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Defining and documenting threats in the context of ill-treatment and torture. Medical and psychological perspectives.

Pau Pérez-Sales*

Threats are a common feature of detention and interrogation settings and have long been regarded as a routine procedure. Despite their prevalence and propensity to amount to ill-treatment and torture, threats have not been systematically and thoroughly analysed in case documentation processes. Given a lack of understanding, threats have unduly been considered a form of "torture-lite" at best by some juridical actors. However, its effect as an instrument of coercion can be devastating – engendering states of fear and anxiety and forcing its subject to act against their will.

There is an important lack of theoretical reflection on what threats are, what types exist and how they impact the survivor. In this editorial, we aim to partly fill this gap from a medical and psychological perspective, providing a framework of understanding that will hopefully improve conceptual and practical assessment, documentation and qualification.

Voices from survivors.

Threats are a universal and widespread practice with a prevalence reported between 30 and 83% in epidemiological studies. The most commonly reported types are threats of beatings and of further torture, death threats, sexual threats, threats (including sexual assault) against relatives, false accusations and indefinite detention or deportation (i.e. Ben Farhat et al., 2018; Gilinskiy, 2011; Jovic & Opacic, 2008; Moreno et al., 2015; Opačić et al., 2005; Wolfson, 2010)

Table 1 shows a selection of testimonies from the Basque Country. In a study of a sample of 200 survivors assessed with the Istanbul Protocol (IP), threats *per se* were one of the three methods of torture that people indicated as a personal breaking point. Survivors who tolerated pain, dry asphyxiation (the "bag") or strenuous exercise broke down when they perceived immediate and credible threats directed at their parents, partners or children.

Defining Threats.

Threats are a form of communication between perpetrator and victims that entails a message of coercion or punishment. A threat communicates that danger is coming and pursues to instil intense aversive emotions with the aim, most of the time, to force the person to act against their will. When a threat produces mental suffering, its most likely effects are anxiety or fear, although other emotions (shame, guilt, rage…) can also appear. Both fear and anxiety will need to have special careful consideration when assessing threats. Taking this together, we can define threats in the context of ill-treatment and torture as **the explicit or implicit expression of intentionally harming a person, in order either to coerce with the purpose to change opinions, intentions or behaviours or to punish, through the production of mental suffering, usually fear and anxiety**.

The Istanbul Protocol recognises threats as a method of torture including, specifically, three categories: i. "Threats of death, harm to

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Box 1. Threats – Testimonies from survivors (Argitutz et al. t 2015)

"The worst was fear. (...) Feeling you have lost control. You know that torture exists, but you cannot imagine what fear means in that situation, every minute, for five days. It breaks you." (NLMAP02)

"And then they scared me with so many threats you knew could be real... I was very scared because at the end it reminded me of all the friends that have been detained ... and I was afraid of being undressed by them, or raped or... I don't know... I imagined myself in a thousand situations..." (OAEM04)

"Imagine how I was that I told them crying, shock me now, shock me now. (...) That situation was ... I don't know, you can stand physical harm, but before suffering such harm it is the fear, the anticipation of whether he is going to hit me or not? (...) They also realized this, they saw how I was shaking, crying, screaming, I don't know." (JZLV03)

"They started with blows, while asking me questions... then they began to threaten me with electrodes, brought them and put them on my limbs, but did not connect them, I was so afraid, such anguish... then, those screams... I said no, please, that I would tell them everything." (OBS02)

But the scariest thing was to go back to the cell, because I had no distraction there. I used to think about things but that... that was hard, I could not rest, all the time thinking about the threats they had made basically against my family. (...). They said they would detain my sister and rape her…anything you can imagine… When I went to the cell... going over all that they had told me and I could not get it out of my head, I could not." (JZLV05)

"In that situation you cannot be critical and ended up believing many threatening messages that they gave me. You are convinced that everything is possible for them… It is easy to give an opinion now.. you have to have been there…" (ILMW02)

Box 2. Categories of fear-production methods according to the Torturing Environment Scale

a. Manipulation of hopes and expectations;
b. Threats to the person (e.g. endless isolation, endless interrogation, rape, pain, torture, death);
c. Threats against family or relatives (next-of-kin) (e.g. rape, detention, punishment, retaliation), or threats against other detainees);
d. Anguish associated with lack of information or undue procedures (e.g. relatives of people detained/disappeared; detention without proper legal safeguards);
e. Experiences of near death (e.g. mock executions, dry/wet asphyxia);
f. Witnessing others' torture or death;
g. Use of situations evoking insurmountable fear (e.g. phobias, total darkness)

Source: Pérez-Sales (2017)

Table 1. Conceptual map of Threats.

Author and channel	Characteristics of the aversive consequences announced by the threat	Purpose	Credibility	Consequences – mental suffering
• Person in an official capacity Institution • Non-State actors • Verbal – direct threat • Contextual Threat • Non-verbal Communication • Private versus public expression (including media or internet)	• Explicit versus Implicit threats • Concrete, detailed and explicit versus vague and undefined threats • Physical versus psychological including cultural elements • Predictable versus Unpredictable threats • Based on universal fears or phobias. **Relationship with other methods, time and frequency** • Immediacy: the "proximity" criteria. • Cumulative: Combined with other methods to increase the effect: • Sustained in time: chronic threats	*Conditional Threat – Coercion* • Force change in intentions, decisions or behaviours *Unconditional Threats* • Punish • Humiliation • Loss of control-helplessness • Discrimination • Isolation-Breaking networks	• Consequences are proportional to the threat • Irrational threats • Plausible including concrete plans and steps • Perceived results of being compliant and non-compliant; keeping the word. Additional elements: • Historical or political context • Context of impunity • Lack of legal safeguards • Conditions and environment being a threat in themselves.	*Control* • Rational analysis of foreseen consequences *Aversive emotions* • Fear • Anxiety

family, further torture, imprisonment, mock executions"; ii. "Threats of attack by animals, such as dogs, cats, rats or scorpions" and III. "verbal sexual threats" (OHCHR, 1999, §145, 245 o-p). The category of "fear-producing actions" in the Torturing Environment Scale is instructive in illustrating the types of acts at issue here (Box 2)

Drawing the conceptual map

The conceptual field of threats is extraordinarily complex, with overlapping concepts and types. Figure 1 is an attempt to condense and organise all the components present in a threat with relevance to the assessment of torture victims. It distinguishes threats by the type of act that generates them, by the aversive consequences they announce, by the purpose, by the immediate and long-term consequences in terms of mental suffering and by the main elements linked to the credibility of the threat. Each element in the model will be described in detail in the following.

This map is relevant in that it shows: (a) that there are multiple kinds of threat that go far beyond the explicit and verbal and (b) that every threat calls for an analysis of the intrinsic components, which indicate that it is purposive, credible and causes severe suffering.

Sender

A threat is a communication of intention to harm by a person in an official capacity or from any institution directly or indirectly related to the state. In certain circumstances, non-state actors can also produce threats amounting to ill-treatment and torture when the state fails in the duty to protect, or the actor can act with official capacity.

Channel – How the threat is communicated

Besides the direct verbal threat, there are other channels to express the intention to harm:

Contextual threat. The human brain processes a direct threat (e.g. a gun pointed to the head) in a different way to a contextual threat (e.g. returning to a cell through a dark, isolated corridor). Analysis of context is, at least, as necessary as the threat itself.

The threat is produced through the creation of an atmosphere. Being in a small place where escape is impossible or where the elements at sight (objects hung on the walls, placed on the floor or tables) have a clear frightening connotation, including potential torture instruments.

A context is a combination of all the multimodal sensory details of the environment, the internal affective and cognitive states at that moment, and the assessment of danger (Glenn et al., 2017). Fear conditioning does not need a full appraisal and recall in memory of the threatening situation's details. A single element of the context that reminds an experience of the threatening context might be enough if paired with an unsurmountable emotion.

In a similar vein, there is a difference between *Intimidation* (i.e., creating an atmosphere that fosters a general sense of fear) from *threat* (i.e. an action that means an imminent danger to the person). Both need to be considered and documented, and viewed as interrelated.

Non-verbal communication. This includes non-verbal elements relevant in the interaction, including expression, distance, attire (including wearing balaclavas, uniforms or guns), displaying physical signs announcing aggression (including the use of the fists or hands, hostile movements of the body, etc.) or exhibition of violent attitudes or behaviours (breaking objects, hitting walls or furniture, ill-treating another detainee).

Virtual threats or threats without the physical presence of the author. Threats can occur through the media (e.g., radio, TV,

newspapers) or the internet (including social media), with a direct mention of the victim's name or mentioning the family, group or community to which he or she belongs.

What is to be feared: characteristics of the aversive consequences announced by the threat.

There are different kinds of foreseen aversive consequences that will elicit a different response from the person being threatened:

1.- Explicitness and implicitness: One aspect that makes threats challenging to describe and the document is that they do not need to be overt. Threats might be *explicit* (i.e. "we will kill you" "we will detain your family") or *implicit* (i.e. "your brother is in the university, isn't he?", "it is difficult to get insulin in this area"; "the authorities have never come for a visit here in years", "we have all the time in the world").

A related distinction exists between threats that are *concrete, detailed and specific* ("we will fire you out") and those that are *vague and undefined* ("There will be consequences that you will regret all your life"). The relevance of the distinction is that while in concrete threats, the person can make a cost-benefit analysis and decide whether it is worth assuming risks, in vague threats, the person is left to his or her imagination on what can happen. For some people, a vague threat may mean imagining the worst possible outcome ("catastrophising"), while for others, it may mean minimising it ("nothing will happen").

2.- Physical and psychological threats, including cultural elements. Threats might be *physical* (i.e. "nobody has survived without water", "we will beat you and your son") or *psychological* (i.e. "we might inform your wife and kids of your affair"). In psychological threats, there is a unique subjective element in how specific contents affect each person depending on its salience. These depend on personal (including present and past history), cultural and sociological elements. These elements help in determine the *breaking point* for that person. For example, certain animals' presence may be perceived as highly threatening to a detainee of Muslim origin and not to people from other cultural backgrounds.

These essential elements should ideally be assessed through a full forensic assessment, including a psychosocial and clinical history and an anthropological expert opinion.

3.- Predictable versus unpredictable threats. Predictable threats occur linked to an external stimulus, like a fixed time, a fixed space or a fixed person, while unpredictable threats can occur at any time, space or context. The classical learned helplessness model refers to a *prolonged, unpredictable and unescapable aversive stimulus,* with the perception of lack of control, which ultimately leads to *defeat* (Hiroto & Seligman, 1975; Seligman, 1972). It has been suggested that defeat is a model of understanding depression under chronic threat conditions (Pryce et al., 2011).

Predictable threats (for instance, with a signal some minutes before the aversive stimulus) produce (a) focused attention on the threat, (b) ignore the surrounding context, (c) peaks of intense fear dependent on threatening cues. On the contrary, unpredictable threats (no advice on when the threat would happen) produce (a) general and continuous hyper-vigilance (b) attention to context and surroundings (c) generalised fear and chronic anxiety (Wieser et al., 2016).

This is also relevant to the criteria of *immediacy* or **"***proximity criteria***"**. According to the foregoing discussion, the idea that a threat to produce severe mental suffering must be immediate, as some jurisprudence suggests, is only partially true. While immediate threats produce an increase in fear, delayed or indef-

inite threats produce an increase in anxiety. Both imply severe suffering. Furthermore, in the long term, anxiety can produce similar levels of psychological pain and mental suffering than those produced by fear.

4.- Universality and unknowability. Clinical psychology collects more than 200 terms related to different kinds of fears or phobias. There has been a lot of discussion in psychology on whether there are some "universal fears". These categories would be helpful in terms of doing a quick assessment. Valadao Dias & V Oliveira (2016) used psychometric measures to build a hierarchy of human fears. They found five categories of fears: (1) Social fears, (2) Agoraphobic fears, (3) Fears of bodily injury, death and illness, (4) Fears of the display to aggressive scenes, and (5) Harmless animals' fears. From a phenomenological point of view, Carleton has proposed that all fears have a common underlying factor: *Fear of the Unknown1 (FOTU)*. It is defined as "*an individual's propensity to experience fear caused by the perceived absence of information at any level of consciousness or point of processing*". (Carleton, 2016).

5.- Increased by cumulative elements. Threats have a cumulative effect when being chronic or combined with other torture methods. As an example, experimental neuroimaging research shows that 24 hours of sleep deprivation increases fear consolidation in people submitted to threats. Furthermore, evidence suggests that this relates to a decline in cortical inhibitory inputs to the amygdala, where emotional processing of threats takes place (Feng et al., 2018). Similarly, five nights of sleep restriction increases the negative valence assigned to threatening stimuli (Tempesta et al., 2020). So, there is a cumulative effect of sleep deprivation in the perception of threats.

Different experimental models have analysed the way that human beings process chronic threats. A detention environment may be perceived as a context of chronic stress. Qualitative studies show that three themes are central to processing and mastering chronic threats: (a) Difficulties in finding meaning to the frightening experience, (b) Practical problems that are impossible to solve that foster a sense of lack of mastery and helplessness over ones' destiny and (c) The threat damages one's sense of worth and self-esteem (Taylor, 1983). Analysing these elements can help address the severity of a chronic threat.

