018:

> "the delegation noted that medical examinations, whether in the police stations or at a medical centre, still took place in the presence of police officers. (…) the CPT reiterates its recommendation that steps be taken to ensure that all health care examinations are conducted out of the hearing and - unless the doctor concerned expressly requests otherwise in a given case - out of the sight of police staff" (CPT, 2020).

### Regulations and recommendations in Catalonia and Spain regarding medical visits

The Charter of Citizens' Rights and Responsibilities in relation to health and healthcare sets out a regulatory procedure to follow in the doctor-patient relationship. Medical visits must be confidential and private, and the presence of anyone other than medical personnel must be expressly consented to by the patient (Generalitat de Catalunya, 2015).

Violations of the provisions of the Istanbul Protocol (among other regulatory provisions) may act to prevent detainees from giving an account of the origin of the injuries and might contribute to impunity. The Spanish Ombudsman in its 2019 report expressed concerns

that medical examinations were carried out in places of deeprivation of liberty as well as highlighting the lack of privacy and due guarantees (Defensor del Pueblo, 2019).

## Conclusions

The subject of medical examinations merits special consideration since almost all detainees interviewed reported that they were not informed of their right to a medical examination, and even being obviously injured, they either did not receive medical examinations, or where these had been carried out, police had been present in the medical units. This represents a serious breach of national and international regulations, which require that medical examinations are conducted in privacy in the sole presence of medical personnel, with no presence of the detention unit.

*References*

Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (2020) *To the Spanish Government on the visit to Spain carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 6 to 13 September 2018*. https://rm.coe.int/16809a5597

Defensor del Pueblo (2019) *Informe anual 2018. Mecanismo nacional de prevención. Supervisión de lugares de privación de libertad en España, de acuerdo con el Protocolo facultativo a la Convención de las Naciones Unidas contra la tortura y otros tratos o penas crueles, inhumanas o degradantes (OPCAT)*. https://www.defensordelpueblo.es/wp-content/uploads/2019/09/Informe_2018_MNP.pdf

Gallego, D. (2017) *Posibles consecuencias jurídico-penales de la entrega definitiva de las armas por parte de la organización terrorista ETA [Possible criminal legal consequences of the final delivery of arms by the terrorist organisation ETA]*. RJUAM, n.º 36, 2017-II, pp. 75-94

García, T (28th October 2019). *Detenidos de excepción y heridos por balas de goma [Exceptionally detained and injured by rubber bullets]*. El Salto. https://www.elsaltodiario.com/cataluna/detenidos-excepcion-represion-protestas-balas-goma-sentencia

Generalitat de Catalunya. Departament de Salut (2015) *Carta de drets i deures de la ciutadania en relació amb la salut i l'atenció sanitària* [Charter of Rights and Duties of Citizens in Relation to Health and Health Care*]*. https://catsalut.gencat.cat/web/.content/minisite/catsalut/ciutadania/drets-deures/carta-drets-deures.pdf.

Generalitat de Catalunya (2017*). Informe sobre els incidents dels dies 1 al 4 d'octubre de 2017. Pacients atesos durant la joranda electoral i dies posteriors a conseqüencia de les càrregues policials de l'Estat [Report on the incidents from 1 to 4 October 2017. Patients treated during election day and subsequent days as a result of state police charges]*. https://www.documentcloud.org/documents/4113650-232799c8-755f-4810-ba56-0a5bbb78609c.html#document/p3

Jones. S. & Burgen. S. (2017, Oct 2). *Catalan referendum: preliminary results show 90% in favour of independence*. The Guardian. https://www.theguardian.com/world/2017/oct/01/dozensinjured-as-riot-police-storm-catalan-ref-pollingstations

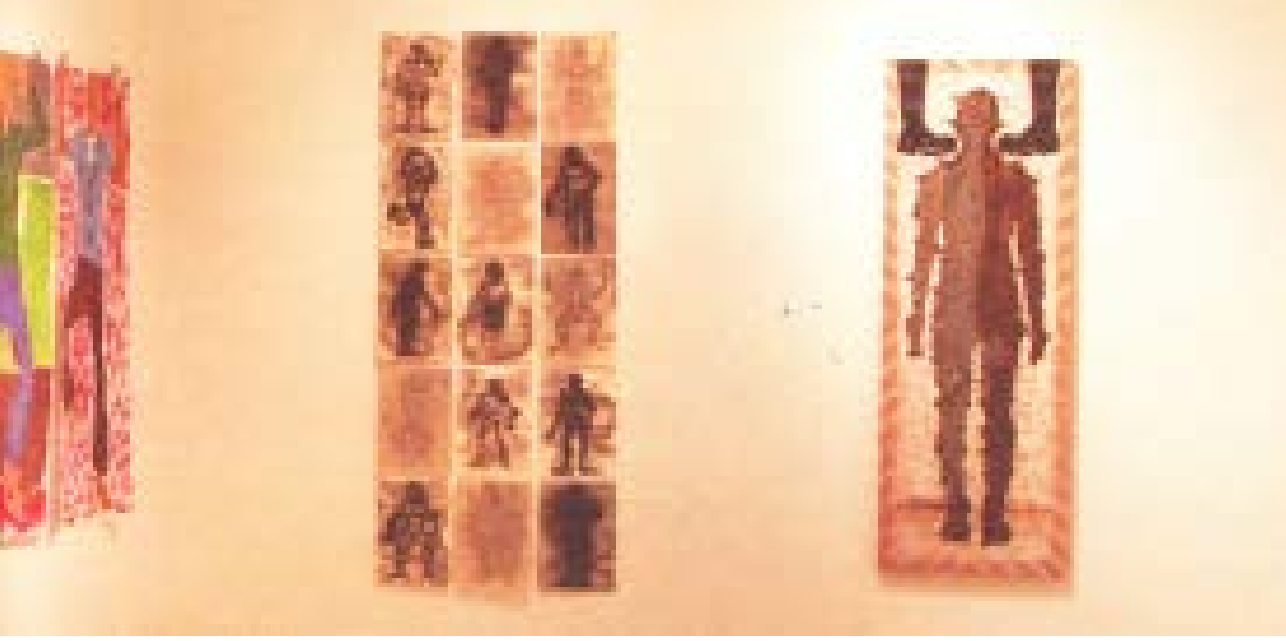
Palou, J. (2017). *Violación de derechos civiles y políticos. Cataluña, Septiembre y Octubre de 2017 [Violation of civil and political rights. Catalonia, September and October 2017]*. Iridia. http://iridia.cat/wpcontent/uploads/Informe-DDHH_1OCT-CAST.pdf

SIRECOVI (2019) *Protocol of visits to people imprisoned since 14th October during social protests against Supreme Court ruling 459/2019*. University of Barcelona. http://www.ub.edu/ospdh/sites/default/files/documents/publicacions/sirecovi._report_people_in_provisional_imprisonment_after_social_protests_on_supreme_court_sentence.pdf

Supreme Court of Spain, 14 October 2019 (459/2019. Special Proceedings 20907/2017) Supreme Court of Spain. https://cdn.20m.es/adj/2019/10/14/4019.pdf. Available in English from http://www.poderjudicial.es/cgpj/es/Poder-Judicial/Noticias-Judiciales/El-Tribunal-Supremo-condena-a-nueve-de-los-procesados-en-la-causa-especial-20907-2017-por-delito-de-sedicion

United Nations (1999) *Istanbul Protocol. Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. Professional Training Series No.8/Rev.1. OHCHR. https://www.ohchr.org/Documents/Publications/training8Rev1en.pdf

United Nations (2015) *Standard Minimum Rules for the Treatment of Prisoners (The Nelson Mandela Rules)*. United Nations. https://undocs.org/A/RES/70/175



# Tortured, 15 paintings by torture victims and their families.

**Duayjai Group. Full body drawings. Bangkok. Thailand.**

The Duayjai Group, in Thailand, organises workshops of art therapy through Body Map activities. The ones depicted here are part of a collection of paintings made by torture victims and their families from the Patani area, in South Thailand. These paintings included in the Tortured Art Exhibition and are part of a book recently published with the support of the Cross Cultural Foundation.

Further information: duayjaigroup61@gmail.com

# Civilizing Torture: An American Tradition, by W. Fitzhugh Brundage

*Published by Harvard University Press.* 2018. Cambridge. (ISBN 9780674737662)

**John W. Schiemann***

*Civilizing Torture: An American Tradition* is part history of torture in America, from the colonial period to the present, and part intellectual history about the debates surrounding torture in the same time span. The writing is lively and engaging despite its academic heft.

The introduction sets out the book's framework, explaining that the phrase "American Tradition" refers to "the debates that Americans have waged regarding torture. Like a minuet . . . the debates have unfolded in predictable fashion," invoking American exceptionalism of rationality, constitutional protections of liberty, and other claims to civilization (2).[1] On the assumption that "[t]orture cannot be disentangled from the discourse surrounding it," Brundage argues that the historical study of torture in the US means identifying not just acts of violence "but also the explanations, justifications, and denunciation of them" and so he "traces debates over forms of violence and coercion that at least some contemporaries labeled as torture" (6). Doing so reveals a "choreography," "a strikingly consistent pattern" in which both those defending torture and those opposed do their best to align their position with "the nation's professed principles and with the dictates of modern civilization". The choreography appears to have the following seven stages:

1. Officials respond to allegations of torture with categorical denials;
2. More evidence by accusers prompts officials to admit a few exceptional mistakes;
3. Defenders "dismiss victims as neither credible nor deserving of sympathy;"
4. Supporters of victims risk guilt by association;
5. Defenders claim that methods were justifiable and effective;
6. Opponents claim that methods were immoral and ineffective;
7. Once torture ceases the debate shifts to the significance of practice.

The remainder of the book is organized chronologically into eight chapters, each of which treats a different period or episode of torture in American history. Chapter one relays anecdotes, memoirs, and reports of torture by both North American Indians and European colonists in pre-revolutionary North America, showing how each side believed the other had violated the norms and customs of warfare. The second chapter examines early cycles of prison reform in the new democracy, resulting in punishments often amounting to torture and eventually the establishments of state institutions with total control over their charges. Chapter three turns to the torture of slaves in the antebellum South, with a focus on the ex-

1 All numbers in parentheses refer to page numbers in the book.

*) Professor of Government & Law, Fairleigh Dickinson University.
Correspondence to: jws@fdu.edu.

https://doi.org/10.7146/torture.v30i1.118434

ploitation of stories of cruelty to mobilize support for the abolitionist cause and the backlash it engendered among slavery's southern supporters. Chapter four turns to *bellum*: the civil war between the North and the South and the conditions that led to atrocities on the battlefield and in the prison camps. Chapter five explores the episodes of torture prior to 9/11: the Philippine-American War from 1899-1902. The chapter summarizes the multiple factors that led to torture and other abuse by occupying American forces. Chapter six recounts the post-Civil War emergence and movement to the shadows of the so-called "third degree". Chapter seven traces the US government's efforts to develop a science of torture early in the Cold War and then the applications of torture on the "frontiers of American empire" in Vietnam and Latin America. The eighth and final chapter brings the narrative up to the present by discussing both torture for national security reasons after 9/11 and torture in the Chicago police department.

The book is organized chronologically but Brundage does not systematically trace the debates according to the choreography in the introduction. Each chapter after the introduction is essentially freestanding. Perhaps given the historical span and varying contexts, it should not be surprising that there appears to be no single choreography but rather quite different American dances with torture over time. Indeed, occasionally the author digresses from torture in America or even torture entirely.