1 **Fear of death** is discarded due to several reasons (a) It requires the notion of death. Children before ten have a fear of the unknown, fear of darkness or fear of snakes, but not fear of death. It requires elaborated cognitive processing and learning. (b) Death is not necessarily avoided. In different studies fear to death is *associated with insufficient certainty that an afterlife is real or desirable and that the process of dying seen as suffering in itself*. Regarding **Fear of pain**, there are complex elements of attribution of meaning and learning that mediate between pain and suffering. Pain might not be fear-provoking if (a) it is short-term (b) it serves a higher and desirable purpose (c) its intensity is bearable and manageable (d) it does not bear to sequel (permanent damage). What makes a pain unbearable is *uncertainty regarding the duration, intensity, and injuriousness associated with it.* These elements could dramatically increase fear and anxiety. So fear of pain requires learned appraisals and attributions and appears logically reducible. Finally, **Fear of the unknown** cannot be reduced to any other fear. A review of ethological, neurobiological, psychophysiological and clinical evidence suggests that it is the essential and nuclear element of all fears (for a detailed review, see Carleton, 2016). Nevertheless, although fascinating it might be, this is quite a theoretical debate, with practical implications.

Purpose

6.- Conditional os unconditional. Threats can be *conditional* when used in a coercive way to force a change in intentions, decisions, or behaviours. The person who threatens focuses on his demands, while that the person being threatened focuses on the costs of compliance or non-compliance (Milburn, 1977). An essential element determining the entire process is the differential way the senders perceive the threatening message versus the way the receivers perceive them.

However, threats can also be *unconditional* when the purpose is, among other possible reasons, to *punish* by instilling fear and producing emotional suffering, to *humiliate or discriminate* the threatened person to produce a *general feeling of loss of control and helplessness*.

Social fear. A specific form of punitive torture is when the target is not the subject itself but the human group that the person represents. Since the early works of Elizabeth Lira in Chile, it is well-known that social fear inhibits political participation and solidarity (Lira, 1991). A recent experimental study with 671 opposition supporters in Zimbabwe showed that even mild fear compared to placebo reduced dramatically hypothetical and behavioural dissent measures. Fear is a powerful demobilising element in a society (Young, 2019). While in interrogational torture, threats are conditional, in punishment, discrimination, retaliation or revenge, threats are unconditional.

Lack of intention to threaten. An aspect of the context of the interaction might be considered a threat without a willingness to threaten from the person that is threatening the other. This introduces the complex debate of "purposefulness" and "intention to harm" in the legal world. Threats without intention can amount to Cruel, Inhuman and Degrading Treatment (CIDT). There are elements unknown in the interaction that are unique to the person. For instance, breaking social distance in a person that was sexually abused can be immediately interpreted as a menace of rape. Especially relevant are "threatening" procedures that are considered "routine" or "standard" by the threatener (like being kept naked or with a blindfold due to security standard procedures).

Credibility: proportional, rational, plausible and compliance-dependent.

As a relational construct, that the threat is credible is essential. There is not much experimental research on how to define and measure credibility. Furthermore, which is the impact of the credibility of the threat on subjects. Credibility highly depends on the particular interaction between perpetrator and victim. Four psychological elements are especially relevant:

a. Threats should be **proportional**. For instance, paradoxically, a huge threat associated with a minimal demand tends to be incredible, like if a parent says to a child, "*If you do not do your homework, I shall kill you*". (Milburn, 1977)
b. A threat is perceived as more dangerous when there is a component of **irrationality**. The idea that the perpetrator is out of control makes the menace more uncontrollable and more dangerous. Irrationality is part, for instance, of the good guy/bad guy threatening method. One interrogator plays the irrational and the other the rational role. The difference between a hard to believe and an irrational threat will depend on context and associated non-verbal communication elements.

c. **Plausible**. A threat is more credible when the perpetrator explains the **plans and steps** that will follow to make it real, and they are perceived as feasible.
d. **Perceived result of compliance and non-compliance**. Credibility is related to whether the danger is real in case of non-compliance and the perception that the threatening person will keep their word if the person is compliant. There is a lack of credibility if the person thinks that being compliant with demands will not mean relieving the threat or that the threat can even be worst. For example, providing some information will ultimately increase and not decrease pressure and threats.

These four elements add to four additional global elements that increase the likelihood that the threat becomes real: **Historical or political context**, including the idea of torture being used as a social control method or discrimination. **Context of impunity**, meaning the likelihood that the threats will be carried out without real legal or political implications for the author. Moreover, the likelihood that this is authorised and protected by the chain of command. **Lack of legal safeguards** during the process and perception of an absence of the possibility of help. **Conditions and place of detention** being a threat in itself: a clandestine place of detention or detention without time constraints.

Medical and Psychological consequences

We will review the neurobiological foundations of the impacts and consequences of threats, focusing on Fear and Anxiety.

Neurobiological substrates of Threats and Fear

There is a tradition in neuropsychology to study and define the so-called neural **Fear-circuits** or the brain's fear system that comes from the 1950s. This notion has been challenged in recent years, and there is growing evidence of the existence of a **Threat Systems** instead (LeDoux, 2014). Subjective experiences of fear do not correlate well with measures of behavioural or neurophysiological responses. Threats presented subliminally can elicit a peripheral physiological response even if they are unaware of the threat and lack feelings of fear (LeDoux, 2020; Mertens & Engelhard, 2020). Threats can operate in the background, and the victim might not know about them. There is a Threat Circuit that controls human defence response. Fear and Anxiety are mental states that correspond to the subjective dimension of Threats (LeDoux, 2014; LeDoux & Pine, 2016).

There is also considerable confusion resulting from the interchangeable use of the terms "fear" and "anxiety". To avoid this, most authors propose that the mental state *fear* be used to describe feelings that occur when the source of harm, the threat, is either immediate or imminent. Whereas *anxiety* is used to describe feelings that occur when the source of harm is uncertain or is distal in space or time (LeDoux & Pine, 2016). In other words, fear is distinguished from anxiety by being present-oriented and certain, rather than future-oriented and uncertain (Carleton, 2016). The two conditions are related to different brain parts (Gullone et al., 2000; J. LeDoux, 2020; J. E. LeDoux, 2014). Fear has its neural nucleus in the amygdala and Anxiety in the brain stem. Both interact with the pre-frontal cortex (conscious process) and memory (identifying past instances of danger).

As elicited by an imminent threat, fear leads to selective attention on the menace and a blind spot (scotoma) towards other peripheral stimuli. Anxiety, on the contrary, is char-

acterised by a sustained state of heightened vigilance to the entire surrounding environment due to the need to locate and face an uncertain danger. This distinction has implications in terms of how things are remembered and the level of detail in memories expected in the assessment.

Anxiety is an undervalued emotion in front of fear. It is assumed that "it is normal" to be anxious, and, for many experts, it does not qualify for "severe mental suffering". This is a misconception. While it is a normal life element to experience occasional anxiety, anxiety that is persistent, seemingly uncontrollable, and overwhelming produces severe suffering and can be extremely disabling.

The conscious experience of fear depends on a set of processes in which there is a subjectivity component that requires an individualised assessment. Among the processes involved are sensory perception, how this perception interacts with previous memories and experiences to arouse emotions with its associated body response, how it challenges self-schemas, and how emotions are interpreted into feelings. Added to this are the narrative built upon these feelings and the way the person tries to cope with them.

Interoceptive threats.

Most people are familiar with the external sensory receptors that send signals to the mind that can constitute signs of threat and alarm. Much less well-known are the interoceptive receptors.

Interoceptive receptors inform the person about internal signals: visceral pain (i.e. headache), functioning (heart rate, breathlessness, hunger) etc. Interoceptive threats are perceptions of threat that come from inner receptors in the body.

An example is breathing difficulties. Research shows that dyspnoea increases CO_2 levels, which triggers interoceptive receptors that transmit the signal, increasing anxiety levels. The purpose is to open airways and create maximum tension to breathe, although sometimes anxiety will provoke more dyspnoea. This anxiety reaction can be easily conditioned: the person might not have breathing difficulties but just be *expecting* breathing difficulties, and the level of anxiety and dyspnoea will also increase. Furthermore, the extreme form of fear is panic. Panic attacks are usually associated with dyspnoea, and dyspnoea can trigger panic attacks. This is the physiological reason that explains that dry and wet asphyxia as torture methods produce insurmountable fear and anxiety, leading to panic from the very first moment. They result from the activation of innate defensive responses with a mutually potentiating effect of dyspnoea and anxiety (Lang et al. 2011). This effect is so powerful that it appears with both predictable threats (the person is told 20 seconds in advance of the breath occlusion) and unpredictable threats (there is no advice of the occlusion). *F*ear and anxiety will appear in any case.

Measuring fear: psychophysiological test.

Numerous psychophysiological measures have been proposed to quantify body responses to fear and anxiety. Among others, Facial Temperature, Eye Blinking Rate with a high-speed camera, Electromyography to measure Blink reflex, Electro-dermal activity-Skin Conductance Response, Pupillometry, Changes in Electro-encephalogram, Heart rate variability, Breath rate.

All of them provide useful measures for experimental research. Their applicability in naturalistic settings is advancing at a considerably high speed, and they will likely be used in the future. As for now, measures of fear have a low to moderate correlation with subjective

measurements of fear; most devices require cooperation from the subject, and in any case, calibration and validation are complex. Thermal Cameras are the technology that is most used in interrogational settings. Fear is associated with decreased facial temperature during 4-5 seconds, 2 seconds after the threatening stimulus. While fear can be detected, anxiety gives blunt and unspecific measurements, and it is generally more difficult to detect and measure with any device (Choi et al., 2015; Christopoulos et al., 2019; Hyde et al., 2019; Maffei & Angrilli, 2019; Pinkney et al., 2014; Sonkusare et al., 2019).

People especially vulnerable to threats.

There are people more vulnerable to present *strong fear responses*. When available measures provide reliable determinations of the body's answer to a threat, reflecting a combination of both conscious and unconscious process, science will be able to detect if a person has a high susceptibility to fear beyond her subjective experience. Technology will measure biological proneness to fear and anxiety responses. People with a greater tendency to couple aversive stimuli and fear and thus develop *long-term introjection of fear.* A comprehensive review (Lonsdorf & Merz, 2017) suggest that (a) there is a significant genetic component, (b) high levels of sex hormones (i.e. contraceptive treatment) are protective and correlate with a lower fear acquisition, (c) high levels of cortisol seem to inhibit fear acquisition circuits, and it relates to a lower prevalence of Post-Traumatic Stress Disorder (PTSD) under threat conditions. This is the basis for the use of Beta-Blockers for early treatment of PTSD

These biological elements should not obscure the importance of previous life experiences. Exposure to child maltreatment and exposure to recent adverse events increases fear responses by making it more difficult to discriminate relevant from irrelevant threats producing indiscriminate arousal ((Lonsdorf & Merz, 2017)

Cognitive characteristics of the survivor determining fear and anxiety responses.

Table 2 summarises the most relevant elements: high perception of being in control and high self-efficacy as protective elements and high Intolerance to Uncertainty and Ambiguity, and the use of Thought Suppression as vulnerability elements.

Control. Being in control means being able to face the conflict between Goals (i.e. survive, dignity, protect others) and Short-term (i.e. Physical and mental suffering) and Long-Term (Guilt, Social rejection) Costs. The ruminations and anguish around the decision itself produce severe mental suffering, even when the person can ultimately retain a sense of control. Some authors have proposed that being at the mercy of others and lack of control are linked to PTSD and are, indeed, the central mechanism explaining the clinical impact of torture (Basoglu, 2017).

Table 2. Cognitive elements in coping with threats.

Protective elements	Vulnerability elements
• Control	• Use of Thought Suppression
• Self-efficacy	• Intolerance to Uncertainty
	• Intolerance to Ambiguity

Some authors have proposed that fear and anxiety on the one hand and perceived control on the other are two sides of the same coin. This is not strictly true. Rather, they are opposing and conflicting processes. It is possible to experience high levels of fear and anxiety and have a sense of control and vice versa. The control circuit is of higher order and tries to inhibit the fear and anxiety responses by downsizing them. When it fails and anxiety and fear override control, there is a global sense of powerlessness and helplessness. Some describe fear and anxiety as "hot processes" and control as "cooling processes" (Kotabe & Hofmann, 2015).

A related concept is the **Perception of Self-efficacy** (Bandura, 1977; Benight & Bandura, 2004). Self-efficacy does not relate to the situation (as control does). It describes a general trait related to the perceived capability to manage one's functioning and the environmental demands after a traumatic experience. Enhancing perceived self-efficacy has been shown as a useful therapeutic approach in torture survivors (Morina et al., 2018).