Along the way, however, Brundage makes some valuable points both about elements of torture specific to different historical episodes and more generally. For example, in chapter one, "The Manners of Barbarians," Brundage notes that "[w]herever Indians practiced torture, they did so according to traditions that were as coherent as any that regulated in Europe" (15). Ritual torture cohered with spiritual beliefs about countering vengeful souls, cultural norms and customs related to clan, honor, just retribution, and the practice of Indian warfare, which did not include prisoner exchanges. In chapter three on slavery, he demonstrates the role of political institutions, including courts and the law, in carving out a legal space for torture and other cruelty in the private sphere on the plantation. This served to sustain and maintain the slave order by "instilling terror" in the slaves (99, 102). Chapter six on police torture traces the connection between the police use of the "third degree" and the lynching of African-Americans in the US South.

More thematically, his review identifies some factors common to both the military and domestic incarceration contexts as well as shared features within each. Common to all is the demonization of a certain class of people rendering them "unworthy of sympathy" and so torture-able (331). "The history of torture, above all, reveals the toxic consequences when rhetoric and policies that dehumanize 'the enemy within' or a foreign foe exploit popular anxiety about security" (332). To this necessary condition is added, in the military context, poor training and counterinsurgency against an indigenous population fighting for independence or counter-terrorism conflicts. In both, the enemy blends with the local population. To the necessary condition of racism in the domestic incarceration context (whether prison, plantation, or police station) are added institutional rules, social norms, and cultural practices which formally prohibit torture but make its informal practice pos-

sible by creating a space for it to flourish out of sight (333).

*Civilizing Torture* amplifies the echoes of pre-9/11 American experiences with torture – dehumanization of the enemy, justifications for torture, claims of efficacy, the fleeting nature of the public debate about torture and what it meant, and more – and in so doing reminds us of how the traditional seems forever new — and so is repeated all too often.

# Tortura e migrazioni

# Torture and Migration, by Fabio Perocco (ed.)

*Published by Ca' Foscari Editions*: Venezia, 2019, 430 p, ISBN [ebook] 978-88-6969-358-8; [print] 978-88-6969-359-5).

**Iside Gjergji***

Reviewing this volume edited by Fabio Perocco and published as *open access* by University of Venice Ca' Foscari Editions[1] is no easy task. What makes it hard to sum up this work is not its length (430 pages), but rather its interdisciplinary approach, the depth of observations, the richness in contents and points of view and its geographical width. Yet, these aspects make the book fundamental for anyone willing to understand migratory movements in today's world. Its main merit is having addressed, consistently and systematically, the close relation that has come to be, over the course of decades, between torture and migration. Such relation is no recent piece of news: for a long time, torture has been indicated as one of the most widespread reasons for leaving, one of the most frequent experiences lived along the migration path and, more and more often, a reality that migrants are forced to tackle in receiving countries. Nevertheless, the scientific narrative of such relation is often limited, fragmented and, sometimes, manipulated. Torture has so far been extensively studied systematically in relation to power (MacMaster, 2004), wars and dictatorships (Hajjar, 2013; Cohen, 2005). It is considered as lying at the basis of modernity (Reemtsma, 2012) or of the process of civilization (Linklater, 2007), but it has been analyzed less intensively as a structured element of migration. The volume therefore deserves to be recognized as one of the works that can pave the way for an innovative field of research.

The volume, including a broad and sharp introductory essay by Fabio Perocco, is divided in three parts. The first part, composed of three essays, is devoted to the theoretical analysis of the concepts of torture, racism, politics, society, law, and migration policies. It highlights the (historically) unbreakable bond between torture and racism and between torture and current social and political dynamics. Here torture is analysed as a social phenomenon, produced by state institutions and by the modelling of relations within a specific political, legal, economic, social and symbolic system. The general invitation is to "think from the extremes, think of torture, of migration *with* and *beyond* existing tools […] to think of the enigmas of the relationship between torture and migrations and find again the political freedom to act" (p. 86).

The second part, the core of the volume (composed of thirteen essays), aims at analysing and proving that, at a global level, there is a long-lasting war against migrants, which has created universal preconditions for the massive use of torture practices against them. The connection between torture and migration is considered in the contexts of Spain, Belgium, United Kingdom, United States,

1 Free download from: https://edizionicafoscari.unive.it/it/edizioni4/libri/978-88-6969-359-5/.

*) Centre for Social Studies, University of Coimbra, Portugal
Correspondence to: isidegjergji@ces.uc.pt

https://doi.org/10.7146/torture.v30i1.118739

Brazil, Argentina, the Balkans, Morocco, Sudan-Israel, Libya, the central Mediterranean and Italy. These essays, though using different investigation and analysis instruments, paint a full picture, rich in details, colors and words, which is also achieved through the use of fresh and effective language; under this profile, it is a welcome breath of fresh air within the global scientific literature, which often stubbornly encloses itself in jargon, difficult for others to understand and to clarify the connections between history and biographies.

The last part, constituted by four essays, focuses on the medical-psychological dimension of torture in migration. There is complete reconstruction of the state-of-the-art in global scientific literature starting from 25 years ago, with the very first epidemiological studies. Other essays relate migration to mental health, investigating both psychopathological reactions in traumatized people and the effects of trauma experienced during their migration path, together with mental illness issues due to the harsh living conditions in receiving countries. It also offers an in-depth look into psychological disorders deriving from torture and their impact on access to international protection, in as well as emphasis on the necessary healing process from the damage caused by torture.

This book is also an important tool to better understand the present, since it makes intelligible today's close port policies in the Northern Mediterranean, as well as the wall between Mexico and the US, or the one between Morocco and Spain. It helps us understand how these repressive and securitarian migration policies violate the prohibition of torture and of inhuman or degrading treatment (Algostino p. 110-112; Ounniche, Saaid p. 291-292; Omizzolo p. 312-316), which clearly constitute a crime against humanity under international law. Although criminal responsibility is personal, *i.e.* lies with those who personally practice torture, governments are not exempt from responsibility: "Those who, by externalising borders, relocate and outsource torture and inhuman or degrading treatment, are co-responsible, as are those who take measures to close ports, condemning shipwrecked persons to inhuman or degrading treatment" (p. 111).

Moreover, what clearly stands out in the overwhelming majority of the essays – which constitutes one of its distinctive analytical features – is the fact that the economic dimension is often included in the analysis. In this book, torture against migrants is not only explained through a political dimension (which includes only government and state actions), but it also takes into account that the tortured are actually meant to enter the labour market, both in the countries of arrival and in transit. Such a perspective, outlined in different nuances, gives the volume a very interesting character.

If a downside were to be identified in this volume, perhaps it could be that in some essays there is an overlap between torture and degrading or inhuman treatment. Such overlap may be considered scientifically valid or acceptable from a medical or sociological point of view, but from a legal or political perspective the equivalence runs the risk of banalising torture.

The essays in the volume are written in four languages: Italian, English, French and Spanish. Intertwining reflections by sociologists, philosophers, lawyers, doctors and activists from several countries in the world was not easy, yet it was certainly needed, especially for those who conceive research as something inseparable from social action, who wish for knowledge not to be left to rot in academa but rather spread and flourish as energy triggering social transformations.

*References*

Cohen, S. (2005). "Post-Moral Torture: From Guantanamo to Abu Ghraib". *Index on Censorship*, *1*, 24-30. https://doi.org/10.1080/03064220512331339427

Hajjar, L. (2013). *Torture: A sociology of violence and human rights*. Routledge.

Linklater, A. (2007). "Torture and Civilisation". *International Relations*, *21*, 111-118. https://doi.org/10.1177/0047117807073771

MacMaster, N. (2004). "Torture: From Algiers to Abu Ghraib". *Race and Class*, *46*, 1-21. https://doi.org/10.1177/0306396804047722

Reemtsma, J. P. (2012). *Trust and violence: An essay on a modern relationship*. Princeton University Press.

# Criminalisation of torture and enforced disappearance in Thailand: Progress on draft legislation

**Torture Journal Editorial Team* on behalf of Cross Cultural Foundation (CrCF), Thailand**

In 2007, Thailand ratified the UN Convention Against Torture and in 2012, signed the International Convention for the Protection of All Persons from Enforced Disappearance. 13 years on however, the country has yet to criminalise torture and enforced disappearance under domestic legislation.

Following a recommendation from the UN Committee Against Torture in 2014, the 'Suppression and Prevention of Torture and Enforced Disappearance' Bill was drafted. At the time of writing, the Bill remains entangled in a legislative process fraught with political obstacles and delays.

The failure to criminalise torture and enforced disappearances leads to a lack of prompt, effective, and independent investigations, and forges a climate of impunity. The UN Working Group on Enforced or Involuntary Disappearances has recorded 79 cases of enforced disappearance that are pending investigation in Thailand. No perpetrator in any of these cases has successfully been brought to justice.

The drafting and passing of legislation is thereby critical to ensuring effective access to justice and legal assistance as a means to investigating and ultimately ceasing violations.

An overview of the timeline and details of the draft Bill are as follows:

- In 2012, Thailand signed, but has yet to ratify, the International Convention for the Protection of All Persons from Enforced Disappearance.
- In 2014, the Suppression and Prevention and of Torture and Enforced Disappearance Bill was drafted following the recommendation of the UN Committee Against Torture.
- In 2016, the draft Bill was submitted before the Council of State and the National Legislative Assembly for review and final approval.
- In October 2018, the draft law was endorsed by the Council of State, the Cabinet, and the Coordinating Committee of the National Legislative Assembly (NLA).
- In December 2018, many civil society organizations (CSOs), namely the Cross-Cultural Foundation (CrCF), submitted a letter to the NLA, expressing concerns regarding the lack of CSO participation in the process and requesting to observe the ad hoc committee sessions, but were denied permission.
- In March 2019, the NLA decided to take the discussion and consideration of the draft Bill out of their agenda in the second reading due to strong opposition from high ranking security officials.
- In May 2019, a new parliament was formed following a general election. During this time, CrCF and other human rights organ-

*) Correspondence to: publications@irct.org

https://doi.org/10.7146/torture.v30i1.120594

isations developed the CSO version of the draft law. This version provides that:

a. Intentional infliction of severe pain or suffering for any reason based on discrimination constitutes torture.
b. The act of torture may not be justified in any circumstances, even in time of public emergencies.
c. Superiors of the offender must be held accountable for an act of torture and enforced disappearance committed by their subordinates.
d. All persons deprived of liberty must enjoy fundamental safeguards that guarantee their freedom from torture, cruel, inhumane and degrading treatments or punishments, and enforced disappearance.
e. Allegations must be reviewed by civilian courts which shall be granted powers to intervene and issue injunctions that offer immediate remedies for the victims.

- In early 2020, the Draft Act on Prevention and Suppression of Torture and Enforced Disappearance was submitted to the Standing Committee on Legal Affairs, Justice, and Human Rights of the Thai Parliament.

Despite efforts to codify the crimes of torture and enforced disappearance under Thai law, the country's pledges to do so remain unfulfilled. Without this law, there is no foreseeable end to the rampant culture of impunity in Thailand. Victims of torture and enforced disappearance will continue remain in the shadows without access to protection from the state.

# Launch of IRCT Report on Conversion Therapy*

**Torture Journal Editorial Team**

On 23 April 2020, IRCT published its research on the global practice of conversion therapy. The report, entitled "*It's Torture Not Therapy,*" compiles information on the "practices, practitioners and roles of states in conducting, supporting, promoting and acquiescing in conversion therapy" and is intended to supplement the Expert Statement of the Independent Forensic Expert Group on the same issue, also printed in this edition of Torture Journal.