On the negative side, there is **Intolerance to Uncertainty** (IU). Individuals who are Intolerant to Uncertainty interpret the unknown in the future as a source of anxiety, even when the possibility of its occurrence is low (Carleton, 2012). High Intolerance to Uncertainty, as a trait of the personality of the survivors, is associated with: (a) *Higher responsivity to an ambiguous threat*, even when the threat is mild, and more difficulties in fear extinction (Morriss, Saldarini, & van Reekum, 2019) (b) *Once the ambiguous threat turns into a direct threat, there is a relief*, as measured, for instance, in lower Skin Conductance response (Morriss, Saldarini, Chapman, et al., 2019) (c) IU is positively related to *worry and rumination* (Dugas et al., 2001) and it is associated with a higher prevalence of PTSD (d) A higher intolerance to Uncertainty predicts *higher perception of pain* (Donthula et al., 2020). (e) People with a high intolerance to Uncertainty feel more threatened when deciding upon potential harm to others (for instance, a relative) than having to decide upon harm to oneself (Jacoby et al., 2019).

Intolerance to Uncertainty plays a key role in understanding fear responses. It helps to understand why torture survivors sometimes say that when confronted with uncertainty and fear, it can sometimes be a relief when physical pain finally appears. Alternatively, why a threat to a friend or a relative can be more damaging than a threat to oneself.

Individuals who are **Intolerant of Ambiguity** (IA) need clear rules and tend to interpret ambiguous situations as a menace (Grenier et al., 2005). While Intolerance to Uncertainty refers to an unpredictable component in the future, Intolerance to Ambiguity refers to the uncertainty of the present. People with a high intolerance to Ambiguity suffer when (a) placed in environments where rules are unclear or random; for instance, today is rewarded, tomorrow is punished. (b) Situations where the perpetrator generates contradictory emotions of fear and protection in the victim, preventing them from knowing what kind of relationship to establish.

Finally, **Thought Suppression** is a trait and indicates the tendency to avoid thinking on painful thoughts or memories. There are underlying neurobiological differences that make some people more prone to thought suppression (Cowan et al., 2017). Interesting enough, both thought-suppression and excessive thought (rumination) produce adverse effects and predict proneness to suffer intrusive symptoms and PTSD. (Wenzlaff & Wegner, 2000).

Table 3.

From a medical and psychological point of view	From a legal perspective
• Context including environment and non-verbal communication. • Combination with other methods that potentiate the impact • Immediacy • Chronic – Sustained in time • Conditionality (Coercion) – Unconditionality (Punishment, Humiliation, Discrimination) • Credibility including - Proportionality and Irrationality - Plausibility and planification - Expected outcome of compliance - Historical and political context including political costs Mental suffering: fear and anxiety responses (including past fear experiences and determination of biological and cognitive vulnerabilities – TU, TA, TS)	• Context including - Legality, - Vulnerability (situational and dispositional) - Totality: combination or sequential methods • Perception: subjective appraisal • Practice: Knowledge and experience of patterns and predispositions. • Proximity (spatial and temporal), including immediacy, powerlessness and constraint.

Conclusions

Where does this complexity leave us concerning understanding and documenting threats? There are clear challenges for both health and legal practitioners who are faced with this phenomenon. In this issue, Ergun Cakal (2021) presents a conceptual and jurisprudential review of threats as a form of ill-treatment or torture. Table 3 compares the main elements of analysis arising from the medical and psychological review in this editorial compared to Cakal's legal review. While the legal review emphasises the 3 P (Perception, Practice and Proximity), the medical and psychological review emphasises mental suffering (anxiety and fear) plus the 5 C (Context, Combination and Chronic, Conditionality and Credibility).

The table shows that the two perspectives do not show important conflicts beyond the specific mnemonics being C or P.

When read together, they articulate the central importance of foregrounding the victim's appraisal of the threat and the context in which it is communicated – that this is predominantly a subjective assessment.

Some elements arise from this medical and psychological theoretical analysis that might qualify the legal perspective in the future.

1. When threats are one of the core elements of a torturing environment, they need a specific assessment by the lawyer and the forensic expert. Threats are often deployed interactively to take advantage of specific vulnerabilities and produce the maximum

fear and anxiety.

2. Some jurisdictions consider that threats involve physical harm. An integral view should consider that attacks on identity and psychological suffering are not necessarily associated with a threat of *physical* harm.
3. Some jurisdictions also consider that the threat must be communicated. The review shows that (a) a threat can be contextual (b) the person threatening might not be aware of the threat, but this could still qualify as CIDT.
4. This editorial review shows that it is not necessary for a victim actually to experience fear or terror. It is the intention of the person making the threat to produce the suffering with a certain purpose what matters. Nevertheless, the level of mental suffering (fear or sustained anxiety) is a robust direct indicator of the threat's severity and credibility.
5. Cakal's review (this issue) examines the legal principle that threat must be "credible, real, and imminent" and interprets this to be qualified based on the victim's perception. The medical review enlarges this perspective to consider that. Credibility includes elements related to the historical and social context, the characteristics of the person who threatens, the threatened person, and the interaction between both.
   - It must be considered in the context of other potentiating elements
   - Immediacy is not necessarily the only possibility. Chronic or delayed threats might produce similar mental suffering.
6. Threats sometimes are made real to be credible, and punishment and threats alternate. The distinction between threat and assault might be subtle, and the physical and psychological are intertwined. Threats are a form of psychological assault.

In brief, the medical and psychological and legal review are basically coincident, although the medical and psychological review offers opportunities to enlarge the analysis and to consider further additional criteria. The research on threats as torture is in its beginning. Field studies should confirm which of the above criteria are more relevant to understand the experience of victims and work in the rehabilitation of consequences.

In this issue…

Suzanne Portnoy, Nicholas Nelson, Jenna O. Kupa, Isabelle Rocroi, Emily Tatel, Alejandro Diaz, and Kala M. Mehta present a cross-sectional study on patterns of torture among forcibly displaced Eritrean men in the US. This is the first study of its kind and provides valuable data on prevalent methods, and clinical impacts in a sample of 59 survivors assessed using the Istanbul Protocol. Following the call for contributions from the Journal, Juliet Cohen, B Gregory, K Newman, E J Rowe, and D Thackeray present preliminary data on the feasibility and results of Remote medico-legal assessment by telephone during Covid-19, showing that it can be safely used with some special considerations decribed in the paper. We are now expecting results from the comparision between telephone and video assessments. Vipin Vijay, Sanjeev Sahni and Danial Andzenge present a qualitative study on the Experiences of survivors of commercial sexual exploitation at RP homes in India with an analysis of the elements that facilitate the rehabilitation according to the voice of survivors. Hoffmann et al. conducted an uncontrolled pilot study on the use of effective rehabilitation methods of EMDR with children in war contexts, showing that the method deserves further testing.

The IRCT conducted an open discussion on Survivor Engagement in the work of Rehabilitation Centers for torture survivors. Berta Soley has summarised the conclusions and included an interview with Lynne Walker that shares how the Tree of Life Trust has incorporated this perspective for more than ten years.

In recent months, during a year when organisations that provide services for survivors of torture faced new challenges during the global COVID-19 pandemic, some of the people who have been leading the anti-torture movement for years have passed away. We have paid tribute to Javier Enriquez Sam (1960-2021), Gerald "Jerry" Gray (1935-2020), Sister Jean Abbott (1943-2021), Jose María "Chato" Galante (1948-2020), Gianfranco De Maio (1963-2020) and Sister Dianna Ortiz (1958-2021). Many more people have left us in these months, but let the testimony of Javier, Jerry, Jean, Chato, Gianfranco and Dianna serve as a tribute. They have left behind them a light that we will try to follow.

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Perception, practice and proximity. Qualifying threats as psychological torture in international law

Ergün Cakal[1]

Key points of interest

- International law prohibits threats made by state officials when amounting to torture or ill-treatment.
- What remains problematic, however, is how they are qualified as torture or ill-treatment in criminal justice and other processes.
- Appraising the victim's *perception* of *practice* and *proximity* of state authorities to harm helps qualify threats as "real, credible and immediate".

Abstract

Background: International law prohibits threats made by state officials when amounting to torture or other forms of ill-treatment (hereafter "ill-treatment"). Yet, there remains a pressing need to better distinguish in practice the threatening acts which amount to torture or ill-treatment (and as *prohibited*) from acts which fall short. Responding to this need, this article reviews the literature and offers a discussion towards functionally *conceptualising* and, in turn, *qualifying* threats as torture or ill-treatment.

Method: Following a systematic full-text search of databases with the relevant English-language keywords, journal articles, NGO reports, case-law and UN documents were selected based on their relevance for conceptual, evidentiary and legal critique of threats-as-torture.

Discussion: Prevailing legal reasoning around threats-as-torture centres on the words "real, credible and immediate", with inadequate explication as to their application. To this end, this article proposes that an assessment of the *perception* of *practice* and *proximity* of state authorities to *harm* could be used to help qualify threats as "real, credible and immediate" and therefore torturous.

Keywords: fear, threats, coercive interrogation, duress, psychological torture.

I. Rationale and purpose

The prevalence of threats has been documented in a number of jurisdictions including, to name but two, Turkey and Israel-Palestine (see TIHV, 2019, p. 45; PCATI, 2019: 61% survivors reported use of threats). In some studies with torture survivors, credible and immediate threats have been considered a distinctly harmful method of torture, especially when they involved threats to relatives (see e.g. Argituz et al, 2014). Threats have been associated with severe mental suffering,

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psychiatric sequel (see Baldwin et al, 2014; Başoğlu, 2009; Reyes, 2008), and chronic pain and other somatic symptoms (see Olsen et al, 2006; Punamäki et al, 2010). In an oft-cited study, Başoğlu et al found that the "[f]ear of threat to safety and loss of control over life appeared to be the most important mediating factors in PTSD and depression" (2005, p. 580).

Notwithstanding this, there exists a considerable degree of ambiguity with respect to the harm (also referred to as "mental anguish" in shorthand) required to bring a threatening act within the ambit of the prohibition against torture or ill-treatment, beyond the fear and stress inherent in and therefore seemingly acceptable to criminal justice practice (e.g. policing and imprisonment). That is to say that threats are often difficult to legally assess and qualify, being disguised under standard operating procedures as legitimate use of force. States have been reluctant to prohibit what they characterise and minimise as mere "certain verbal and non-physical techniques" (House of Commons) or "non-violent psychological pressure through a vigorous and extensive interrogation" (Landau Commission). Courts are also known to legitimise such practices as they are "typically very protective of the police and the integrity of the establishment" (Gudjonsson, 2003, p. 617). This is particularly seen, as the Council of Europe's Committee for the Prevention of Torture (CPT) has noted, in any "criminal justice system which places a premium on confession evidence [as it] creates incentives … to use physical and psychological coercion" (2002, §35). The need for clarification and explication, therefore, is patently pressing.

The salience of this pursuit is amplified in light of contemporary struggles particularly against coercive interrogation that have the propensity to amount to torture and ill-treatment. Indeed, in making a convincing case for a protocol on non-coercive interviewing, the UN Special Rapporteur on Torture (UNSRT) at the time Juan Mendez pointed out that, depending on their "degree, severity, chronicity and type, undue psychological pressure and manipulative practices" may amount to ill-treatment (2016, §44). The ensuing effort has been to formulate guidelines outlining good interviewing practices but, significantly, not the redlines or functional criteria demarcating the coercive from non-coercive. This is also very much a need the subsequent UNSRT (2020, §38) identifies in pointing to the "practical importance of continuing to clarify the fault lines between lawful non-coercive investigative techniques and prohibited coercive interrogation".[1]

This article focuses primarily on interrogational contexts, and secondarily draws on cases involving non-custodial settings. Whilst threats aimed at extracting confessions and information remain the focus, threats for other purposes such as intimidation, punishment and discrimination are also discussed where relevant. My aim is twofold: to outline the current jurisprudence on threats via a literature review and to elaborate and explicate a new conceptual approach to help qualify threats, particularly those which are subtle and tacit, as torture or ill-treatment. This article takes a first step in identifying the factors relevant to considering such covert threats as torture.

Part II locates existing literature which define and categorise threats – illustrating and invoking acts considered relevant to the discussion. Part III enumerates the normative

1 Needless to say, this has been a long-standing issue (see also UNSRT, 2001, §7, urging states to raise judicial awareness on threats).

prescriptions which squarely and specifically prohibit threats which amount to torture or ill-treatment under international law, before offering a review of the relevant case-law. Part IV details concepts upon which legal assessments and qualifications are – or should be – made. Part V problematises the judicial reasoning and formulations in the uses of "real", "credible" and "immediate", articulating them through the three notions of *perception*, *practice* and *proximity*.

II. Definition and categorisation

The idea of anticipated harm propelled for a coercive end is at the centre of the definition of "threat": e.g. "a threat of harm made to compel a person to do something against his or her will or judgement" (Black's Law Dictionary, p. 542, 8th Edition, 2004) or "declaration of an intention to punish or hurt … a menace of bodily hurt or injury, such as may restrain a person's freedom of action" (OED, 1990). In the absence of coherent and universal distinctions between the notions of "threat", "fear", "coercion", "intimidation", "distress", "duress" and "anguish", this article treats them as near-synonymous as does the surveyed literature, except where specified.

There is no universally accepted legal definition of a threat or an authoritative list of what constitutes a fear-inducing method which violate the prohibition of torture and ill-treatment. A survey of the jurisprudence reveals that threats are "neither definitively nor consistently defined" (Guiora, 2008b, p. 88). Guiora ventures one definition of threats as entailing "interrogation methods inducing a suspect to provide his interrogator(s) with information when under the impression that to do otherwise will result in penalty either to himself or to others" (2008a, p. 414). Argituz et al propose another definition as the "advance notice of harm that is going to be brought about if the detainee's actions do not go in the direction desired by the questioner" (2014, p. 77).

The category of "fear-producing actions" in Pérez-Sales' Torturing Environment Scale is instructive in illustrating the types of acts at issue here, as follows: a. hopes and expectations; b. threats to the person (e.g. endless isolation, endless interrogation, rape, pain, torture, death); c. threats against family or relatives (next-of-kin) (e.g. rape, detention, punishment, retaliation), or threats against other detainees); d. anguish associated with lack of information (e.g. relatives of people detained/disappeared); e. experiences of near death (e.g. mock executions, dry/wet asphyxia); f. witnessing others' torture or death; g. use of situations evoking insurmountable fear (e.g. phobias, total darkness); h. other situations provoking fear or terror (2017, p. 360). Moreover, Ojeda also formulates a similar categorisation as: threats to self or to other; threats of death, physical torture or rendition; mock executions; forced witnessing of torture (visually or aurally) (2008, p. 3).

There is significant overlap in references to notions of *threatening* and *fear-inducing* methods. For instance, the *Istanbul Protocol* recognises threats, in its multitude of derivations, as a method of torture including: i. "threats of death, harm to family, further torture, imprisonment, mock executions"; and, ii. "threats of attack by animals, such as dogs, cats, rats or scorpions" (OHCHR, 1999, §145 o-p). Recognised visually-oriented threats extend to displaying torture equipment and dangerous objects or animals (see Reyes, 2007, pp. 604-605) and the mere presence of "wooden sticks, broom handles, baseball bats, metal rods" etc. (CPT, 2002, §39; see also ACHPR, *Elgak and Ors v. Sudan*; ECCC, *Duch, Case No. 001*, §245).

III. Legal anchoring: a review of prohibitions and case-law

This section canvasses and draws upon sources of law with varying degrees of authority and scope. I merely seek to reproduce salient points in the law and literature, without detailed comment as to weight or priority.

Prohibitions

Despite the definitional ambiguities, coercive and threatening acts by officials are widely recognised to invoke the prohibition of torture and ill-treatment. Remaining alert to the "problems posed in respect of securing evidence of non-physical forms of torture", the UNSRT mandate has consistently held that "fear of physical torture may itself constitute mental torture" as: "serious and credible threats, including death threats, to the physical integrity of the victim or a third person … especially when the victim remains in the hands of law enforcement officials" (UNSRT, 2001, §§7-8 and 3; see also UNSRT, 1986, §119; UNSRT, 1998, §208). The UN Committee Against Torture (CAT) has also consistently found threats as amounting torture and ill-treatment (2008a, §7; 2006, §24; 2003, §§143-144).

Furthermore, Principle 21 of the *UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment* (UNGA, 1988) prohibits (1) taking "undue advantage of the situation of a detained or imprisoned person for the purpose of compelling him to confess, to incriminate himself otherwise or to testify against any other person", and (2), "threats or methods of interrogation which impair his capacity of decision or his judgement" during interrogation.

Similar prohibitions also emanate from international criminal law and international humanitarian law. Notably, article 55 of the *Rome Statute of the International Criminal Court* prohibits "any form of coercion, duress or threat" during investigations. Moreover, *Geneva Conventions*, at several points, prohibit prisoners of wars from being subjected to threats, coercion or insults during and outside of interrogations. Article 17 of the *Third Geneva Convention,* for instance, states that: "[p]risoners of war who refuse to answer may not be threatened, insulted, or exposed to unpleasant or disadvantageous treatment of any kind." Article 4 of the *Protocol Additional to the Geneva Conventions* prohibits "(a) violence to the life, health and physical or mental well-being of persons, in particular murder as well as cruel treatment such as torture, mutilation or any form of corporal punishment … (and) (h) threats to commit any of the foregoing acts." Furthermore, *ICRC Commentary to the Additional Protocols* provide that "[i]n practice threats may in themselves constitute a formidable means of pressure and undercut the other prohibitions. The use of threats will generally constitute violence to mental well-being within the meaning of subparagraph (a)" (ICRC, 1987, §4543. p. 1376).

In sum, the prohibition of threats under international law amounting to torture and ill-treatment is clear.

Case-law

This clarity quickly dissipates upon even a cursory reading of the case-law. There is a gap between these prohibitions and case law, which the existing scholarship doesn't address. Taking it as a given, I do not seek to explain the existence of this gap. Instead, what I will try to do is to explicate an approach in applying the prohibitions on threats. There are some examples of threats such as mock executions which would more clearly fall afoul of the prohibitions. In most other instances, particularly with less overt threats, we are compelled to more carefully appraise

impact and gravity. Taking stock of the complexities posed by interrogational stressors, the element of severity remains central and problematically significant. What will be seen is that the law equates severity of harm with the appraisal of threats, subjectively and objectively.

I have also chosen not to dwell on distinguishing between threats as torture *from* ill-treatment – as both are prohibited. It suffices to say that, as with Mendez and Nicolescu (2017, p. 244), I presume that intentionality is broader than solely the deliberate as it can also be satisfied by recklessness (though not negligence). The case-law cited below posits that intentionally or recklessly deploying fear to create a threatening situation against the individual, either directly (explicit threats) or indirectly ("atmosphere of terror"), falls afoul of the prohibition of torture. This may not be so readily presumed in non-interrogational and non-custodial settings – where the purpose and intent may not be as patent.

Due to its relatively extensive life-span and case-law, I will primarily consider cases from European jurisprudence which are conducive for both mentioned purposes (i.e. outlining the jurisprudence and indicating a conceptual framework). To start chronologically, the *Greek Case* is arguably the first international case which identified non-physical torture to include: "mock executions and threats of death, various humiliating acts and threats of reprisals against a detainee's family" (ECommHR, §186). The European Court of Human Rights (hereafter "the European Court") further articulated its position on threats in *Campbell and Cosans v. United Kingdom* where it found that "provided it is sufficiently real and immediate, a mere threat of conduct prohibited by Article 3 may itself be in conflict with that provision. Thus, it established the rule that to threaten an individual with torture might in some circumstances constitute at least 'inhuman treatment'" (§26, as followed in *El Masri v Macedonia* (where applicant was threatened with a gun), §§ 202-204; *Husayn (Zubaydah) v Poland*, §501 (where the applicant was threatened with ill-treatment)).

Gäfgen v. Germany somewhat advanced the discussion. There, the European Court rendered torture "the real and immediate threats of deliberate and imminent ill-treatment … [as having caused] considerable fear, anguish and mental suffering" (§103), and considered it noteworthy that the threat "was not a spontaneous act but was premeditated and calculated in a deliberate and intentional manner" (§104). Furthermore, the state of "particular vulnerability and constraint" (the applicant was handcuffed in the interrogation room) and the "atmosphere of heightened tension and emotions" (the police were under pressure to locate the whereabouts of a kidnapped child) (§106) in which the threat took place was also an explicit factor in the Court's assessment (see §§80-81). The Court ultimately prescribed that whether any threat of physical torture amounted to psychological ill-treatment depended on the individual circumstances of a case primarily "the severity of the pressure exerted and the intensity of the mental suffering caused" (§108).

The requirement of *real danger* also emerges as a central criterion when surveying Inter-American jurisprudence, where "real danger of physical harm" is held to amount to psychological torture (*Baldeón-García v. Peru*, §119, citing *Maritza Urrutia; Cantoral-Benavides*). In *Tibi v. Ecuador,* for instance, the Inter-American Court recognized that "threats and the real danger of subjecting a person to physical injury, under certain circumstances, cause such a moral anguish that they may be considered psychological torture" (§147).

Several points discerned from the review can be readily summed up without necessitating elaboration. Firstly, there has been no explicit judicial reasoning speaking to any qualitative hierarchy between the *verbal* and *non-verbal*, the *explicit* and *implicit*. Secondly, the following categories (inexhaustive, overlapping) of threats have been found to violate the prohibition of torture and ill-treatment: threats to life (including non-verbal threats such as display of torture implements and mock executions); threats to inflict violence; threats to family members; and, witnessing the tortured, the executed and the enforced disappeared. Additional cases will be relied upon in the following sections.

These cited cases involve explicitly serious threats to a person. Critically missing in the jurisprudence is what and how threats falls short of "sufficiently real and immediate". The question thus becomes how we should interpret the qualifying criteria we are collecting in the foregoing jurisprudence ("real", "severe", "immediate", "credible", "premeditated", "imminent", "particular vulnerability", "constraint"). A functional appraisal is appropriate here. For severity, we must naturally turn to the psychological impact of threats; for immediacy, we may well ask: "how imminent?" There is also a seemingly objective question about measuring credibility – that there are substantiated grounds that the communicated threat will be acted upon, e.g. previous or personal (witnessing) knowledge of the perpetrator's ill-treatment or impropriety. In sum, judicial reasonings become underpinned by a language of risk appraisal.

What is essentially called for is an appreciation of state power through the eyes of the individual, by assessing the likelihood that a threat would be acted upon. Although a question with clearly different legal parameters, the UN Committee Against Torture has adopted a similar approach in guiding their assessments under article 3 (non-refoulement) of whether the risk of torture upon deportation – in a third country – is "foreseeable, personal, present and real" (CAT, 2017b, §11). The language of risk appraisal will be returned to in Part V.

IV. Contextual considerations: legality, vulnerability and totality

As with all psychological methods of torture, threats are difficult to identify due to overarching conceptual and evidentiary complexities (see Cakal, 2018; 2019) due to not leaving physical marks, being trivialised by state authorities, and being combined with other methods (see, e.g., CAT, *Martínez v. Mexico*; CAT, S.*S.B v. Denmark*). Here, the considerations of *legality, vulnerability* and *totality* are employed to assist in contextually situating the use of threats, explicating and contesting what is obfuscated as "standard operating procedure" and underappreciated as "mild" force.

Legality

The spectrum of harm is broader than the gruesome instances illustrated by the case-law – which are arguably easier to assess as unjustified uses of state power – whereas those conceived to be tacit, mundane and everyday become difficult to assess and qualify as being harmful. To put this another way, while uses of minimal discomfort have been argued as remaining legitimate (as law enforcement institutions inevitably instil some degree of fear and anxiety), accusatorial, protracted or suggestive interviews overlaid with implicit or explicit threats are problematic. Discussed at length elsewhere (Pérez-Sales, 2017, p. 328), the contestation between discomfort and pain, worry and fear become central here.

It should be accepted that the state takes an "inherently threatening position" against

the individual (Guiora, 2008b, pp. 88-89). This necessitates a certain determination of the "baseline" or "inherent inequality" of the interrogation process and, in turn, "whether an interrogator's actions increased this inherently threatening situation to impose undue force on the individual to confess" (Guiora, 2008a, p. 414).

Advancing a more categorical argument, Ginbar observes that "international law does not recognize 'coercive interrogation' that is lawful or justifiable" (p. 277). He couples the prohibition against "physical or moral coercion … in particular to obtain information" as found in *Geneva Convention IV* (§§ 5, 27, 32, 37) with *UN Body of Principles'* edict to interpret ill-treatment in a manner to "extend the widest possible protection" to argue that any form of coercion amounts to ill-treatment (p. 277).

Yet, not all fear arising out of criminal justice practice is legally unjustified, particularly that which is implicit in custodial and interrogational settings. The level of fear acceptably "inherent" becomes a central question here. This discussion also invokes the requirement, a creation of the European Court, that any allegation of torture or ill-treatment first satisfy a minimum level of severity to violate the prohibition against torture or ill-treatment. The Court has interpreted this in various ways as an experience other than "difficult" or "undoubtedly unpleasant or even irksome" (*Guzzardi v. Italy*, §107).

Also apposite here is the progressive principle from *Selmouni v. France* which "considers that certain acts which were classified in the past as 'inhuman and degrading treatment' as opposed to 'torture' could be classified differently in future" corresponding to prevailing, increasing social standards with respect to human rights protection (§101). This may well see certain acts falling short of the minimum level today prohibited over time. Ultimately, ostensibly *objective* assessments must be strictly checked against the *subjective*, erring on the side of the latter, even if we are to risk "meaningless" saturation (see, e.g. dissenting opinion in *Bouyid v. Belgium*).

It is important to bear in mind that this article overlooks, due to space, the distinction between acts are prohibited as amounting to impropriety or non-compliance with procedural rules and acts prohibited as amounting to torture and ill-treatment – except perhaps to point out that impropriety could be an indicator that harm is also present. The absence of essential safeguards in custody, particularly the access to a lawyer, health professional and the right to notify a third party, are important in this assessment. Conversely, the UNSRT has also stated that there is no simple one-to-one equation here, arguing that the length, prolonged delay or indefiniteness of detention, albeit central and harmful, does not *alone* amount to ill-treatment (UNSRT, 2012, §47). I return to this point below in the discussion on proximity and powerlessness.