The paper identifies a number of practices as used by at least 68 states in conversion attempts including:

- Aversive treatment
- Electroconvulsive therapy
- Medication
- Forced confinement
- Pyschotherapy
- Corrective violence
- Exorcisms and ritual cleansing

### Perpetrators

Whilst the author notes that prevalence of groups of perpetrators varies by country and region, a disturbing number of perpetrators are identified to include health professionals (doctors, psychiatrists, psychotherapists professional counsellors, sexologists and ayurvedic practitioners), with police and religious practitioners also cited. The paper further notes that perpetrators conduct this type of "therapy" under the false guise of medicine and mental health, although it causes significant harm and there is no evidence that it can be effective.

### State Involvement

The report finds that states perpetuate conversion therapy through direct involvement, acquiescence, or financial support, as well as via promotion and endorsement of conversion practices. It highlights that conversion therapy is, in some cases, ordered by state officials and practiced by the police and also finds its practice in publicly funded religious or educational institutions, or in government hospitals.

The authors further discuss the widespread failure of states to regulate conversion practices where they occur, noting a prevalence of practices in government-licensed institutions. Although they may be qualified as torture or ill-treatment as well as child abuse and fraud, practices often remain, the report finds, unsanctioned in the majority of legal or regulatory frameworks.

Finally, the paper highlights examples in which States have promoted and legitimised

*) Full report available at https://irct.org/uploads/media/IRCT_research_on_conversion_therapy.pdf



https://doi.org/10.7146/torture.v30i1.119655

practices through encouragement of its usage by governmental officials and workers and through the provision spaces for practices to be carried out. The report also highlights cases where crimes of "corrective violence" are ignored by both the public and by police.

**Conclusion and Recommendations**

In its conclusion, the report emphasises the role of the state in providing, financing, or encouraging conversion therapy, being complicit in acts carried out by state officials or acquiescing to private practice of conversion therapy.

*IRCT makes 11 recommendations to states including:*

Repeal laws criminalising individuals on the basis of their sexual orientation or gender identity (SOGI); issue an apology for discrimination and historical injustices against lesbian, gay, bisexual, trans and gender diverse communities; ban conversion therapy practices; issue and enforce clear guidance to identified groups of perpetrators that prohibits and punishes conversion therapy; establish a complaints mechanism and programmes to provide full reparation for those harmed by conversion therapy and undertake research on the practice and provide widespread education on SOGI and wider human rights principles.

# Statement on Conversion Therapy

**Independent Forensic Expert Group***

## Introduction

Conversion therapy is a set of practices that aim to change or alter an individual's sexual orientation or gender identity. It is premised on a belief that an individual's sexual orientation or gender identity can be changed and that doing so is a desirable outcome for the individual, family, or community. Other terms used to describe this practice include sexual orientation change effort (SOCE), reparative therapy, reintegrative therapy, reorientation therapy, ex-gay therapy, and gay cure.

Conversion therapy is practiced in every region of the world. We have identified sources confirming or indicating that conversion therapy is performed in over 60 countries[1].

In those countries where it is performed, a wide and variable range of practices are believed to create change in an individual's sexual orientation or gender identity. Some examples of these include: talk therapy or psychotherapy (e.g., exploring life events to identify the cause); group therapy; medication (including anti-psychotics, anti-depressants, anti-anxiety, and psychoactive drugs, and hormone injections); Eye Movement Desensitization and Reprocessing (where an individual focuses on a traumatic memory while simultaneously experiencing bilateral stimulation); electroshock or electroconvulsive therapy (ECT) (where electrodes are attached to the head and electric current is passed between them to induce seizure); aversive treatments (including electric shock to the hands and/or genitals or nausea-inducing medication administered with presentation of homoerotic stimuli); exorcism or ritual cleansing (e.g., beating the individual with a broomstick while reading holy verses or burning the individual's head, back, and palms); force-feeding or food deprivation; forced nudity; behavioural conditioning (e.g., being forced to dress or walk in a particular

*) Djordje Alempijevic, Rusudan Beriashvili, Jonathan Beynon, Bettina Birmanns, Marie Brasholt, Juliet Cohen, Maximo Duque, Pierre Duterte, Adriaan van Es, Ravindra Fernando, Sebnem Korur Fincanci, Sana Hamzeh, Steen Holger Hansen, Lilla Hardi, Michele Heisler, Vincent Iacopino, Peter Mygind Leth, James Lin, Said Louahlia, Hege Luytkis, Jens Modvig, Maria-Dolores Morcillo Mendez, Alejandro Moreno, Valeria Moscoso, Resmiye Oral, Onder Ozkalipci, Jason Payne-James, Jose Quiroga, Hernan Reyes, Sidsel Rogde, Antti Sajantila, Matthis Schick, Agis Terzidis, Jorgen Lange Thomsen, Morris Tidball-Binz, Felicitas Treue, Peter Vanezis, Duarte Nuno Viera

Please send correspondence to irct@irct.org.

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

1 IRCT research on conversion therapy available at https://irct.org/uploads/media/IRCT_research_on_conversion_therapy.pdf.



https://doi.org/10.7146/torture.v30i1.119654

way); isolation (sometimes for long periods of time, which may include solitary confinement or being kept from interacting with the outside world); verbal abuse; humiliation; hypnosis; hospital confinement; beatings; and "corrective" rape.

Conversion therapy appears to be performed widely by health professionals, including medical doctors, psychiatrists, psychologists, sexologists, and therapists. It is also conducted by spiritual leaders, religious practitioners, traditional healers, and community or family members. Conversion therapy is undertaken both in contexts under state control, e.g., hospitals, schools, and juvenile detention facilities, as well as in private settings like homes, religious institutions, or youth camps and retreats. In some countries, conversion therapy is imposed by the order or instructions of public officials, judges, or the police.

The practice is undertaken with both adults and minors who may be lesbian, gay, bisexual, trans, or gender diverse. Parents are also known to send their children back to their country of origin to receive it. The practice supports the belief that non-heterosexual orientations are deviations from the norm, reflecting a disease, disorder, or sin. The practitioner conveys the message that heterosexuality is the normal and healthy sexual orientation and gender identity.

The purpose of this medico-legal statement is to provide legal experts, adjudicators, health care professionals, and policy makers, among others, with an understanding of: 1) the lack of medical and scientific validity of conversion therapy; 2) the likely physical and psychological consequences of undergoing conversion therapy; and 3) whether, based on these effects, conversion therapy constitutes cruel, inhuman, or degrading treatment or torture when individuals are subjected to it forcibly[2] or without their consent. This medico-legal statement also addresses the responsibility of states in regulating this practice, the ethical implications of offering or performing it, and the role that health professionals and medical and mental health organisations should play with regards to this practice.

Definitions of conversion therapy vary. Some include any attempt to change, suppress, or divert an individual's sexual orientation, gender identity, or gender expression. This medico-legal statement only addresses those practices that practitioners believe can effect a genuine change in an individual's sexual orientation or gender identity. Acts of physical and psychological violence or discrimination that aim solely to inflict pain and suffering or punish individuals due to their sexual orientation or gender identity, are not addressed, but are wholly condemned.

This medico-legal statement follows along the lines of our previous publications on Anal Examinations in Cases of Alleged Homosexuality[3] and on Forced Virginity Testing[4]. In those statements, we opposed attempts to minimise the severity of physical and psychological pain and suffering caused by these

2 This statement considers an examination to be "forcibly conducted" when it is "committed by force, or by threat of force or coercion, such as that caused by fear of violence, duress, detention, psychological oppression or abuse of power, against such person incapable of giving genuine consent." International Criminal Court. Elements of Crimes. Art. 7(1)(g)-1. RC/11. 2011:8.

3 Independent Forensic Expert Group. Statement on Anal Examinations in Cases of Alleged Homosexuality. Torture. 2016; 26(2):85-91. Available at: https://irct.org/uploads/media/306a591c5f8207f6107f5c11e8c5c4fc.pdf.

4 Independent Forensic Expert Group. Statement on Virginity Testing. Torture. 2015; 25(1):62-68. Available at: https://irct.org/uploads/media/1d6e1087759460fd9e473273a85c7e95.pdf

examinations by qualifying them as medical in nature. There is no medical justification for inflicting on individuals torture or other cruel, inhuman, or degrading treatment or punishment. In addition, these statements reaffirmed that health professionals should take no role in attempting to control sexuality and knowingly or unknowingly supporting state-sponsored policing and punishing of individuals based on their sexual orientation or gender identity.

**About the Authors**

The opinions expressed in this statement are based on international standards and the experiences of members of the Independent Forensic Expert Group (IFEG) in documenting the physical and psychological effects of torture and other cruel, inhuman, or degrading treatment or punishment (also ill-treatment). Consisting of 39 preeminent independent medico-legal specialists from 23 countries, the IFEG represents a vast collective experience in the evaluation and documentation of the physical and psychological evidence of torture and ill-treatment.

The IFEG provides technical advice and expertise in cases where allegations of torture or ill-treatment are made[5]. Its members are global experts on and authors of the Istanbul Protocol, the key international standard-setting instrument on the investigation and documentation of torture and ill-treatment[6].

IFEG members also hold influential positions in and act as advisors to governments, international bodies, professional health associations, non-governmental organisations, and academic institutions worldwide on forensics in general and more specifically on the investigation and documentation of torture and ill-treatment.

**Medical and Scientific Validity**

There is no empirical evidence to support pathologising or medicalising variations in sexual orientation and gender identity. Studies have found that variation in sexual orientation is ubiquitous and that there is substantial variability in patterns of sexual and gender expression both between individuals and within individuals across time[7]. The World Medical Association (WMA) has strongly emphasised "*that homosexuality does not represent a disease, but a normal variation within the realm of human sexuality*."[8] For almost half a century, the Diagnostic and Statistical Manual of Mental Disorders (DMS-III, 1973) has stopped recognising homosexuality as a disorder. Similarly, for three decades, the World Health Organisation (WHO), which issues the International Statistical Classification of Diseases and Related Health Problems, has not defined

5 See, e.g., Independent Forensic Expert Group. Statement on Hooding. Torture. 2011; 21(3):186-189; Independent Forensic Expert Group. Statement on access to relevant medical and other health records and relevant legal records for forensic medical evaluations of alleged torture and other cruel, inhuman or degrading treatment or punishment. Torture. 2012; 22 (Supplementum 1):39-48. Independent

6 United Nations Office of the High Commissioner for Human Rights. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the "Istanbul Protocol"). United Nations; 2004. HR/P/PT/8/Rev.1.

7 World Health Organization. Proposed declassification of disease categories related to sexual orientation in the international statistical classification of diseases and related health problems (ICD-11). Bulletin of the World Health Organization 2014;92:672-679.

8 World Medical Association. Statement on Natural Variations of Human Sexuality. World Medical Assembly; 2013.

homosexuality as a disorder (ICD-10, endorsed in 1990). Moreover, in 2018, the WHO declassified all remaining disorders correlated with same-sex attraction, such as ego-dystonic sexual orientation[9], which had been (mis)used in the past to justify conversion therapy, thereby eliminating all medical bases correlated to sexual orientation that can be used to justify conversion therapy.

To our knowledge, there also are no credible scientific peer-reviewed studies that demonstrate that conversion therapy in any form is effective. On the contrary, in 2009, the American Psychological Association conducted a systematic review of peer-reviewed journal literature on conversion therapy and concluded that "*the results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same-sex attractions or increase other-sex sexual attractions through [sexual orientation change efforts]*."[10] In 2016, the World Psychiatric Association issued a statement finding that "*[t]here is no sound scientific evidence that innate sexual orientation can be changed.*"[11] Practices that purport to change an individual's sexual orientation or gender identity therefore lack any foundation in science or medicine and are unlikely to be effective. Instead, they are based on an antiquated misconception about the nature of sexual orientation and gender identity.