Vulnerability

Vulnerability may be approached in two different ways: *situational* and *dispositional*. The situational approach "draws attention to the situation of people who find themselves at elevated fragility or 'risk of harm' due to biological circumstances, situational difficulties or transgression" (Brown 2015, pp. 28-31). The dispositional accounts advance that all individuals are inherently vulnerable – as we are all dependent thus could be put under duress by criminal justice practice – thereby shifting the focus from the individual to systemic characteristics. It may also be that an individual's perception may be more severe than what we attribute to it from a position of "reasonableness" or "objectivity".

An indispensable point to factor in is that no one reacts identically to identical treatment. A prominent dimension of psychological torture is mapping psychological vulnerabilities of a human being in personalizing the treatment or punishment. One way is the use of elements of personal identity (e.g. gender, age, culture, religion) against the person; another is the use of cultural and religious elements to produce mental suffering. Certain acts in and of themselves may be viewed as harmless when divorced from the symbolism, connotations and meaning attributed by the victim (e.g. the taboo of nakedness, forceful breaking of religious obligations or rules linked to dressing, food or practices).

The legal assessment of the minimum level of severity – not just limited to psychological torture – also "depends on all the circumstances of the case, such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim" and that context must be taken into account, including an "atmosphere of heightened tension and emotions," also drawing in context and totality of conditions and treatment (*Bouyid v Belgium*, §86).[2] Leaning on such a more embodied and embedded approach to vulnerability would help correct the underestimation of the impact inherently stressful environments inflict on particular individuals (Dehaghani, 2020). I will return to this in the discussion on perception.

Totality

The analysis of torture methods should not obscure the fact that in many cases it is not a question of the application of isolated methods of torture, but of the combination or sequential accumulation of methods. It must also be born in mind that there is a fluid continuum between torturous acts and methods *and* conditions and context. That is to say that it is difficult to distinguish between the stressors part of the background environment and actions that are readily identifiable in the foreground as distinct torture techniques. Coercion is profoundly difficult to accurately measure as it depends on a matrix of factors, physical, cultural, linguistic and individual. Pérez-Sales holds that the "presence or absence of torture is defined not by technique, but by the context and the way in which techniques are applied" (2017b, p. 8). His Torturing Environment Scale emphasises both the specific and cumulative nature of detention conditions to counter this problem (Pérez-Sales, 2017).

There also seem to be relatively numerous documented cases of ill-treatment where threats are singularly considered, making it seem relatively easier to isolate them, at least jurisprudentially (see, e.g., ECHR, *Gäfgen v. Germany*). This is an illusion, however; context is inescapable. That is to say, whilst threats are said to be torturous on their own as a rule of thumb, it is clear from cases following *Gäfgen* that contextual factors predominate in judicial assessments of torture or ill-treatment. Cases following *Gäfgen* have not expanded upon threats though some have emphasised the importance of contextual factors (e.g. an "atmosphere of heightened tension and emotions", *Bouyid v. Belgium*, §86; *Al-Masri*, for instance, did not elaborate at all).

There have been similar rulings seemingly indicating the sufficiency of certain threats on their own (*Prosecutor v. Brdanin*, 2004, §516:

2 *Soering v. the United Kingdom* is a similar point of reference here where the Court had particular regard to documented conditions of death row, the personal circumstances of the applicant, especially his age and mental state at the time of the offence (§111).

where the threat of rape *on its own* constituted an assault; *Prosecutor v. Simić*, 2003, §723: where an unloaded gun was pressed to the heads of interrogees and pulled, the "psychological burden on the detainees was immense"). The preponderance of the International Criminal Tribunal for the former Yugoslavia (ICTY) jurisprudence, however, has also relied on a notion of "atmosphere of terror", which in *Delalic* denoted a fear in all persons subjected to a regime. There, the ICTY ruled:

> It is clear that, by their exposure to these conditions, the detainees were compelled to live with the ever-present fear of being killed or subjected to physical abuse. This psychological terror was compounded by the fact that many of the detainees were selected for mistreatment in an apparently arbitrary manner, thereby creating an atmosphere of constant uncertainty. (§1087)

Conversely, in one report, the UNSRT observes that the "mere fact of detention had the same implication" as the threat of torture (2001, §7). This may, at first glance appear to be a potentially controversial claim that does not find immediate substantiation in international law. As put earlier, not all fear arising out of detention gives rise to an unacceptable level of harm. Yet, when we frame it contextually (here perhaps drawing on the absence of crucial safeguards and due process), the appraisal would become substantiated and grounded.

Similarly, a focus on the accumulation of certain psychological stressors (both context and methods) is merited in better understanding and assessing the environmental harms at play informing the appraisal of a threat. That is, manipulation and compounding stressors in terms of environmental conditions and treatment must also be borne in mind. Solitary confinement and denial of visits, for instance, can be used as non-verbal "softening" methods when coupled with coercive interviewing including threats. The potentially powerful influence of the physical regime of confinement is irrefutable as it "supports and facilitates these pressures and the effect becomes more pronounced the longer the total period of detention in police custody" (Hilgendorf & Irving, 1981, p. 81). The surrounding circumstances of the arrest and custody (such as how sudden and violent the arrest was) and the timing of the interrogation (i.e. day or night) are likely to be instructive here to understand the mental and physical state of the victim (Gudjonsson, 2003, p. 311-12).

Başoğlu also notes this problem concerning the inclination to treat specific systemic conditions, albeit harmful, as background factors "rather than as an independent force or factor that exacerbates the harm, or as a form of torturous treatment itself" (2018, p. 140). He further finds that increasing awareness of the pains and long-term harms of imprisonment:

> may well mean that the calculus applied to certain forms of previously unquestioned "lawful" confinement must be modified and made more stringent. Among other things, this knowledge makes it much easier to demonstrate that certain prison procedures and practices were, in fact, "calculated to disrupt profoundly the senses or personality," given what correctional officials and prison staff knew or should have known about the harmfulness of such conditions and treatment. (2018, p. 144)

The UNSRT (2020 §47(a)) has also recently outlined a useful taxonomy to under-

stand the environment in which psychological stressors (including fear-inducing mechanisms such as direct or indirect threats) are conveyed and amplified – and the common aspects of stress and coercion which affect how a particular situation is experienced and perceived. He identifies the following aspects in this respect: security (inducing fear, phobia and anxiety); self-determination (domination and subjugation); dignity and identity (humiliation, breach of privacy and sexual integrity); environmental orientation (sensory manipulation); social and emotional rapport (isolation, exclusion and betrayal); and, communal trust (institutional arbitrariness and persecution). These may be instructive in the complex challenge presented by appraisals of fear and threat.

To also more comprehensively capture the context in which torture is inflicted, the European Court has developed extensive jurisprudence on psychological suffering inflicted directly or as exacerbated by subjecting individuals to "permanent states of anxiety" (*Azzolina et Autres c. Italie*, §133) including in specific contexts such as incommunicado detention (*Aydin v. Turkey*, §84), extraordinary rendition and secret detention (*Husayn (Abu Zubaydah) v. Poland*, §§509-510), ill-treatment outside a formal place of detention and mass arrests accompanied by gratuitous violence (*Azzolina et Autres c. Italie*, §§133-134). The jurisprudence of the CAT, the Human Rights Committee and the Inter-American Court is also replete with similar findings speaking predominantly to "anguish and distress" or "great suffering and anguish".[3]

V. Conceptual contours: towards qualification

The legal review in Part III implicated a number of factors at play in qualifying a threat as causing sufficient mental anguish to rise to the level of torture or ill-treatment: the content of the threat; the context in which it was communicated (upon the totality of the victim's experiences); how it was perceived (believed/apprehended/appraised); how the victim's perception is checked, corroborated and qualified. Putting these factors together suggests a key question: did the victim perceive/believe that the state authorities were able, prone and close to act upon the threats made? This assessment would incorporate both an objective and a subjective aspect: that is, how it was perceived by the victim (subjective) upon the backdrop of conditions and treatment, and broader context (objective).

These inform the belief of the likelihood that threats would be carried out, the consequences of the threat and the emotional response of those subjected. The three lenses of *perception*, *practice* and *proximity* admittedly overlap and cannot be strictly delineated. They are offered as broad heuristic groupings covering a range of factors. Bearing this in mind, the following discussion will aim to locate their core, through selective illustrations from the case-law. I should repeat here that my concern is more in addressing instances of covert or more ambiguous threats rather than overt threats, say mock executions, that much more readily rise to the level of torture. Thus the

3 See, e.g., *Bousroual v. Algeria*, CCPR/C/86/D/1085/2002, §§9.8, 10; *Giri v. Nepal*, CCPR/C/101/D/1761/2008, §7.7; *Kimouche v. Algeria*, CCPR/C/90/D/1328/2004, §7.7; *Quinterrros v. Uruguay*, CCPR/C/19/D/107/1981, §14; *Larez v. Venezuela*, CAT/C/54/D/456/2011, §6.10; *Ali v. Tunisia*, CAT/C/41/D/291/2006, §2.5; *González v. Mexico*, Preliminary Objection, Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 205, §§424-440; *Álvarez v. Guatemala*, Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 253, §301.

focus becomes an exercise in explicating the gravity of the more tacit instances of threats.

Perception: subjective appraisal

Perception, or subjective appraisal, is advanced here as the subjective measure of severity of harm (namely, mental anguish). It centres on the individual appraisal of the likelihood of the threatened act being carried out as well as the gravity of the suffering experienced. The following aims to partly map out the considerations with respect to what informs and warps perception.

Naturally, the meaning a victim brings to a stressor is significant, as the appraisal of threat "occurs at the information-processing level of analysis embodied in the brain … [and as such] being threatened with a handgun can on be psychologically traumatizing if one knows what a gun is" (Başoğlu, 2018, p. 190). Individual vulnerabilities may influence the perception as may the conditions. Coercion therefore not only stems from "external stimuli but also from self-induced pressures, which results from an individual's interpretation of and chosen response to events, both real and imagined" (Dimitriu, 2013, p. 549).

Accepting some variance, Başoğlu (2018) concludes that fear in the face of threats to safety is in fact universal cutting across cultures and species, (p. 34) and that "threat appraisal can override many other factors that mitigate the effects of trauma, including resilience" (p. 28). Outlining the related stresses involved in interrogation, Pérez-Sales also states that that the individual in interrogation usually:

> feels high levels of anxiety and fear because of the conditions of detention (even if they are not harsh conditions), isolation (including being alone with one's thoughts), lack of control and uncertainty about what will happen next, how long the situation will last and the potential consequences. This can clearly impair the subject's ability to remember, to think clearly and logically, and to make proper decisions. Thus, the experience of interrogation is not a neutral encounter between two people, even under normal conditions. (2017b)

An individual's perception may indeed be sufficient to deem a threat to violate the prohibition of torture or ill-treatment. Such a conclusion – at least in terms of degrading treatment – was drawn by the Grand Chamber of the European Court in *Bouyid v. Belgium* where it held that: "it may well suffice that the victim is humiliated in his own eyes, even if not in the eyes of others" (§87). The characteristics of the victim are as always at play here including, to name but a few, age and gender (Shaked-Schroer et al, 2015, p. 78), social status (see Davis & O'Donohue, 2004), ethnicity, health, lack of life experience, unfamiliarity with police procedures and failure to understand legal rights, and "cognitive skills (e.g. intelligence, reading ability, attentional deficits, memory capacity), personality (e.g. suggestibility, compliance, assertiveness, self-esteem, tendency to confabulate, anxiety proneness), specific anxiety problems (e.g. claustrophobia, fear of being isolated from significant others, extreme fear of police dogs), mental illness (e.g. depressive illness, psychosis) and personality disorder" (Gudjonsson, 2003, pp. 311-312).

Ultimately, it is argued that, as with many legal qualifications of belief, this remains open to being weighed against and corroborated by more contextual factors, such as established *practice* and *proximity* – to which the discussion will now turn.

Practice: knowledge and experience of patterns and predisposition

The concept of practice here is defined as a pattern, contextually-informed and objectively verifiable, showing that the authorities are *prone* or *predisposed* to act on threats. It need not necessarily be profoundly historic or systemic as it may be specific to a period of time such as a highly politicised or pressured event (e.g. elections) or the aftermath of a violent attack (or in the case of *Gäfgen* a kidnapping where time was of the essence), geographical location such as a certain notorious police station, or towards a member of a particular social group such as ethnic minorities, human rights defenders etc.

There are numerous cases in which the use of methods other than threats inform the victim's appraisal of the threat. On the backdrop of a "pervasive climate of fear", in *Elgak and Ors v. Sudan*, the African Commission found a violation of torture and ill-treatment (not specified) based on a mixture of credible threats, threats of rape, cigarette burns, and the display of torture instruments. The victims there, who were human rights activists, argued that the "pervasive nature of the threats was both real and serious and the circumstances in which they found themselves were so serious that they caused them severe mental pain and suffering" (§76). Beyond underscoring the importance of totality of treatment, this case exemplifies the importance to the assessment of credibility on the materialisation of threats by way of the infliction of physical pain.