**Physical and Psychological Effects**

Conversion therapy represents a form of discrimination, stigmatisation, and social rejection. Many conversion therapy practices bear similarity to acts that are internationally acknowledged to constitute torture or other cruel, inhuman, or degrading treatment or punishment. Those include beatings, rape, forced nudity, force-feeding, isolation and confinement, deprivation of food, forced medication, verbal abuse, humiliation, and electrocution. These specific acts as well as the entire period during which the individual experiences them is recognised internationally to subject individuals to significant or severe physical and/or mental pain and suffering.

The fact that a treatment or practice has a valid medical use does not mean that it is not physically and psychologically harmful to individuals. In addition, a valid medical use for some conditions does not mean that the treatment is valid to treat other conditions under different circumstances. For instance, ECT or electroshock therapy applied with muscle relaxant and general anaesthesia is a recognised and valid form of treatment for psychiatric patients suffering from treatment-resistant, life-threatening depression. But in almost every instance, individuals will experience significant disorientation, cognitive deficits, and retrograde amnesia, which can be severely distressing. Concerningly, ECT is reportedly used for conversion therapy in some countries, although it is unproven and therefore medically invalid. In countries where ECT is still administered in its unmodified form (i.e., without anaesthetic

9 "The gender identity or sexual preference is not in doubt but the individual wishes it were different because of associated psychological and behavioural disorders and may seek treatment to change it." World Health Organization. The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. 1992.

10 American Psychological Association. Task Force on Appropriate Therapeutic Responses to Sexual Orientation. Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation. 2009.

11 World Psychiatric Association. Position Statement on Gender Identity and Same-Sex Orientation, Attraction, and Behaviours. World Psychiatry. 2016;15(3):299–300.

and muscle relaxants), it not only causes significant psychological harm, but leads to violent convulsions commonly resulting in joint dislocations and bone fractures.

Medication is also used in conversion therapy and can cause significant physical and mental adverse effects. When such medication is medically inappropriate or used forcibly or without the individual's consent, it is likely to intensify the psychological terror or trauma related to the experience of conversion therapy and has been recognised as a method of torture or other cruel, inhuman, or degrading treatment[12]. Neuroleptics, anxiolytics, and anti-depressants (including thioridazine, citalopram, fluoxetine, and risperidone) have been used on individuals to diminish their sexual desire. In addition, they are often prescribed due to the false belief that psychosis or other mental disorder is the underlying cause of an individual's particular sexual orientation or gender expression. These anti-depressants, mostly from the selective serotonin reuptake inhibitor group, may cause sexual dysfunction, while anti-psychotic medications may cause movement disorders, mental slowing, tiredness, memory problems, numbness of the body, weight gain, and sexual dysfunction, among other effects, which serve only to compound an individual's distress and suffering.

All forms of conversion therapy, including talk or psychotherapy, can cause intense psychological pain and suffering.[13,14,15,16] All practices attempting conversion are inherently humiliating, demeaning, and discriminatory. The combined effects of feeling powerless and extreme humiliation generate profound feelings of shame, guilt, self-disgust, and worthlessness, which can result in a damaged self-concept and enduring personality changes. The injury caused by conversion therapy begins with the notion that an individual is sick, diseased, and abnormal due to their sexual orientation or gender identity and must therefore be treated. This starts a process of victimisation through conversion therapy. Individuals who have undergone the practice often experience a decrease in self-esteem, episodes of significant anxiety, depressive tendencies, depressive syndromes, social isolation, intimacy difficulties, self-hatred, sexual dysfunction, and suicidal thoughts. In many studies, the rates of suicidal ideation and suicide attempt are several times higher than in other lesbian, gay, bisexual, trans, and gender diverse pop-

12 UN Human Rights Councils. Report of the United Nations High Commissioner for Human Rights. 31 January 2017. A/HRC/34/32.

13 Dehlin J, Galliher R, Bradshaw W, Hyde D, & Crowell K. Sexual orientation change efforts among current or former LDS church members. Journal of Counseling Psychology. 2015;62(2):95-105.

14 Ozanne Foundation. 2018 National Faith & Sexuality Survey. https://ozanne.foundation/faith-sexuality-survey-2018/. Published July 8, 2019.

15 Shidlo A & Schroeder M. Changing sexual orientation: a consumers' report. Professional Psychology-Research and Practice, 2002;33: 249-259.

16 Haldeman, D. Therapeutic Antidotes: Helping gay and bisexual men recover from conversion therapies. Journal of Gay and Lesbian Psychotherapy. 2002; 5 (3): 117-130.

ulations who have not been exposed to conversion therapy[17 18 19].

Conversion therapy can often lead to posttraumatic stress disorder[20,21]. Group therapy, camps and retreats may incorporate highly traumatic elements such as exposure to physical, verbal, and sexual abuse and humiliation. Talk or psychotherapy can also become a repeatedly traumatic event. Session after session, the individual is confronted with their own "deviancy," while repetition and duration increase its intensity and importance. We have seen that conversion therapies can lead to avoidance behaviours, hypervigilance (e.g., difficulty falling or staying asleep), intrusive flashbacks, traumatic nightmares, and other symptoms of posttraumatic stress disorder.

Children and minors are particularly vulnerable[1,2,22]. In children and minors exposed to conversion therapy, psychological symptoms are expressed in a significant loss of self-esteem and a sharp increase in suicidal or depressive tendencies. These can often lead to school dropout and the adoption of high-risk behaviours, self-destructive behaviours, and substance abuse. Conversion therapy causes a delay in sexual and personal development, which can lead to depression, increased feelings of guilt and stress, and can also bring about feelings of social rejection and social isolation. Minors are at especially high risk to develop serious psychological disorders afterwards, due to the loss of self-esteem, negative feelings toward oneself, self-loathing, feelings of debasement, and the forced rejection of one's own identity.

The long-term duration of many conversion therapies can be particularly harmful. Individuals often undergo therapy for several years to more than a decade[23,6]. The long-term duration creates chronic stress, which has been known to result in many negative health consequences, including stomach ulcers, gastrointestinal disorders, skin diseases, sexual and eating disorders, and migraines. Psychosomatic symptoms can be especially pronounced in children who are unable to express their difficulties and may manifest their distress through eczema breakouts, insomnia, sleep disorders, vomiting, asthma, and impaired growth or development. Psychological symptoms can become chronic. Despair, disillusion, and shame can last for many years. Even into adulthood, studies have found that exposure to conversion efforts results in adverse mental health outcomes, including severe psychological dis-

17 Turban JL, Beckwith N, Reisner SL, & Keuroghlian AS. (2020). Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. *JAMA Psychiatry. 2020;77*(1):68.

18 Ryan C, Toomey RB, Diaz RM, & Russell ST. Parent-initiated sexual orientation change efforts with LGBT adolescents: implications for young adult mental health and adjustment, Journal of homosexuality, 2009; 67(2):159-173.

19 The Trevor Project. National Survey on LGBTQ Mental Health 2019. https://www.thetrevorproject.org/survey-2019/?section=Conversion-Therapy-Change-Attempts. Published June 2019.

20 Shidlo A & Schroeder M. Changing sexual orientation: a consumers' report. Professional Psychology-Research and Practice, 2002;33: 249-259.

21 Horner J. Undoing the Damage: Working with LGBT clients in post conversion therapy. Columbia Social Work Review. 2010;1:8-16.

22 Fjelstrom, J. Sexual orientation change efforts and the search for authenticity. Journal Of Homosexuality, 2013;60(6): 801-827.

23 Dehlin J, Galliher R, Bradshaw W, Hyde D, & Crowell K. Sexual orientation change efforts among current or former LDS church members. Journal of Counseling Psychology. 2015;62(2):95-105.

tress, lifetime suicidal thoughts, and lifetime suicide attempts[24, 25].

In both adults and minors, the failure of conversion therapy often exacerbates the individual's feelings of inadequacy, self-worthlessness, and shame[26,27]. Individuals often feel intense guilt of failure, reinforced by the idea that they are ill, unacceptable, incurable, and a burden to their families.

When health professionals are involved in the performance of this harmful act, in our experience, their involvement is likely to exacerbate the pain and suffering experienced by individuals given the betrayal it represents of the social norm of trusting health professionals. Betrayal of the fragile trust between patient and clinician can have severe consequences, leading to feelings of guilt, rejection, and humiliation. The individual can lose self-esteem and may exhibit anger or withdrawal, which will impair their future interpersonal and romantic relationships and professional life.

Where conversion therapy is ordered, conducted, or supported by public authorities, the experience of being betrayed by the law likely adds to the individual's mental pain and suffering. These amplify any shame and stigma they may already experience, including social rejection, victimisation and punishment by their family or religious community, and conflict with their faith.

### Cruel, Inhuman, and Degrading Treatment and Torture

Torture and other forms of cruel, inhuman, or degrading treatment or punishment are unequivocally prohibited, without exception, by the UN Convention against Torture[28] as well as other international and regional human rights instruments. The UN Committee against Torture, the UN Special Rapporteur on Torture, the UN Subcommittee on Prevention of Torture, and the Office of the High Commissioner for Human Rights (OHCHR) have stated that conversion therapy contravenes the prohibition against torture and other cruel, inhuman, or degrading treatment or punishment. In its 2015 annual report, the OHCHR stressed that states "*have an obligation to protect all persons, including LGBT and intersex persons, from torture and other cruel, inhuman or degrading treatment or punishment*" and found that conversion therapy breaches this duty[29].

In May 2018, the UN Independent Expert on Sexual Orientation and Gender

24 Turban JL, Beckwith N, Reisner SL, & Keuroghlian AS. Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. JAMA Psychiatry. 2020;77(1):68.

25 Ryan C, Toomey RB, Diaz RM, & Russell ST. Parent-initiated sexual orientation change efforts with LGBT adolescents: implications for young adult mental health and adjustment, Journal of homosexuality, 2009; 67(2):159-173.

26 Dehlin J, Galliher R, Bradshaw W, Hyde D, & Crowell K. Sexual orientation change efforts among current or former LDS church members. Journal of Counseling Psychology. 2015;62(2):95-105.

27 Haldeman, D. Therapeutic Antidotes: Helping gay and bisexual men recover from conversion therapies. Journal of Gay and Lesbian Psychotherapy. 2002; 5 (3): 117-130.

28 United Nations Office of the High Commissioner for Human Rights. Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Available at: http://www.unhchr.ch/html/menu2/6/cat/treaties/opcat.htm

29 UN Human Rights Council, Report of the Office of the United Nations High Commissioner for Human Rights, Discrimination and violence against individuals based on their sexual orientation and gender identity. 4 May 2015. A/HRC/29/23.

Identity observed that: "*The violence reported against persons on the basis of their actual or perceived sexual orientation or gender identity also includes …so-called 'conversion therapy'. Considering the pain and suffering caused and the implicit discriminatory purpose and intent of these acts, they may constitute torture or other cruel, inhuman or degrading treatment or punishment in situation where a State official is involved, at least by acquiescence*."[30] Subsequently, the UN Special Rapporteur on Torture in July 2019 affirmed that: "*given that 'conversion therapy' can inflict severe pain or suffering, given also the absence both of a medical justification and of free and informed consent, and that it is rooted in discrimination based on sexual orientation or gender identity or expression, such practices can amount to torture or, in the absence of one or more of those constitutive elements, to other cruel, inhuman or degrading treatment or punishment*."[31]

Based on these findings, the UN Committee against Torture, the UN Independent Expert on Sexual Orientation and Gender Identity, the UN Special Rapporteur on Torture, and the OHCHR have all called upon states to ban the practice. In 2016, the UN Committee against Torture recommended that a state take "*the necessary legislative, administrative and other measures to guarantee respect for the autonomy and physical and personal integrity of lesbian, gay, bisexual, transgender and intersex persons and prohibit the practice of so-called 'conversion therapy'.*"[32]

**State Involvement and Responsibility**

The UN Convention against Torture and other international and regional human rights instruments not only prohibit torture, but oblige states to prevent public authorities from "*directly committing, instigating, inciting, encouraging, acquiescing in or otherwise participating or being complicit in any acts of torture*" and other cruel, inhuman, or degrading treatment or punishment[4]. In several countries, we have found that public officials are directly involved in the provision of conversion therapy. In some cases, the therapy is offered and performed by medical personnel in state hospitals, public clinics, schools, and juvenile detention centres. Sometimes, the therapy is performed pursuant to an order by public officials, judges, or the police. All these acts would seem to contravene the international legal obligations of these states to prohibit and prevent torture and other cruel, inhuman, or degrading treatment or punishment.

Furthermore, states have a responsibility to "*prohibit, prevent and redress torture and ill-treatment in all contexts of custody and control*," not just those operated by public entities[33]. We have found in almost 30 countries that conversion therapy is being committed, instigated or supported by private institutions and private individuals acting in an official capacity and executing a state function. This includes health professionals in private clinics performing con-

30 UN Human Rights Council, Report of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity. 11 May 2018. A/HRC/38/43.

31 UN General Assembly. Interim Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, relevance of the prohibition of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment to the Context of Domestic Violence. 12 July 2019. A/74/148.

32 UN Committee Against Torture. Concluding observations on the fifth periodic report of China. 3 February 2016. CAT/C/CHN/CO/5

33 UN Committee Against Torture. General Comment 2, Implementation of article 2 by States Parties. CAT/C/GC/2/CRP.1/Rev.4.2007

version therapies or private schools providing it. The UN Convention against Torture and other human rights instruments require that states oversee the provision of services that are in the public interest, such as health and education. As stated by the UN Committee against Torture, states have the special duty to protect the life and personal integrity of persons by regulating and supervising these services, regardless of whether the entity providing them is public or private[1]. Accordingly, personnel in private hospitals and clinics as well as teachers are considered to act in an official capacity on behalf of the state, as they are executing a state function[34] and should similarly be prevented from directly committing, instigating, inciting, encouraging, acquiescing in, or otherwise participating or being complicit in any acts of torture and ill-treatment, including conversion therapy.

In over a dozen countries, we found that conversion therapy practices, e.g., beatings, isolation, exorcisms, and "corrective" rape, appear to take place primarily in the private sphere by religious practitioners, traditional healers, or sometimes by community and family members. These acts which are not originally directly attributable to the state (i.e., acts committed by private individuals) can nevertheless lead to state responsibility, due to the lack of due diligence to eliminate, prevent, investigate, and punish acts of torture and other cruel, inhuman, or degrading treatment or punishment. The failure of the state to act in due diligence leads to a form of encouragement or *de facto* permission of those harmful practices[1].

The UN Committee against Torture has applied this principle to states that have failed to prevent and protect victims from gender-based violence, such as rape, domestic violence, female genital mutilation, and trafficking[1]. A parallel can thus be drawn to the obligation to ban the practice of female genital mutilation which also takes place in a context of profound discrimination. As stated by the UN Special Rapporteur on Torture: "*Domestic laws permitting the practice contravene States' obligation to prohibit and prevent torture and ill-treatment, as does States' failure to take measures to prevent and prosecute instances of female genital mutilation by private persons*."[1]

Children enjoy special protection. An alarming number of minors are subjected to conversion therapy; indeed, minors may account for the majority of all cases[35]. The UN Convention on the Rights of the Child requires the best interests of the child to be a primary consideration in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities, or legislative bodies[36]. The Convention on the Rights of the Child requires states to take all measures to "*protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child*."[3] Conversion therapy, which is rooted in profound

34 UN Committee Against Torture. General Comment 2, Implementation of article 2 by States Parties. CAT/C/GC/2/CRP.1/Rev.4.2007

35 Mallory C, Brown TNT, & Conron KJ. Conversion therapy and LGBT youth. Williams Institute, UCLA School of Law. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-LGBT-Youth-Jan-2018.pdf. Published January 2018.

36 United Nations. Convention on the rights of the child. 20 November 1989. United Nations Treaty Series. vol. 1577. Art. 3(1).

discrimination, lacks scientific and medical validity, is ineffective, and is likely to cause the minor significant or severe pain and suffering, clearly violates these standards. When a minor is subjected to conversion therapy, in addition to amounting to torture or other cruel, inhuman, or degrading treatment, it may constitute a form of child abuse and neglect.

**Professional and Ethical Standards**

Conversion therapy is inconsistent with the fundamental ethical principles and professional duties of health professionals for the following reasons:

1. It is clear that conversion therapy is a form of cruel, inhuman, or degrading treatment when it is conducted forcibly on individuals or without their consent and may amount to torture depending on the circumstances, namely the severity of physical and mental pain and suffering inflicted. International standards of professional ethics unequivocally prohibit health professionals from participating in or condoning any treatment or procedure that may constitute cruel, inhuman, or degrading treatment or torture[37,38].
2. Variation in sexual orientation and gender identity is not a disease or disorder. Health professionals, therefore, have no role in diagnosing it or treating it. The provision of any intervention purporting to treat something that is not a disease or disorder is wholly unethical[39]. If adults voluntarily seek out assistance in hope of changing their sexual orientation, ethical professionals are advised to explain why they don't attempt this type of practice and not to refer clients to someone who does[40].
3. Conversion therapy is ineffective and harmful. Health professionals must abide by their core ethical principles to act in the best interests of patients (beneficence) and to "do no harm" (non-maleficence)[41]. The likely harm of conversion therapy cannot be outweighed by any clinical benefits, as there are none. Moreover, health professionals are prohibited from offering treatments that are recognised as ineffective or purport to achieve unattainable results. Offering conversion therapy thereby constitutes a form of deception, false advertising, and fraud[42].
4. Ensuring informed consent may be impossible in most circumstances. As noted in previous statements, examinations based on profound discrimination may create situations where a person is incapable of

37 World Medical Association. Declaration of Tokyo - guidelines for physicians concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment. World Medical Assembly; 1975. Rev. 2006.

38 United Nations. Body of principles for the protection of all persons under any form of detention or imprisonment. United Nations; Dec. 1988. A/RES/43/173.

39 World Psychiatric Association. WPA position statement on gender identity and same-sex orientation, attraction, and behaviours. World Psychiatry. 2016;15(3):299–300.

40 American Counseling Association. Ethical issues related to conversion or reparative therapy. https://www.counseling.org/news/updates/2013/01/16/ethical-issues-related-to-conversion-or-reparative-therapy. Published 16 January 2013.

41 World Medical Association. Declaration of Geneva. World Medical Assembly; 1948. Rev. 2017.

42 World Medical Association. International Code of Medical Ethics. World Medical Assembly; 1949. Rev. 2006.

giving genuine consent[43]. This is likely the case when conversion therapy is being conducted based on the order of a public authority, when the individual's liberty is restricted, or when the individual is a minor coerced by family members or others in a position of authority or trust.

In the case of conversion therapy, informed consent would require that an individual is informed about the practices that will be applied, as well as their ineffectiveness, the likely physical and psychological harm that will result, and the inability to achieve the desired result. The individual's consent must be considered invalid if acquired without this knowledge or as a result of false information; and it should be considered suspect, particularly in the case of minors.

5. Conversion therapy creates an inherently discriminatory environment. Even when an individual wants the therapy, the individual may be motivated by self-hatred or a conflict between their actual sexual orientation or gender identity and the self-image that they feel it is safe or acceptable to present to themselves and others. It would be counter therapeutic for the practitioner to add to those internalised feelings. Their efforts would be ineffective in reducing the individual's desires even if the individual's behaviour changes, leaving the client with unexpressed feelings that have the potential to be very damaging[44]. Instead, any psychiatric or psychotherapeutic approaches to treatment must not focus on the individual's sexual orientation or gender identity, but on the conflicts that may arise between their orientation, identity, and religious, social, or internalised norms and prejudices[45].

## Role of Health Professionals in Policing and Punishing Sexual Orientation and Gender Identity

The practice of conversion therapy runs contrary to respect for the dignity, humanity, and rights of individuals, including to privacy, self-determination, non-discrimination, and to be free from torture and ill-treatment.

Most major medical and mental health organisations have repudiated the practice of conversion therapy. It continues, however, to be widespread and practiced by health professionals and others due to pervasive discrimination and societal bias against lesbian, gay, bisexual, trans, and gender diverse individuals. This represents a challenge to individual health professionals and medical and mental health professional organisations.

Health professionals who are conducting conversion therapies are contributing to a social, cultural, or state-sponsored system of profound repression and stigmatisation against their patients, targeted on the basis of their sexual orientation and gender identity. Health professionals should understand that by providing these treatments, they are serving to perpetuate social customs and

43 Independent Forensic Expert Group. Statement on Anal Examinations in Cases of Alleged Homosexuality. Torture. 2016; 26(2):85-91. Available at: https://irct.org/uploads/media/306a591c5f8207f6107f5c11e8c5c4fc.pdf.

44 British Psychological Society. Guidelines and literature review for psychologists working therapeutically with sexual and gender minority clients. February, 2012: 71-73.

45 World Medical Association. Statement on Natural Variations of Human Sexuality. October, 2013.

norms that are in conflict with their ethical obligations and respect for the rights and dignity of individuals, and that, ultimately, they may be facilitating or participating in cruel, inhuman, or degrading treatment or torture.

The WMA has condemned conversion therapy as a violation of human rights and has called for its practitioners to be denounced and subject to sanctions and penalties[46]. It has also called on national medical associations to "*promote ethical conduct among physicians for the benefit of their patients. Ethical violations must be promptly corrected, and the physicians guilty of ethical violations must be disciplined and rehabilitated*."[47]

As more awareness is raised about the issue of conversion therapy both globally and nationally, national medical and mental health associations should create accessible mechanisms for the public to register complaints against health professionals who offer conversion therapy or who have harmed them by performing this practice. Health professionals who conduct conversion therapies violate the basic standards and ethics of our profession and should be reported by their colleagues to the appropriate authorities[48]. National medical and mental health associations should encourage and support health professionals in denouncing this practice and reporting colleagues who practice it.

Recently, there has been a growing trend to call for a ban on conversion therapy in many parts of the world, although few countries have done so yet[49]. National medical and mental health associations should support these legislative initiatives and the development of programmes to support individuals who have been harmed by the practice[50].

## Conclusion

Conversion therapy has no medical or scientific validity. The practice is ineffective, inherently repressive, and is likely to cause individuals significant or severe physical and mental pain and suffering with long-term harmful effects. It is our opinion that conversion therapy constitutes cruel, inhuman, or degrading treatment when it is conducted forcibly or without an individual's consent and may amount to torture depending on the circumstances, namely the severity of physical and mental pain and suffering inflicted.

As a form of cruel, inhuman, or degrading treatment or torture, states have an obligation to ensure that both public and private actors are not directly committing, instigating, inciting, encouraging, acquiescing in or otherwise participating or being complicit in conversion therapy. States also have a responsibility to regulate all health and education services, which may be promoting this harmful practice.

Health professionals that offer conversion therapy are violating the basic standards and ethics of our profession. Health professionals should understand that by offering these treatments, they are serving to perpetuate

46 World Medical Association. Statement on Natural Variations of Human Sexuality. October, 2013.

47 World Medical Association. Declaration of Madrid on Professional Autonomy and Self-Regulation. 2009.

48 World Medical Association. International Code of Medical Ethics. World Medical Assembly; 1949. Rev. 2006.

49 End of a 'cure'? U.S. ban on gay conversion therapy gains ground. Reuters. 13 June 2019. https://www.reuters.com/article/us-usa-lgbt-religion/end-of-a-cure-us-ban-on-gay-conversion-therapy-gains-ground-idUSKCN1TE2AA.