Known or uncertain fate of third-parties, related or with a similar profile, is also rendered significant in the jurisprudence. In *Estrella v. Uruguay*, the UN Human Rights Committee found that the victim was "subjected to severe physical and psychological torture, including the threat that the author's hands would be cut off by an electric saw, in an effort to force him to admit subversive activities" (§8.3). At one point, the victim was threatened with: "we are going to do the same to you as Victor Jara". Relatedly, in *Mukong v. Cameroon*, the Human Rights Committee found a violation of article 7 of the *International Covenant on Civil and Political Rights* (cruel, inhuman and degrading treatment), where the victim had taken threats of death "seriously, as two of his opposition colleagues, who were detained with him, had in fact been tortured" (§2.5). Moreover, finding torture in *Maritza Urrutia v. Guatemala*, the Inter-American Court established that, amongst other methods such as hooding and sensory bombardment, the victim was "shown photographs of individuals who showed signs of torture or had been killed in combat and […] was threatened that she would be found by her family in the same way. The State agents also threatened to torture her physically or to kill her or members of her family if she did not collaborate" (§85).

The fact that threats follow other violations are also instructive here. Illustrating this, in the *Case of the "Street Children" (Villagran-Morales et al.) v. Guatemala*, the Inter-American Court held that a person "unlawfully detained is in an exacerbated situation of vulnerability creating a real risk that his other rights, such as the right to humane treatment and to be treated with dignity will be violated" (§166). Conflating the verbal and the non-verbal, the case also expounded the stance that "creating a threatening situation or threatening an individual with torture may, at least in some circumstances, constitute inhuman treatment" (§165). The Court also required threats as needing to be "sufficiently real and imminent" – going on to rule that, for the reasons outlined, they were.

In *Prosecutor v. Krnojelac*, the ICTY concluded that it was inhuman and degrading

treatment for detainees to be subjected to a torture regime with individuals being randomly selected for beatings which all others heard (§56) creating a "climate of fear" (§194; see also *Prosecutor v. Blaskic*, §700; *Prosecutor v. Naletilic*, §394; *Prosecutor v. Simić*, §§731, 967). It may be important to note that these cases emanate from the concentration camp, explicitly dehumanising milieu common to violations of international criminal law – and serves to emphasise the context upon which threats are made.

Through these examples, we see that state authorities support the credibility of their threats in producing mental anguish through various means – including display of photos and demonstration of their knowledge, power and predisposition to harm – with impunity – as the victim is made to believe that the act is imminent and forthcoming. This is also coupled up with the proximity (or the physical possibility of the authorities to act to achieve the threatened consequences) – to which the discussion will now turn.

Proximity: powerlessness and constraint

Cases involving police interrogations heard before international courts feature distinct tactics that draw our attention to *proximity*, *powerlessness* and *constraint*. These are readily discerned in a custodial context but perhaps less so in the non-custodial. Subject to the victim's perception, additional aspects are implicated: the physical closeness of state officials essentially to the threatened target of harm be it the victim or their family members; the prospects of impunity; and, strength of legal protections as applied to the specific situation.

The notion of *powerlessness* has been deployed by commentators to capture such dynamics. Even in the absence of coercion, to quote Gudjonsson, the "interrogator is part of a system that gives him or her certain powers and controls (arrest and detention, power to charge, power to ask questions, control over the suspect's freedom of movement and access to the outside world)" (p. 25). Powerlessness may be compounded as the individual to whom a threat is made is put into a dynamic of responsibility, or perceived "complicity", for another's suffering (see *Jager v. Netherlands*).

A number of cases directly invoke physical proximity. An illustrative case is found in *Nechiporuk and Yonkalo v. Ukraine* where a couple were taken into police custody. There, the European Court held that the husband's knowledge of his wife's custody, as well as her being in an advanced stage of pregnancy, "must have exacerbated considerably his mental suffering" (§156). Similarly, in *Elci v. Turkey*, a husband and wife were brought into interrogation together, before being interrogated separately, the husband was then threatened that his wife would be raped if he failed to confess. This was held to amount to ill-treatment (for a similar case see UN Human Rights Committee in *Khalilova v. Tajikistan*).

In a non-custodial context, in *Musayev and Others v. Russia*, the European Court found it to be inhuman and degrading treatment for the victim to have witnessed the "extrajudicial execution of several of his relatives and neighbours [before being] forced at gunpoint to lie on the ground, fearing for his own life" (§169). Similarly, in the Inter-American Court *Case of the Rochela Massacre v. Colombia*, three survivors of a massacre who "felt the possibility that they might die in those moments as well […] knowing that the paramilitaries could return at any moment" (§135). There, the Court underscored the "intense psychological suffering of the survivors" and the "profound fear that they would be deprived of their lives in a violent and arbitrary manner" arising from the witnessing of torture and execution in finding that it constituted torture (§136).

Relatedly, the "distress and anguish" engendered by the uncertainty of enforced disappearances coupled with a lack of an adequate response on behalf of the authorities have also drawn the ire of the European Court. *El-Masri* supports the position that enforced disappearance is a contravention of article 3 as the Court there found that the applicant's solitary confinement in the hotel "must have caused him emotional and psychological distress", that "prolonged confinement ... left him entirely vulnerable" and that he "undeniably lived in a permanent state of anxiety owing to his uncertainty about his fate" (§202). Similarly, the Inter-American Court has ruled that "it is inherent in human nature that all those subjected to arbitrary detention, incommunicado, torture and forced disappearance experienced intense suffering, anguish, terror, and feelings of powerlessness and insecurity" (*Goiburu et al v. Paraguay*, §157).

Even in the absence of explicit threats, the power differential between the state and the individual remains to be of contextual importance. The European Court has recognised that "persons who are held in police custody or are even simply taken or summoned to a police station for an identity check or questioning [and] more broadly all persons under the control of the police or a similar authority, are in a situation of vulnerability" (*Bouyid*, §107). Similarly, in *Magee v. the United Kingdom*, (not finding a violation of the prohibition of torture and ill-treatment but right to a fair trial (article 6)), the European Court observed:

> The austerity of the conditions of his detention and his exclusion from outside contact were intended to be psychologically coercive and conducive to breaking down any resolve he may have manifested at the beginning of his detention to remain silent. Having regard to these considerations, the Court is of the opinion that the applicant, as a matter of procedural fairness, should have been given access to a solicitor at the initial stages of the interrogation as a counterweight to the intimidating atmosphere specifically devised to sap his will and make him confess to his interrogators. (§43)

Such considerations have also been closely examined in other jurisdictions such as the United States. In *Oregon v. Mathiason*, for instance, the Oregon Supreme Court broadly recognised that "[a]ny interview of one suspected of crime by a police officer will have coercive aspects to it, simply by virtue of the fact that the police officer is part of the law enforcement system which may ultimately cause the suspect to be charged with crime". The US Supreme Court also followed this reasoning in *Miranda v. Arizona* where it "concluded that without proper safeguards the process of in-custody interrogation of persons suspected or accused of crime contains inherently compelling pressures which work to undermine the individual's will to resist and to compel him to speak where he would not otherwise do so freely" (§467). In *Dickerson v. United States*, the Supreme Court ventured that:

> custodial police interrogation, by its very nature, isolates and pressures the individual … that even without employing brutality, the 'third degree' or other specific stratagems, custodial interrogation exacts a heavy toll on individual liberty and trades on the weakness of individuals. We concluded that the coercion inherent in custodial interrogation blurs the line between voluntary and involuntary statements … (§435)

In sum, proximity, particularly arising out of spatial (i.e. location, physical context) and temporal (i.e. timing, duration) factors, informs an assessment of *vulnerability* and *imminence* that a threat *can* and *will* be acted upon. In other words, the closer one is to a law enforcement official, whether in custody or in the community, the more heightened one's vulnerability as tempered by the known *practice* of the state in applying the force legitimately.

Towards qualification

The following questions may assist in crystallising the assessment and adjudication of threats in practice:

1. What were the series of events and stressors present in the environment in which the threat was made?
   This alludes to discussions of contextualisation, totality and accumulation which were made above. These circumstances would also help in inferring purpose and intent, if not already explicit. See Part IV.
2. Does the threatened act amount to torture or ill-treatment?
   This is a broader assessment of the content of the threat, or the threatened consequences (i.e. serious harm being inflicted to family member; possibility of sexual violence; humiliation, etc.), and invokes the specific jurisprudence pertaining to the assessment of that act. Excluded here would be legal sanctions compliant with international human rights law, for instance. Reference to legality of the threatened outcome (e.g. a proportionate sentence of imprisonment through due process) may be instructive here. This is about the nature of the outcome, and not how it is made. If the threatened outcome does not amount to torture or ill-treatment, there is no need to proceed. See also legality in Part IV.
3. Did the victim (person to whom the threat was made) perceive/believe that the official (person making the threat) was *willing* and *able* to act upon the threat?
   This is a subjective assessment of the victim's appraisal of the situation based on their understanding and knowledge of state practice, including as informed by: vulnerabilities, previous experience, membership of a group at particular risk of torture, knowledge of historical patterns, strength of procedural safeguards, materialisation of threats, and prospects for impunity. See discussion on perception and proximity in Part V.
4. How likely was it that the threat could or would be acted upon?
   This is an objective assessment of the particular risks (also as above historical patterns, facts in similar cases), access to person, strength of procedural safeguards, political or institutional pressure.

Far from being prescriptive, these questions are offered as summary and suggestion.

Conclusions

This article has considered the existing literature prohibiting, conceptualising and differentiating various types of threatening acts, whether verbal, non-verbal, explicit or implicit. It has canvassed and drawn on different legal contexts to look at how threats might rise to the level of torture. Explicating and elaborating the jurisprudence, it has been argued that the detainee's *perception* of the likelihood of the announced harm is central to any judicial assessment, and could be checked against the *practice* and *proximity* of state authorities to *harm*. Given contextual and subjective complexities, rule formulation is patently fraught. Indeed, as there is "no one kind of interrogation" there can be "no singular set of rules" (David et al, 2017, p. 10), and legal text remains "rather

abstract and not easily translated into concrete procedural rules for the interrogator" (Dimitriu, 2013, p. 561). Conceptualisation, however, is a necessary first step.

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Remote medico-legal assessment by telephone during COVID-19: Monitoring safety and quality when documenting evidence of torture for UK asylum applicants

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Key points of interest

- Psychological medico-legal reports can safely be produced by telephone assessment
- The reports can follow Istanbul Protocol Principles
- But they are more likely than face-to-face assessments to be incomplete, in terms of both full disclosure of torture experiences and psychological assessment

Abstract

Introduction: Due to the COVID-19 pandemic, Freedom from Torture developed remote telephone assessments to provide interim medico-legal reports, ensuring people could obtain medical evidence to support their asylum claim.

Method: To audit this new way of working, feedback was collected from the doctors, interpreters, individuals being assessed, and senior medical and legal staff who reviewed the reports. This paper presents findings from the first 20 assessments.

Results: Individuals assessed reported that the doctor developed good rapport, but in 35% of assessments reported that there were some experiences they felt unable to disclose. In 70% of assessments, doctors felt that rapport was not as good compared to face-to-face. In the majority of assessments, doctors were unable to gain a full account of the torture or its impact. They reported feeling cautious about pressing for more information on the telephone, mindful of individuals' vulnerability and the difficulty of providing support remotely.

Nevertheless, in 85% of assessments doctors felt able to assess the consistency of the account of torture with the psychological findings, in accordance with the Istanbul Protocol (United Nations, 2004).

Factors that hindered the assessment included the inability to observe body language, the person's ill health, and confidentiality concerns.

Conclusion: This research indicates that psychological medico-legal reports *can* safely be produced by telephone assessment, but are more likely to be incomplete in terms of both full disclosure of torture experiences and psychological assessment. The limitations underline the need for a follow-up face-to-face assessment to expand the psychological assessment as well as undertake a physical assessment.

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Introduction

Freedom from Torture is a human rights charity in the UK providing therapy, support and medico-legal reports for survivors of torture. At the onset of the COVID-19 pandemic in the UK some legal processes for asylum seekers were suspended but others continued. Some substantive asylum interviews and hearings have since restarted. Prior to COVID-19 the Home Office already carried out some interviews by video conference, and it is planned to roll out this option much more extensively.

Rapid change in working practice was required to meet the continuing need for medical evidence for asylum applicants. Guidance was developed for doctors to switch to remote psychological assessments, taking account of the evidence from the rapid change to remote working for the majority of medical appointments at that time, and from more established remote work in mental health services and telephone helplines. While physical examinations had to be suspended, telephone assessments focussed on the account of torture and the psychological assessment but also noted physical symptoms, underlying health conditions and the presence of physical lesions and confirmed the need for face-to-face examination to document physical evidence of torture.

The aim was to ensure people had access to evidence if they needed to progress their asylum claim during lockdown, or make arguments as to why their case could not progress at that time. Reports could also provide other evidence on aspects such as suicide risk, fitness to give evidence or psychological issues which could go to credibility, for example through discussing clinical reasons relating to memory that could account for differences between accounts.

Many asylum seekers either did not have a device with video function or reliable internet access, particularly during the lockdown. There were also initial security concerns about confidentiality with some video platforms. Only Skype for Business was authorised organisationally at this point, due to confidentiality concerns, but this did not support a three-way video function with an interpreter without all users having a business account. The service therefore began with telephone assessments, using three-way calling facilities with interpreters when necessary.