50 American Psychiatric Association. Position Statement on Conversion Therapy and LGBTQ Patients. 2018.

social customs and norms that are in conflict with respect for the rights and dignity of individuals; they are engaging in false advertising or fraud; and they may be facilitating and participating in cruel, inhuman, or degrading treatment or torture. Where minors are concerned, in addition to torture and other cruel, inhuman, or degrading treatment, they may be facilitating or perpetrating child abuse and neglect.

Health professionals should refuse to conduct conversion therapy and report their colleagues who advertise, offer, or perform them to the appropriate authorities. National medical and mental health associations should take steps to hold practitioners accountable and work with civil society and government officials to pass laws that ban conversion therapy.

# Evaluation of the dismissed forensic medicine specialists and other forensic professionals in Turkey

**Alper Keten, MD***

The right to work, one of the fundamental human rights, expresses the right of all individuals to maintain a dignified life by having an income, earned through work (UDHR, 1948). Following the coup attempt on 15 July 2016, the Turkish government declared a state of emergency on 20 July 2016. This lasted 730 days until 20 July 2018. During this period, 32 decrees were issued by the Turkish government. With these decrees, 150,348 public officials including judges, prosecutors, civil servants, teachers, bureaucrats, medical doctors and academics were dismissed without any investigation (Turkey Purge, 2019). With regard to the group of forensic professional experts, many have been dismissed following decrees issued by the Turkish government.

It was found that 105 forensic experts and/or forensic professionals were dismissed by government decrees. Nearly all of the dismissed specialists were male (n =101, 96.04%). Nine (8.57%) were doctors of medicine working in forensic medical sciences and 96 (91.43%) were forensic specialists. Thirty (14.25%) of these were working at a higher educational institution and 75 (85.75%) were working at the Council of Forensic Medicine. Five (4.76%) of these cases were professors and directors of an institute. Thirteen (12.38%) were associate professors, 3 (2.85%) were assistant professors, 54 (51.42%) were specialists, and 30 (14.25%) were assistants.

Protecting freedom and human rights in various ways is essential to democracy. The freedom of the press and civil society movements was significantly suppressed by the Turkish government. Many professional groups, including forensic specialists and medical doctors, have an important role in preventing the abuse of power. Following the coup attempt, many forensic experts were dismissed by the Turkish government. The number of forensic experts dismissed in Turkey is higher than the sum of forensic experts found in many European countries.

Forensic services in Turkey are mainly provided by forensic institutions. There is also a forensic medicine department in almost all medical faculties in Turkey. According to official data, there were nearly 600 forensics experts in Turkey (The Society of Forensic Medicine Specialists, personal communications, July 15-19, 2019). When the number of dismissed forensic experts is examined, it is seen that approximately 20% have lost their jobs. As in Continental Europe, an important function of forensic experts in Turkey is to identify and prevent human rights violations. Forensics experts should perform these tasks objectively according to international protocols (Istanbul Protocol, The Minnesota Protocol, etc.). The expulsion and detention of many forensic experts without investigation has led to many undesirable effects, including the discontinuation of forensic services and intimidation of other experts. However, the dismissal of so many forensic experts is used to intimidate other professionals and prevent them from

*) Institute of Forensic and Traffic Medicine, Heidelberg University, Heidelberg, Germany
Correspondence to: alper.keten@med-uni.heidelberg.de

https://doi.org/10.7146/torture.v30i1.117717

objectively reporting and investigating human rights violations. In addition, it is difficult for forensics experts to exercise their profession freely within the established legal practices in Turkey, since they are actually prohibited from working as independent experts. This situation is controversial in terms of universal legal norms that provide occupational safety (UDHR,1948).

Many international organisations have reported on these human rights violations. Nils Melzer, the United Nations Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, has noted an increase in torture and maltreatment practices in Turkey and has suggested, that these are carried out by designated teams within the state's security services. According to his report, the Turkish State has refused to comment on the allegations (OCHCR, 2016). Furthermore, The Stockholm Freedom Center reports that family members of detainees are also under threat (2017). In another report on the subject, the US-based human rights organisation, Human Rights Watch (HRW), provides further details on torture and also alleges, that kidnappings by state forces are also present (HRW, 2017).

Prof Dr. Sebnem Korur Fincanci, who is a forensics expert and president of the Turkish Human Rights Association, was sentenced to prison and dismissed from her job as a university lecturer after signing a so-called peace statement, which urged an end to state-sponsored violence in Turkey. She had decided to independently investigate the case of a detainee who allegedly died from torture in detention (Cumhuriyet, 2018).

She found, that the official autopsy records made no mention of torture, despite previous allegations by the detainee that he was subjected to torture in detention, which raises questions about forensics experts' objectivity when carrying out their duties.

The Turkish State also issued a decree that permanently prevented persons dismissed, in the aftermath of the attempted coup d'état and the subsequent state of emergency from working in civil service again. They are also often intentionally prevented from completing the administrative and legal procedures that would allow them to work privately and employees of public administration are given the right to subjectively refuse service to anyone without facing any legal action. This leaves many highly qualified forensic science and other experts unable to find employment and support themselves and their families.

The suppression or dismissal of forensic experts or other medical professionals for political reasons can lead to serious human rights issues. In order to prevent such issues, necessary policies should be developed within legal limits by the international community.

*References*

*Gözaltında işkence sonucu ölen Gökhan öğretmen, 1.5 yıl sonra 'pardon' denilerek görevine iade edildi.* (2018, February 28). Cumhuriyet. http://www.cumhuriyet.com.tr/?aspxerrorpath=/haber/turkiye/935144/Gozaltinda_iskence_sonucu_olen_Gokhan_ogretmen__1.5_yil_sonra__pardon__denilerek_gorevine_iade_edildi.html

OHCHR. (2016, December 2). *OHCHR | Preliminary observations and recommendations of the United Nations Special Rapporteur on torture and other cruel, inhuman and degrading treatment or punishment, Mr. Nils Melzer on the Official visit to Turkey – 27 November to 2 December 2016.* https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20976&LangID=E

*Police Torture and Abductions in Turkey.* (2017, October 12). Human Rights Watch. https://www.hrw.org/report/2017/10/12/custody/police-torture-and-abductions-turkey

Stockholm Centre for Freedom (SCF). (2017). *Mass Torture and Ill-treatment in Turkey.* https://stockholmcf.org/wp-content/uploads/2017/06/Mass-Torture-And-Ill-Treatment-In-Turkey_06.06.2017.pdf

Turkey Purge | *Monitoring human rights abuses in Turkey's post-coup crackdown*. (n.d.). https://turkeypurge.com/

UN General Assembly arts 23-24. (1948). *"Universal declaration of human rights"* (217 [III] A). United Nations. http://www.un.org/en/universaldeclaration-human-rights/

# Johan Lansen 1933 – 2019

**Christian Pross***

Johan Lansen, painting by Anne Pross, 2013.

Johan Lansen, a deeply valued colleague, teacher, advisor, clinical supervisor and personal mentor for many, died at age 86 on November 26, 2019 in his hometown of Amersfoort in the Netherlands.

I first met Johan at a human rights conference in Norway in 1990. His presentation "Psychiatric Experience with perpetrators and countertransference feelings in the therapist" (Lansen, 1991) impressed me profoundly. It was unusual at the time for a trauma and human rights professional to talk about perpetrators. Reflecting on the abyss, the dark side of the human condition, was an important dimension of Johan's professional life. His contribution to the first book published by the Berlin Center for the Treatment of Torture Victims carried the title "What does it do to us?" In this chapter he describes how caregivers working with torture survivors can be drawn into the client experience, and how the client's feelings of humiliation, anxiety, powerlessness and worthlessness can be transmitted to the therapist. Johan had faced this abyss as a child survivor during the Nazi occupation of the Netherlands.

During that first encounter, I sensed some defense and distance, an unspoken message from him: "Can one trust this young German?" So it was all the more surprising that we eventually became confidantes and friends. How did this happen?

As head physician of the Sinai Center, a Jewish psychiatric hospital for Holocaust survivors in Amersfoort, he was invited in 1991 to assist the foundation of the psychosocial counseling center for Nazi Victims ESRA, located in the Berlin Jewish Hospital. During his trips to ESRA[1] he also visited our newly-founded Center for the Treatment of Torture Victims. Over time he came to appreciate our work and

*) Christian Pross, MD
Center UEBERLEBEN, Germany
www.christian-pross.de

1 More information on ESRA can be found (in German): https://www.hagalil.com/esra/esra-3.htm

https://doi.org/10.7146/torture.v30i1.119738

the "young German" who was its director. We hired him as our first clinical case-supervisor.

On his first visit to Berlin he only stayed a few days, on the next one a little longer, and so forth. He gradually managed to overcome his reservations and distrust of the country of his persecutors. After leaving the Sinai Center he shifted a large part of his work to Germany, where trauma therapy was unknown territory in the early 1990s. As a result, Johan was much in demand as an expert, consultant and supervisor for a number of German treatment centers.

These centers and I personally, are deeply grateful and enormously indebted to Johan. He was our anchor, guiding us through the difficulties of our founding period, seeing us on our way to professionalization and co-authoring some of our key publications.

I quote from the prologue of my book "Wounded Healers" (Pross, 2009) in which I portrayed Johan under the pseudonym: "Jens".

> Whenever an institution is on fire, it is Jens who will be called for help. At the source of the fire, where the ceiling is about to tumble down, at the hottest and most dangerous spot – that is where Jens sits. People run out of meetings crying, slamming doors, ranting and raving, insulting each other. Jens cannot be taken aback, does not lose control. He does not say much, he gets up and drafts a scheme on the flipchart. It is not so much what Jens says. It is how Jens says it. It is his appearance, his charisma. He sits amid this minefield with the simple message: "As long as I sit here, no bomb will go off."
>
> Jens conveys an aura of maturity, benevolence, heartiness and dignity but also of a certain strictness. He stands above things - serene, with a great sense of humor and a bit of rascality, as if saying: "Well this is just how it goes, when human beings are together…" Everybody in the room feels that Jens is a man who has been confronted with much more severe and threatening situations in his life, who knows how to deal with that and what can happen to people working with survivors. Jens is a modest, rather inconspicuous man who does not make a big fuss about himself. One can imagine him as a coxswain on a fishing boat in the open sea. Such deep sea fishermen are often silent people who for days stoically endure a heaving deck, hold the rudder and ship the cutter safely back to the port.

Several times a year Johan came to Berlin accompanied by his faithful companion Harrie van Dooren. I went to see him as often as possible in Amersfoort. Eventually, Johan would invite me for an expert talk, where he presided amid his huge library. Here I was his student and he was my teacher.

One of Johan's achievements is the co-foundation of the training institute for supervision in the Berlin Center for the Treatment of Torture victims in 2006. Johan together with his colleague, Ton Haans from Centrum 45, the Dutch trauma center for survivors of war and persecution, trained a dozen caregivers in Berlin – including me – to become clinical supervisors. Since then around 130 health professionals have been trained at this institute in the "Lansen/Haans" trauma-specific supervision technique. These training courses continue to this day, directed by the psychologist and supervisor Nora Balke at the Center Ueberleben (former Treatment Center for Torture Victims), and include instruction abroad in Turkey, Iraq, Georgia and Ukraine.

Johan served as a consultant, trainer and supervisor in many countries in Africa, the Middle East, Eastern and South Eastern

Europe. He worked for the International Rehabilitation Council for Torture Victims, the War Trauma Foundation of the Netherlands and the Editorial Board of Intervention – International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict. His publications on trauma therapy, vicarious traumatization and supervision have served as a guide for caregivers worldwide.

For many of us Johan was a role model and a father figure. We have learned so immeasurably much from him and will always carry him in our hearts.

*References*

Lansen, J. (1991). Psychiatric experience with perpetrators and countertransference feelings in the therapist. *Journal of Medical Ethics, 17* (Suppl), 55–57. https://doi.org/10.1136/jme.17.suppl.55

Pross, C. (2009). *Verletzte Helfer* (pp.18-19). Klett-Cotta Verlag.

# Psychiatric experience with perpetrators and countertransference feelings in the therapist[1]

**J. Lansen MD**

*Former Medical Director of Sinai Centrum, the Jewish Community Mental Health Services in The Netherlands, PO Box 66, 3800 AB Amersfoort, The Netherlands and Johannes Wier Foundation for Human Rights and Health Care, The Netherlands*

Therapeutic work on man-made disaster victims is work which leaves no one untouched. It is the kind of work that, in many ways, frequently involves therapists personally. It may also be the cause of vehement disagreements about treatments, resulting in fights and splits in treatment teams. The work may end tragically.

I think this also applies to treatment of that other category of people involved in man-made disaster, the perpetrators. However, we know much less about this. Danieli (1984) made a study of the countertransference feelings of about 60 Holocaust survivors' therapists. She came up with, among others, the following themes: guilt, rage, dread and horror, grief and mourning, shame, inability to contain intense emotions, and utilization of defenses such as numbing, denial and avoidance.

It is remarkable to find in her description the way in which therapists are inclined, with regard to Holocaust survivors, to act as their 'parent(s)' or their 'child'.

Acting the part of the parent, in terms of Transactional Analysis, the Negative Nurturing Parent, the therapist especially wants to prevent, out of fear and guilt, the patients from suffering again. The therapist may also move into the position of the Negative Controlling Parent when he/she gets infuriated by the patient because of his/her very obstinate complaints, or because the patient attributes the part of the persecutor (the Nazis) to the therapist.

In terms of Transactional Analysis one may also watch the therapist taking up the Child-part. This is expressed in many ways in the above-mentioned thematical row and the reason behind this is that the therapist wants to behave like a good child, with respect to the parents who have already suffered very much and who have to be spared by all means. Furthermore, the therapist is a fearful child, because he cannot cope with these horrible stories. The therapist is also ashamed because he has not experienced anything of this suffering himself. Moreover, the therapist may act like a strong child that

1) Reprinted from: Lansen, J. (1991). Psychiatric experience with perpetrators and countertransference feelings in the therapist. *Journal of Medical Ethics, 17*(Suppl), 55–57. doi: https:/doi.org/10.1136/jme.17.suppl.55




https://doi.org/10.7146/torture.v30i1.118585

would preferably quickly save its parents by means of its power ( nd impatience!). Eventually, the therapist may come to look at these helpless, unsavable parents, as being quite tiresome. Also the danger exists that a sadistic child will look for sensational stories that may offer extra suspense: the 'child' in the therapist will continue to ask exaggerated and needless questions about persecution and war stories.

The psychological effects of working with victims are described in a different way by McCann and Pearlman (1990). The significance of their account is that because of the material - the patient's state of being traumatized - the therapist risks the danger of becoming traumatized himself. Therapists themselves get nightmares, fearful thoughts, intrusive images and become suspicious towards their fellowmen. These authors think the nature of the material itself is dangerous to several basic securities that the therapist, as a human being, has concerning himself and the world. Under the influence of the powerlessness of the patients the idea arises that having a grip on life is an illusion. In addition, the therapist working with victims may become estranged from his family, his friends and his colleagues, because he is exposed to tales of horror and confronted with a cruel reality.

Perpetrators of violence against their fellowmen are numerous in our world. At first sight, it is remarkable that we do not know much about the psychological effect that treating dangerous criminals, torturers and war criminals of major or minor caliber has upon a therapist. Part of the explanation may be that treatment is often restricted to somatic treatment by a general practitioner, a jail practitioner or an internist; as far as psychological or social guidance is concerned, it is frequently of a psychotechnical or psychosocial nature. From forensic psychiatry we know something of the psychological effect on therapists treating perpetrators. Nevertheless, one might expect more literature on the topic, besides that to do with the treatment method and psychodynamic observations. Treating those who commit incest will, for example, indubitably provoke several reactions from the therapist.

The following may be looked upon as a series of impressions gained over the last 25 years or so. These are mainly related to psychiatric examinations, psychiatric-medical, and social psychiatric contacts, as well as psychotherapeutic treatment. Being a consultant in the field of psychosomatic diseases, and, later on, working for the Jewish community and for victims of World War II, I came into contact with many former victms, but also with some ex collaborators from World War II. Some had committed quite severe crimes for which they had been punished. In addition, I got in touch with Resistance people who misbehaved after the war as collaborators' camp guards, with Dutch ex-soldiers from the war between our country and Indonesia who took part in severe repressive actions against the Indonesian people, with several Jewish people who were able to take revenge after their liberation from the concentration camp. All in all, I reached about 50 male perpetrators, amo ngst whom there were at least 12 with whom I had a longstanding and intensive contact.

It was striking, but not contradictory to information amassed by others, that in hardly any of the cases was moral need brought up; at any rate, it was not noticeable in the first instance. As Lifton (1984, 1986) remarks about the Nazi doctors, (and as was also observed earlier by a journalistic investigation in Holland on SS men [Armando and Sleutelaar (1978)]), it is the common-

ness, the triviality, almost the banality, of many of these people which strikes one. In a way, these collaborators seem to feel like the losers in a football match who believe they have only lost because of bad luck or circumstances beyond their control. They felt as if they had been on the right side and had really done a good job.

In this article the point at issue is not a psychological typology of the collaborator, the murderer, or the torturer. My primary issue is the feelings they have as they work with therapists, the feelings which determine and restrict their freedom of action and of treatment. Repeatedly I was asked why I treated this category of people (there is no formal obligation in my case). My answer is that I actually offered some of them further contact out of a kind of benevolent curiosity, when I noticed they were not unwilling to talk. In case of consultations with people who came, hesitatingly motivated, of their own accord (for instance, people who went to the Indies, some ex-Resistance people who were transformed from prisoner into persecutor, the few Jewish perpetrators, some doctors too), I was more likely to offer further contact. However, I did not force myself upon these people; rather I allowed the contact to proceed almost from session to session with the possibility on their behalf to stop at any moment, unless we had decided on regular treatment after going through some kind of initial discussion. Still, even then continuity remained less guaranteed than is the case with 'regular' therapy. Notwithstanding good contact, the feeling that 'this session might also be the last one', always prevailed. This element came from both sides, from the therapist's as well as from the patient's.

The most positive approach I could manage in the case of the perpetrators was usually, initially no more than that of interested curiosity. I was repeatedly assured by them that they did not sense any condemnation or fear within me, nor anything resembling the cold, objective scientist, but rather they saw me more as being something like a Maigret who interestedly looks for the answer to how something fits into the image he forms of a person.

Many of these people show - and this is common knowledge - a strong sense of disavowal, of denial.

They spirited away behind thick walls those mental images and memories, those thoughts which would, if allowed to pervade their humanity, be experienced as a very tragic failure of their existence. They retreated into a kind of superiority: 'I was right, even if what I did then is being looked upon as wrong now'. But sleeplessness, depressive feelings overwhelming one unexpectedly, physical complaints for which no somatic cause can be found, excessive drinking, defective, poor - and time and again failing - relationships: this too, often was their destiny.

Against a background of what I would like to call therapeutic, obliging skepticism, treatment appears, however, to be possible after all. People let themselves go, people talked, people seemed to know very well what they did at that time, people underwent confrontations with their denial-mechanisms.

Whenever, once in a while, they asked me whether I thought them bad, or whether I thought they should do penance, I was perfectly straightforward: 'I don't approve of those deeds. I do not say I am essentially better than you are. You may not have had complete freedom of choice, but you should look into yourself and make sure whether

you are being honest about the (im)possibilities'.

It is of major importance that the therapist dares to account for the personal sympathetic feelings that may occur towards the person facing him. One may enter into his world, into the limitedness of his choice, into the miscarriage of his views on man, into the psychological rightness of the then man who was very wrong ethically. At the same time it is crucially important to that man not to concur in some kind of assumed solidarity-in that case one would come to be an accomplice. On the one hand, we should judge these people, identifying ourselves with them as much as possible. On the other hand, we have to keep our distance and should not join in the 'old-chap' game. In order to relieve their own tension, to avoid exposing nasty feelings of self-reproach and fear, they try to get the therapist to go along with them. This sympathy may occur more easily as the therapist becomes more conscious of his own feelings of aggression, of his own sadism, of his own destructive urges. In every one of us hides a minor fascist that, under the 'right' circumstances, might turn into a major fascist. The client's intuition often leads him to know exactly how the therapist wrestles with his own 'bad' side. The position from which the therapist threatens to slide into a feeling of dislike towards the patient who confronts him with his own shady side and his own unsolved problem, cannot be an easy one. And this gets me to the thematic as Danieli describes them. The therapist's feelings of guilt, rage, horror, the threat of being carried away by intense emotions, by defense mechanisms such as denial and avoidance: they can all occur.

With perpetrators we do not usually experience the same kind of appeal for help as with the victims; our fantasies of being able to save someone are less stimulated by the perpetrators than the victims. On the contrary, we are rather keen to play the part of the prosecutor. We clearly feel better and superior and we get angry when the client does not regard us any differently from himself.

We saw the way in which countertransference feelings in the treatment of victims may be arranged in order of Transactional Analysis's views. This may happen here as well. We occupy the position of the Nurturing Parent less often, but all the more often we threaten to end up as the Negative Controlling Parent. We allow ourselves to be guided into this position by feelings that satisfy us because they confirm our notion of being better than the perpetrators are (apparently we need this to protect us against our own evil), our notion of being in the right facing these persistent attempts at self-justification on the part of the patient as a result of the patient's self-deception. And sometimes we feel like a frightened child, unable to cope with these stories, or a child looking for sensation, or a child who feels trapped.

The material that is introduced during the treatment of perpetrators is shocking: the therapist is confronted with the world of evil. In a way he is tempted to become disloyal towards his belief that, in principle, there is a significant human existence in which human dignity and values prevail, and that it is useful to aim at helping establish such a world, if only in a very small way, by treating perpetrators of torture. This may turn the therapist into a somber man: your partner, your children and your colleagues all notice that for quite a long time after treating perpetrators you do not spontaneously join in the ordinary, nice things anymore. Estrangement threatens to take place. Treatment themes sometimes preoc-

cupy the world of your thoughts. A disturbance of the inner, psychic balance threatens to occur. Basically this is no different from McCann and Pearlman's account of the dangerousness of the material captured within the victim's experiences.

It will be obvious that in this context psychotherapy or, when there is not any mention of long-standing intensive psychotherapy, at any case working with a psychotherapeutic attitude concerning psychiatric and psychological research and advice, is a risky profession. With respect to the profession, as Kohut says (1976), a connection between art and psychotherapy is indispensable. The profession demands a certain kind of childlike openness to new experiences by the grace of a (temporary) lapse of psychological buffers both inside and outside. Some kind of 'lying openly' is required. Bion (Grinberg, Sor, & Bianchedi, 1974) gave a function analysis of the psychotherapist working with (difficult) patients' problems. He uses the notion 'to contain'. The therapist has to be able to contain, to absorb, but also to restrict and restrain; the patient deposits the overwhelming emotional excitement adherent to his problems within the therapist. Winnicot (1965, 1974) uses the concept 'holding environment' with respect to the therapist's position. The therapist has to be capable of enduring the flow of feeling, excitement, mourning and pain. He must innerly transform these and return them digestibly to the patient.