The British Medical Journal has been enthusiastic about remote assessments, declaring that "*if* the *technical connection is high quality, clinicians and patients tend to communicate by video in much the same way as in an in-person consultation" (*Greenhalgh & Kok, 2020: 368). Telephone consultations have been used in General Practice for some time. However, others have sounded strong notes of caution for such a generic endorsement of the use of technology. Royal College of Psychiatrists guidance states that "*For initial consultations (where the patient and clinician are unknown to each other), remote consultations may be even more challenging. Despite this, the alternative of no consultation at all is not preferable and we recommend that initial remote consultations go ahead where possible…. It remains the case that these consultations are limited and those with lack of digital literacy or no access to digital platforms must not be disadvantaged, nor should those who are unconfident about using the technology*" (Royal College of Psychiatrists, 2020).

There is a key difference between consultations taking place in the National Health Service, to address current clinical need, and a medico-legal report (MLR) examination, where the person's past experiences of torture, and other experiences of trauma, must be explored in order to correlate the level of con-

sistency with current clinical findings. MLR assessments cause a degree of anxiety for the person in any situation, knowing they will be asked to recount the experiences they may be desperate to forget. In light of this, caution was needed in balancing any risks to individuals who, during lockdown, would be more likely to be isolated and unable to access support networks, against the need for an assessment when the doctor could less readily assess levels of distress or re-traumatisation compared to a face-to-face assessment. After MLR examinations, some people feel an increase in distress and experience a higher frequency and intensity of PTSD symptoms. In normal times they can visit their family doctor or counsellor, see friends, or gain comfort from attending their place of worship. Few if any of these options were available to them during the lockdown. The MLR process may need to go into exactly those areas cautioned against by the Royal College of Psychiatrists and the guidance given to therapists. Therefore, it was paramount not only to have guidance in place for doctors but also to carry out an audit so that the safety and quality of the assessments could be assessed almost immediately.

The objective of this study is therefore to assess the extent to which telephone assessments can evaluate evidence of torture while monitoring individuals for risk of harm in the assessment process.

Method

1. *Guideline development*: Detailed guidance was developed for doctors undertaking remote assessments, including when a remote assessment might be unsuitable.
2. *Ethics:* Freedom from Torture research ethics committee approved the project. Throughout the process the precept 'first do no harm' was kept in mind. This guided a cautious approach regarding the risk of re-traumatisation and exacerbation of mental health conditions to those examined remotely, and our assessment of the quality of evidence produced in this way.
3. *Training:* Doctors were provided with the new guidance and a short remote training session was held. All the doctors had more than five years post-qualification experience and most had many years broad general medical experience. In addition, all had previously undertaken a comprehensive course of specific training in assessment and documentation of torture provided in-house, and attend regular update training.
4. *Risk assessment:* For each referral, factors were considered that might make a remote assessment unsuitable for that person. These included:
   - Hearing difficulty
   - Learning difficulty or disability
   - Other significant cognitive disability
   - Severe psychiatric disorder or being under the care of a mental health team, for example if the person was known to dissociate, had a diagnosis of psychosis or a high risk of suicide
   - Single parent with dependent children, or children present in their accommodation
   - Age under 18
   - Any other factor identified from the referral documents

   Additional information was gathered from the person's therapist, if with Freedom from Torture, or legal representative, to inform this risk assessment.
5. *Choice:* Individuals considered suitable, and their legal representatives, were offered the choice of a remote assessment to produce an interim MLR, followed by a

face-to face appointment to complete the report when conditions allow, or a place on the waiting list to have a full report once face-to-face assessment was possible.

6. *Sample:* All assessments were carried out between April and July 2020 with individuals in their accommodation, during the complete lockdown period. Assessments were undertaken by a pool of doctors, interpreters and lawyers, with some working with a single client and some with several clients. The age range of clients was 23-53 years and 19 out of 20 were male. Clients came from the following countries (table 1):
7. *Preparation:* Each case file was prepared by an MLR legal officer, summarising key issues to be addressed. The doctor read the documents themselves and a discussion took place prior to the assessment.
8. *Process*: Each assessment was carried out over two phone calls, each up to two hours in length. The doctor first assessed the person's health and vulnerability in the pandemic and made a risk assessment. If safe to do so, they continued the assessment to take an account of the torture and its impact on the person's health, and produced a draft report.
9. *Review:* Each report was reviewed by a senior doctor and lawyer before the doctor completed the report.
10. *Audit*: Feedback was collected from the doctors, interpreters, the individuals assessed and the medical and legal staff who reviewed the reports. For comparison, feedback was also sought from individuals who had had their MLR produced prior to the COVID-19 lockdown, either with all face-to-face appointments or in a few cases, some face-to-face appointments with a phone call to complete the assessment.
11. *Analysis:* A simple analysis of the data is made. Although results are quoted as percentages, it is acknowledged that numbers are relatively small and results comprise both quantitative and qualitative information. Presentation in this format however aims to provide clarity in the comparisons being made.
12. *Future follow-up*: Follow up face-to-face appointments will be offered, when this is possible, for the physical examination and for any areas that could not be covered in the remote assessment, or where an update is needed.

Table 1. Countries of origin

Afghanistan	2
Angola	1
Cameroon	1
DRC	2
Egypt	1
Ethiopia	1
Kenya	1
India	1
Iraq	1
Pakistan	2
Sri Lanka	4
Sudan	2
Zimbabwe	1

The Guidance

The guidance for remote assessments comprised details on the administrative process for setting up three-way calls with an interpreter, the safety-net process for first assessing the person's vulnerability and current health before proceeding to take the torture history, and advice on how to adapt the in-person assessment and examination for the remote

process. The guidance considered both telephone and video calls, but as discussed in the introduction, in this data set only telephone assessments are reported.

The principle of minimising risk guides doctors to proceed with caution, checking the person understands the purpose of the call, gives their consent, understands who will call back if the call drops out, and that they are in a suitably private location to undertake the assessment. The doctor obtains key contact information in case of emergency. A discussion is held about what to do if the person feels upset and overwhelmed or needs a break.

The doctor checks the person's understanding of COVID-19 symptoms and what to do if they become unwell. This is followed by a general review of the person's current health and a risk and safeguarding assessment, checking they feel safe and are able to look after themselves and their dependants. Flexibility is advised once the assessment proceeds to assess evidence of torture, for example by considering starting with the current psychological examination before working backwards to an account of the torture, depending on the doctor's assessment of how the person is responding. Doctors were advised to use some techniques more often and more overtly than when face-to-face, such as checking with the person how they are feeling, asking about silences, demonstrating active listening by summarising or repeating back part of what the person has said, signposting the next topic to be discussed, and using more direct questions to keep the person focussed.

Feedback surveys

After each assessment, the doctor and interpreter completed a survey. Once the report was completed, the medical and legal reviewers also recorded their feedback. The feedback included an evaluation of the extent to which the doctor felt able to gather details of the torture and current psychological state, the extent to which they were able to assess the consistency of the account of torture with the clinical findings in accordance with the Istanbul Protocol. It also included other aspects relevant to their asylum claim such as suicide risk assessment, identifying treatment needs, and fitness to give evidence. A different doctor called the person assessed a few days later to obtain his or her feedback.

The surveys comprised a mix of open and closed questions and responders were invited to add free text to elaborate on their answers. The survey questions asked are in appendix 1.

Table 2. Doctors' feedback

	Fully; as if face to face	**Partially**	**Not at all**
To what extent were you able to obtain an account of torture? (2/20 excluded as torture account already taken)	5%	67%	28%
To what extent were you able to assess the impact of torture?	20%	75%	5%
To what extent were you able to make an assessment of the current psychological condition?	75%	25%	
To what extent were you able to consider consistency of psychological findings with the torture account?	60%	25%	15%

Table 3. Findings that hindered the assessment	
Difficulty reading body language or lack of cues as a general hindrance to their assessment	75%
Not able to develop the same level of rapport	70%
Person's ill health (including mental ill health) during the assessment	35%
Person disclosed that there were areas they did not feel able to discuss remotely	35%
Person's isolation and vulnerability	30%
Safeguarding concerns, e.g. the need for the doctor to self-censor to avoid re-triggering or flare-up of symptoms in the absence of clinical support	30%
Person not alone during their telephone interview	20%
Other factors noted with less frequency were the person's anxiety about COVID-19 and related health issues, and various technical difficulties with the calls.	35%

Results

Doctors' feedback is shown in table 2. Table 3 summarises findings that were felt to hinder the assessment.

Factors noted to have helped the assessment

- A good legal briefing prior to the first appointment allowed doctors to maximise the value of the time spent on the calls and prioritise areas to focus on.
- A good interpreter.
- Two phone calls helped develop rapport and allowed flexibility in responding to the individual's presentation, for example the first call was often shorter, and more detail was gathered in a second longer call.
- Ability to make a brief third call to clarify a specific issue.
- Flexibility in offering breaks.
- Flexibility in approach, for example approaching the torture history later in the second session when the person's psychological state and risk of re-traumatisation had been assessed and better rapport established.

Feedback from people examined face-to-face: Seven responses from people who had had a face-to-face appointment before COVID-19 were gathered for comparison with those of people examined remotely. Comments included that

- panic attacks were exacerbated by the whole MLR process and nightmares and distressing memories increased.
- One individual who had two face-to-face appointments and one remote, found it hard to listen and concentrate on the phone call.

Comments on rapport included that

- "*the doctor was kind and listened to me",*
- *"I could talk openly, valued being heard",*
- *"the office space and the environment created by the doctor made me feel comfortable which made the assessment easier*"
- "*I felt I could say everything I wanted to*".

One person commented *"Some questions were hard to answer, didn't want to answer, felt I had to answer".*

Feedback from people examined remotely: 20 feedback responses were received from those examined by telephone (table 4).

Table 4. Preference for face-to-face vs telephone assessments	
Better to have a face-to-face assessment	42%
Face-to-face or telephone the same	32%
Better to have telephone assessment	26%

Comments that were in common with those made about face-to-face assessments

- "Went OK", "felt comfortable"
- *"Talking about the past creates terrible feelings", "more depressed"*
- *'Able to say everything I wanted to'*
- *There were many compliments to the doctors, that they were comforting, understanding, offered support, helpful*

Other comments

- Five individuals felt it would have helped if they could show the doctor their body.
- One individual felt that a doctor could have understood better how they were struggling mentally and emotionally if they could have seen them.
- Four said they feared anxiety, breaking down or panicking if the assessment had been face-to-face.
- One individual found it difficult to talk on the phone for a long time, difficult to maintain concentration.
- One person had to find a private place in a park to be able to talk.

Comments on disclosure

- 80% of individuals indicated that they had said all they wanted to.
- 40% of individuals remarked that it was difficult talking about past experiences.
- *"There are a lot of things I chose not to talk about".*
- "*I said everything I wanted to say; there are some things I didn't share with the doctor because I didn't want to share them with anyone'.*
- "*I was able to say everything that I wanted to. I admit that I was, however, hesitant to tell everything. I kept a few things back. I was not 100% open, but more than I would have been face-to-face*".
- "*I think face to face would have been more difficult - telling all my experiences. I am not good with face-to-face interviews - I get anxious. Through the phone interview I was able to say everything".*
- *"After 2 days of phone interviews I felt emotionally relieved - it helped me a lot".*

Interpreters feedback

Table 5. Interpreters' responses	
Communication and rapport were not negatively affected by the remote process	42%
Communication and rapport were somewhat negatively affected by the remote process	47%
Communication and rapport were helped by the remote process	11%

19 responses received from interpreters who interpreted during the telephone assessments are shown in table 5.

Comments included:

- 8 respondents noted that video call would be better; among the reasons cited were the loss of body language.
- 2 respondents noted difficulties maintaining a good connection.

- 1 respondent valued the pre-appointment briefing and post-meeting review with the doctor, without the individual.
- 1 respondent noted there was a point where it sounded like the person was sobbing, but then composed himself, whereas face-to-face it would have been easier to know what was happening.

Reviewer feedback

The reviewer feedback surveys were predominantly in a free text format. The percentages quoted below should therefore be viewed as a broad indication of the findings.

There were responses by legal reviewers for 14 cases. In 35% of the responses, the legal reviewer noted within their comments that the doctors' fears around re-traumatisation or significant distress of the person limited the assessment. No other specific limitations from a legal perspective were noted.

In 15 responses by medical reviewers, the free text comments gave a clear indication of the linkage between the psychological findings with the torture described (see Table 6).

Reviewers also found that doctors *were* able to make an assessment of the possibility of fabrication of the psychological findings.

General issues

Confidentiality: There were two cases, where despite best efforts, the person had young children present which limited the extent to which the doctor could explore the account of torture and its impact. In one case the person was in a shared room and their roommate could be heard in the background, but the person wished to continue as they thought their roommate was asleep. In another case the person was taking the phone call out of doors, so again not in good conditions of privacy.