It is common knowledge that it is impossible for patients in treatment- victims as well as perpetrators - to get far beyond the therapist's stage. Therefore, the therapist has to expand and re-organize his inner world. Furthermore, I can only briefly indicate the importance for therapists treating victims and perpetrators of trauma, particularly man-made disaster, to protect themselves and at the same time offer optimum treatment conditions, by taking psycho-hygienic precautions in carrying on their profession. I mention in this connection the importance of good, personal therapy and of good supervision and regular case-discussions with colleagues during which the therapist's own feelings may also be presented for discussion. And eventually there should be professional consideration with respect to the ethical aspects of our functioning.

*References*

Armando, H. S. (1978). *De SSers*. De Bezige Bij.

Danieli Y. (1984). Psychotherapists' participation in the conspiracy of silence about the Holocaust. *Psychoanalytic Psychology; 1*(1),: 23-42. https://doi.org/10.1037/0736-9735.1.1.23

Grinberg, L., Sor, D., & Bianchedi, E. T. de. (1975). *Introduction to the work of Bion*. Clunie Press.

Kohut H.(1978).Childhood experience and creative imagination. In: Ornstein PH, ed. *The search for the self*, (vol 1). International University Press.

Lifton, R. J. (1984). Medicalized killing in Auschwitz. In S. A. Luel & P. Marcus (Eds.), *Psychoanalytic reflections on the Holocaust: Selected essays*. Holocaust Awareness Institute, Centre for Judaic Studies, University of Denver and the Ktav Publishing House.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*(1), 131–149. https://doi.org/10.1007/BF00975140

Winnicot, D. W. (1965). *The maturational processes and the facilitating environment*. Hogarth Press.

Winnicot, D. W. (1974). The use of an object and relating through identifications. In D. W. Winnicot (Ed.), *Playing and reality* (pp. 101–111). Penguin Books.

# Call for papers. Physiotherapy for torture survivors: Is there evidence of its utility in in torture rehabilitation?

**Pau Pérez Sales - Editor-in-Chief, Torture Journal**

**Guest Editor: Eric Weerts - Senior Consultant, Handicap International**

### Background

Physiotherapy, whilst a classical domain in torture rehabilitation since the 1980s, has since been subject to a gradual incline in scrutiny. Although some studies suggest positive outcomes, especially in the framework of combined treatment packages, there is a dearth of both meta-analyses and reviews that support the claim that physiotherapy per se significantly contributes to the overall results of an intervention with survivors of torture.

Some authors suggest that physiotherapy should be part of more holistic Body Awareness Therapy or Narrative Sensorimotor Therapies, thus integrated with psychological therapies. Others suggest that its main field of application is to treat chronic pain in complex cases, although results appear unclear and are subject to debate. Similarly, some authors suggest that excessive psychologisation of pain might hinder the fact that many patients experience physical pain from physical torture that requires both proper medical and traumatological assessment and treatment. They argue against lending excessive weight to psychosomatic theories.

The scarce research available suggest that the best results are obtained through a medical and traumatological in-depth assessment of pain in addition to therapies in which physical exercises and psychological therapy are integrated. Such therapy and physical exercises should be structured to focus on mobility or pain whilst working simultaneously with the memories, emotions and physical consequences of the situations that caused the pain, including, but not limited to, the way in which it is experienced in the body, the relationship between pain and torture and the ways this can be expressed when under pressure. There are a lack of studies however contrasting different approaches to this idea.

### Call for papers

Torture Journal encourages authors to submit papers with a psychological, medical or legal orientation, particularly those that are interdisciplinary with other fields of knowledge. We welcome papers on the following:

a. Reviews, meta-analysis or analytical reflections on models of work.
b. Evidentiary studies on the efficacy of physiotherapy in the work with torture survivors and victims of sexual violence.
c. Selection of patients and programmes – Short-term versus long-term physiotherapy. Minimum interventions in conflict areas.
d. Coordination with primary care, trauma departments and pain units.

e. Measuring pain in multicultural complex environments. Concepts and measures of pain and suffering.
f. Monitoring and measurement tools, beyond pain management. Functional and well-being, psychosocial and mental health measures.
g. Models integrating physiotherapy and psychological processes feasible in low- and middle-income countries.
h. Avoiding dependency with the physiotherapist: models fostering self-sufficiency and promoting resilience in patients.
i. Experiences in group work.
j. Models and evidence in somatosensory therapies.

Added value for relevant research papers:
- Papers that try to isolate the effect of physiotherapy from other elements in a global package of care. Papers that show effects that can reasonably be attributed to physiotherapy.
- Papers that include outcome measures besides qualitative and satisfaction measures.
- Sample sizes that allow for meaningful conclusions with a recommendation of 30 cases as a minimum when conducting statistical analysis.

**Deadline for submissions**
31st August 2020.

**For more information**
Contact Editor-in-chief (pauperez@runbox.com) and Guest-Editor (e.weerts@hi.org) if you wish to explore the suitability of a paper to the Special Section.

**Submission guidelines and links**
- To make a submission, navigate here: https://tidsskrift.dk/torture-journal/about/submissions
- Author guidelines can be found here: https://irct.org/uploads/media/2eefc4b785f87c7c3028a1c59ccd06ed.pdf
- Read more about the Torture Journal here: https://irct.org/global-resources/torture-journal

For general submission guidelines, please see the Torture Journal website (https://tidsskrift.dk/index.php/torture-journal/index). Papers will be selected on their relevance to the field, applicability, methodological rigor, and level of innovation.

*About the Torture Journal*
Please go to https://tidsskrift.dk/torture-journal - a site devoted to Torture Journal readers and contributors – to access the latest and archived issues.

# Call for papers. Continuous Traumatic Stress (CTS): An essential paradigm for understanding the experience and rehabilitation of torture survivors, or an unnecessary distraction?

**Pau Pérez-Sales - Editor-in-Chief, Torture Journal**

**Guest Editor: Craig Higson-Smith - Director of Research, The Center for Victims of Torture (CVT), USA**

### Background

Conceptualisations of traumatic stress that consider traumatic exposure that occurred exclusively in the past may be of limited use when applied to torture survivors who continue to live in real danger. Such danger might arise in many ways, including from continued surveillance and intimidation by agents of authoritarian regimes, enduring conditions of war, or xenophobic violence aimed at refugees and asylum seekers targeting torture survivors living in exile. It was the recognition of the limitation of concepts like posttraumatic stress disorder (PTSD) and complex PTSD that led a group of mental health practitioners in apartheid-era South Africa to coin the term continuous traumatic stress (CTS), which emphasised the challenges of coming to terms with past traumatic events whilst still enduring the threat of current or future harm. Simultaneously, practitioners in Chile and El Salvador were exploring related concepts. More recently, a special edition of *Peace and Conflict, The Journal of Peace Psychology* made progress in this field of research, examining healthy and pathological responses to continuous threat, as well as intervention approaches that explicitly address contexts of ongoing violence.

Regardless of the intuitive appeal of theoretical constructs like CTS, empirical support is scarce, and the *post*traumatic stress paradigm remains dominant in scientific writing about torture. The question arises: *Does the construct of continuous traumatic stress meaningfully add to practitioners' understanding of the experience of torture and support more effective rehabilitation approaches, or is it an unnecessary distraction that takes away from the core issue of coming to terms with past traumatic experiences?*

### Objective

To gather and disseminate scientific perspectives on the utility of continuous traumatic stress and related constructs to understand the experiences and rehabilitation needs of torture survivors globally.

### Call for papers

Torture Journal encourages authors to submit papers with a psychological, medical or legal orientation, particularly those that are interdisciplinary with other fields of knowledge. We welcome papers on the following:

a. Empirical evidence documenting torture survivors' experience of, and response to, ongoing threat and danger in different contexts;
b. Exploration of the links between ongoing threat, continuous traumatic stress and the fundamental rights of torture survivors and refugees;
c. Approaches to the forensic documentation of continuous traumatic stress in torture survivors;
d. Discussion of the role of continuous traumatic stress in transitional justice and peace-building interventions involving torture survivors;
e. Conceptualisations of healthy and pathological responses to ongoing threat in torture survivors;
f. Evidence linking ongoing threat and danger to torture survivors' needs and rehabilitation outcomes;
g. Approaches to assessment of safety, threat and continuous traumatic stress in torture survivors;
h. Clinical approaches to working with torture survivors under conditions of ongoing threat.

**Deadline for submissions**
30th September 2020

**For more information**
Contact Pau Pérez-Sales, Editor in Chief (pauperez@runbox.com) or Chris Dominey, Editorial Assistant (cdo@irct.org).
For more general enquiries, please write to publications@irct.org

**Submission guidelines and links**
- To make a submission, navigate here: https://tidsskrift.dk/torture-journal/about/submissions
- Author guidelines can be found here: https://irct.org/uploads/media/2eefc4b785f87c7c3028a1c59ccd06ed.pdf
- Read more about the Torture Journal here: https://irct.org/global-resources/torture-journal

For general submission guidelines, please see the Torture Journal website (https://tidsskrift.dk/index.php/torture-journal/index). Papers will be selected on their relevance to the field, applicability, methodological rigor, and level of innovation.

*About the Torture Journal*
Please go to https://tidsskrift.dk/torture-journal - a site devoted to Torture Journal readers and contributors – to access the latest and archived issues.

*References*
Martín-Baró, I. (1989). Political violence and war as causes of psychosocial trauma in El Salvador. *International Journal of Mental Health*, *18*(1), 3–20. https://dx.doi.org/10.1080/00207411.1989.11449115
Stevens, G., Eagle, G., Kaminer, D., & Higson-Smith, C. (2013). Continuous traumatic stress: Conceptual conversations in contexts of global conflict, violence and trauma. *Peace & Conflict: Journal of Peace Psychology, 19*(2), 75-84. http://dx.doi.org/10.1037/a0032484
Straker, G. & The Sanctuaries Treatment Team. (1987). The continuous traumatic stress syndrome: The single therapeutic interview. *Psychology in Society*, 8, 48–78.

# How to support the Torture Journal

**Help us to continue keeping the Torture Journal open access and freely sharing knowledge by donating to the IRCT and subscribing. You can donate online at https://irct.org/ Alternative methods are also detailed below.**

## By credit card

Please visit www.irct.org to make a donation using a credit card. All transactions are guaranteed safe and secure using the latest encryption to protect your personal information.

## By bank transfer

**Danske Bank**
Holmens Kanal Branch
Holmens Kanal 2
1090 Copenhagen K
Denmark
SWIFT code: DABADKKK

**Danish Kroner (DKK) account**
Registration No. 4183
Account No. 4310-821152
IBAN DK90 3000 4310 8211 52

**Euros (EUR) account**
Registration No. 4183
Account No. 3001-957171
IBAN DK69 3000 3001 9571 71

**U.S. Dollars (USD) account**
Registration No. 4183
Account No. 4310-005029
IBAN DK18 3000 4310 0050 29

Subscription:
**Write to publications@irct.org to receive an email when a new issue is published or for a printed version (stipulating your profession and address).**

**The Torture Journal is a scientific journal that provides an interdisciplinary forum for the exchange of original research and systematic reviews by professionals concerned with the biomedical, psychological and social interface of torture and the rehabilitation of its survivors. It is fully Open Access online, but donations are encouraged to ensure the journal can reach those who need it (www.irct.org). Expressions of interest in the submission of manuscripts or involvement as a peer reviewer are always welcome.**

**The Torture Journal is published by the International Rehabilitation Council for Torture Victims which is an independent, international organisation that promotes and supports the rehabilitation of torture victims and the prevention of torture through its over 150 member centres around the world. The objective of the organisation is to support and promote the provision of specialised treatment and rehabilitation services for victims of torture.**

**With the generous support of**

Individual donations from readers

OSSTT

**ISSN 1018-8185**