Unsuitability for remote process: In a number of cases the person was not deemed suitable for a remote assessment and was placed on a waiting list for a full face-to-face report when this becomes possible. The numbers excluded were relatively high initially, as a proportion of total referrals, but this proportion reduced as legal representatives understood the COVID situation and the remote assessment process better. The total number of referrals deferred for a face to face assessment during the period of this study was 10, The reasons for this were (in some cases more than one reason applied):

- In 7 cases the person's mental health made them too vulnerable for a telephone assessment
- In 2 cases the documentation of the person's scars was the most important element, so they wanted to wait until a full face-to-face examination could be done.
- In one case young age was the excluding factor.

Discussion

The results indicate that psychological medico-legal reports can be carried out by telephone assessment, but their scope may be limited by this method of communication.

Disclosures

The range of feedback from individuals sug-

Table 6. Linkage of psychological findings

	Good	Partial	Very limited
Linkage of psychological findings with the torture described.	53%	24%	23%

gests some people found telephone assessment easier for disclosure, and others found it perhaps easier to withhold information they did not wish to share. Both those assessed remotely and face-to-face may choose not to disclose everything they can.

In many cases the doctor said that they were not able to gain a full history of the torture or its impact during the assessment. Doctors reported feeling more cautious about pressing for distressing information while on the telephone, mindful of individuals' vulnerability and the difficulty of providing support remotely. Complete disclosure may not be needed if there is already a detailed account elsewhere or if the doctor felt they had enough information to complete the psychological assessment. Reviewing the torture history will need to be an integral part of the later face-to-face assessment as more detail may be be needed to make an assessment of the physical findings. Additional disclosures may be made during subsequent face-to-face assessments and monitoring changes in disclosure patterns will form part of the ongoing audit.

Safeguarding and rapport

Individuals' feedback indicated that they felt doctors were successful in safeguarding their well-being as far as possible and developing rapport, such that they felt listened to, understood and that the doctor was caring and helpful. This matched the feedback from individuals who had face-to-face assessments. Both groups reported that re-experiencing symptoms such as flashbacks and intrusive memories of torture increased in the period after an appointment.

There were differences in the perception of rapport. The majority of those assessed reported that they could say everything they wanted to. In contrast, doctors often felt that rapport was not as good as when they examine people face-to-face. Interpreters also felt that rapport was not as good and took longer to establish. For most of those being assessed, this was their first experience of an MLR assessment, whereas the doctors and interpreters have prior experience of face-to-face assessments. Many doctors commented that the absence of visual cues made it more difficult to assess the level of rapport and so they felt more cautious in their questioning. Unfamiliarity and anxiety with new technology for three-way calls may also have played a part as technical issues were problematic in some of the first cases. With learning and experience and the smooth running of the technical processes, doctors may find their perception of rapport increases.

Several doctors commented that rapport improved in the second telephone call and that they waited until rapport was better established before approaching the torture history. It seems likely therefore that for some at least, there would have been less disclosure in an assessment format with just a single telephone call.

Confidentiality

The presence of others near the person in some assessments, including (in two cases) young children, illustrates the difficulties of ensuring confidentiality for remote assessment. This may also be a further factor limiting disclosure in some cases.

Assessing the consistency of the psychological symptoms with the torture allegations

Assessing the consistency of the psychological symptoms with the torture that the person describes is a key component of a psychological MLR as set out in the Istanbul Protocol paragraph 287. In spite of the limitations doctors faced in obtaining a full history of torture and its impact, in 60% of assessments the doctor

reported that they were able to fully assess the consistency of the psychological symptoms with the account of torture given, and a further 25% were able to make a partial assessment. These findings were mirrored in the feedback of medical reviewers.

This disconnect can be explained by a number of reasons. In many cases doctors had established enough symptomatic detail to demonstrate how they reached diagnoses of Post-Traumatic Stress Disorder (PTSD) and/or depression and to demonstrate how the psychological findings linked to the torture account, for example through the content of nightmares and flashbacks and the timeline of onset and exacerbations of symptoms. Doctors routinely discussed other possible causes of the psychological symptoms as part of this assessment. In some cases, additional history may have been available, for example from a Home Office interview or witness statement, to feed into the assessment. The inability to disclose was often highly relevant to the psychological findings. For example, avoidance behaviour in PTSD or shame resulting from sexual torture provided strong evidence of the psychological impact of torture events even when a full history could not be obtained.

Scope of remote assessments

Review of the reports showed that doctors were able to make detailed self-harm and suicide risk assessments, which included the current risk and consideration of suicide risk if the person is returned to their country of origin. Legal representatives were sometimes seeking specific information in these areas.

If there were differences between accounts, the doctor discussed any clinical reasons relating to memory that could account for these and any inappropriate clinical judgments

made by decision-makers. In all cases doctors considered whether there was any clinical evidence to suggest fabrication of the psychological symptoms. These considerations provide key evidence to inform the assessment of credibility by the decision makers.

Information in the reports may also be useful for the interviewing officer or tribunal in planning how to conduct an interview or hearing with a vulnerable person, on video link or in person. Doctors routinely considered the fitness of the person to be interviewed or give evidence remotely, and in some cases the doctor was able to make specific recommendations to help with this.

Assessing the remote process

It was especially valuable to learn from individuals going through the assessment. When changing a process, the duty of care for, and potential harm to, vulnerable individuals has to be kept in mind. Harm may also be caused if the quality of evidence gathered is affected. Our results to date indicate that 85% of doctors felt able to make an assessment, to a greater or lesser extent, of the consistency of their psychological findings with the torture account given. However, there was a consensus that accounts were likely to be partial, and findings incomplete, notwithstanding the inevitable absence of the physical findings, which had to be pended until a face-to-face examination is possible.

In other areas of medicine there has been relatively little concern expressed about the quality of remote consultations. In the UK both hospital and family doctor consultations have been going ahead remotely, with many commenting they will continue this in the future due to the time saved and increased access. Mental health work has been done remotely in some services for some time, and the use of crisis phone lines is well-established.

In the UK, courts have increasingly moved to remote hearings over several years for bail

hearings, sentencing hearings, and other work, citing the time and money saved as a key driver. The Home Office is now rolling out remote asylum interviews after a pilot, and it appears that even as COVID-19 related restrictions ease and the threat from the pandemic decreases, this will increase. However, research shows that an adverse credibility assessment is more likely when giving remote evidence (Bail Observation Project 2013), and that people are less likely to get bail, and more likely to get longer sentences (Transform Justice, 2017). This is the case particularly if they have a hearing difficulty, cognitive or mental health problems, or need an interpreter (Transform Justice, 2017). It is evident that more than one of these factors will particularly affect survivors of torture seeking asylum in the UK, as almost all need an interpreter and the prevalence of mental health conditions is high. Indeed, hearing difficulty and significant cognitive or other mental health problems were among the exclusion criteria considered in this study. A study comparing telephone and face-to-face advice in social welfare and legal aid (Burton 2018) found that while the telephone offers convenience and accessibility, those with more complex and serious needs as well as those where trust and rapport are more important are much better served by face-to-face communication.

In the examinations reported in our study, the doctors had the advantage of careful case preparation with a legal officer. In contrast to non-medical staff in Home Office or tribunal settings, the doctors have specific clinical skills and experience. This enables them to alter a line of questioning when appropriate to reduce a person's distress, to gauge at what point to approach talking directly about traumatic experiences, to use breaks and/or stop appointments early when a person becomes distressed, and to use second appointments for further development of rapport. In the event that flashbacks or other dissociative episodes are triggered, where the person loses touch with the here and now, they have expertise in using grounding techniques (clinical techniques to bring the person back into the present).

Undergoing asylum interviews or giving evidence to a Court by video link cannot be directly compared with telephone assessments. Medico-legal report examinations, while including a consideration of fabrication of the clinical findings, are not credibility assessments. However, some factors will be common to these different situations, such as the potential for the level of rapport to impact on disclosure, and the importance of making special considerations for those likely to be disadvantaged by the remote nature of the assessment due to cognitive impairment or mental health condition.

In view of these concerns, Freedom from Torture together with the Helen Bamber Foundation (a charity supporting refugees and asylum seekers who have experienced extreme human cruelty, such as torture and human trafficking) have drafted recommendations to the Immigration Tribunals drawing attention to the added vulnerability of victims of torture and other asylum seekers if they are interviewed or required to give evidence remotely. These include the note that "*expert evidence that is produced, including medico-legal reports, may be interim only. Evidence of torture survivors' physical injuries may be inaccessible but that in the current circumstances benefit of the doubt should be applied and interim evidence may be sufficient to substantiate a claim"* (Freedom from Torture and Helen Bamber, 2020:4).

Limitations of this study

Numbers: This study reports on the first 20 remote interim medico-legal reports from

telephone assessments., Findings are limited to this relatively small number and to this medium, limiting the extent of analysis of the data.

Completing the reports: A follow-up paper is indicated, evaluating how the reports change after a face-to-face assessment when the further clinical findings can be considered together with those from the remote assessment. It will be particularly interesting to compare those cases where disclosure was limited with the findings from the face-to-face assessment to see if further disclosures are subsequently made and to examine what impact this has on the report conclusions.

Physical assessment: Once this is added to the reports, it will be interesting if, and to what extent, the report's conclusions may alter.

Outcomes: At this stage, the outcomes in terms of asylum decisions made on the basis of this evidence are not known, or how these psychological reports will be considered. A further paper evaluating this is indicated, once these decisions are made, but may be long-delayed depending on how quickly asylum decisions are processed and appeals heard and to what extent the interim medico-legal reports are relied upon in determining the claims.

Continuing assessments during the era of COVID 19: Although yet to be fully evaluated, early experience with video assessments confirms that not all asylum seekers have access to suitable devices or have the digital literacy or reliable internet access to enable this type of remote assessment. A further audit will aim to compare the telephone assessments with video assessments, now that these have become feasible for some.

Conclusion

Vulnerable survivors of torture are even more vulnerable if they are not able to access the medical evidence needed to support their asylum application. In meeting this challenge, Freedom from Torture has sought to mitigate their vulnerability by providing a remote health assessment and an interim psychological-only medico-legal report, while minimising distress and the risk of re-traumatisation.

The results of our audit so far show that psychological medico-legal reports *can* safely be produced by telephone assessment, but are more likely than face-to-face assessments to be incomplete in terms of both full disclosure of torture experiences and psychological assessment. In many cases high quality evidence can be produced that follows the Istanbul Protocol Principles and addresses other key clinical issues in the claim. In cases where significant limitations have been identified, the reports should be regarded as interim.

Providing these reports has ensured that survivors of torture have access to vital medical evidence for their asylum application during the COVID-19 restrictions. Freedom from Torture continues to learn and strive for the highest quality evidence through different types of remote assessment but considers telephone assessment remains crucial to avoid the 'digital discrimination' highlighted by the Royal College of Psychiatrists.

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Appendix 1

Feedback questions

MLRS Remote Assessments Doctors Survey
Email:

1. Your name (first name and surname):
2. MFID number:
3. Date of last remote appointment:
4. How many appointments did you have?
5. Were your calls made with video or voice only?

If you answered a mix in the above question, please state the reasons why and what proportion of the calls were voice and video:

6. Was the individual alone, or accompanied?

Please provide further details if relevant:

7. To what extent were you able to obtain an account of torture?

Please provide further details if you are able to:

8. To what extent were you able to assess the impact of torture?

Please provide further details if you are able to:

9. To what extent were you able to make a psychological assessment of the current condition?

Please provide further details if you are able to:

10. To what extent were you able to consider consistency of the current psychological condition with the account of torture given?
11. If your answer to the above question was that you were not able or were only partly able to consider consistency of the current psychological condition with the account of torture given, do you believe this is because you were not able to meet with the individual in person?

Please provide further details if you are able to:

12. To what extent were you able to address other specific instructions from the legal representative, such as unfitness to give evidence?

Please provide further details if you are able to:

13. If your answer to the above question was that you were not able to address some or any of the legal representative's instructions, was this a result of not being able to meet with the individual in person?

Please provide further details if you are able to:

14. What factors helped or worked well in the assessment? For example, having a pre-briefing, taking breaks, a second/follow up call, or perhaps you have specific tips for others to use?
15. What factors, if any, hindered the assessment?
16. Did the person identify any areas they did not feel ok to disclose or discuss remotely?

Please provide further details if you are able to:

17. How much contact time with the person was spent on issues not directly related to assessing evidence of torture (and not including consent and other preliminaries) - e.g. identifying current non-torture-related healthcare needs, providing

support and information?

Please provide further details if you are able to:

18. How much contact time with the person was spent on issues not directly related to assessing evidence of torture, including identifying current non-torture-related healthcare needs, providing support and information, that were _directly related to the COVID-19 pandemic_?

Please provide further details if you are able to:

19. How effective did the interventions mentioned in the two questions above appear to be? (Skip this question if not applicable)

Please provide further details if possible, or state if it was not clear how effective the interventions were.

20. Did these interventions affect the process of the report examination?

Please provide further details if possible:

21. Did you feel that you were able to build rapport with the person and establish a trusting professional relationship with the person to the same extent as if you met in person?

Please provide details if possible, including any positive factors that enabled you to build a rapport, such as having a second appointment booked or expectation of a possible physical meeting in future, etc:

22. If you have anything else you would like to add, including any feedback on using this survey, please do so here:

MLRS Remote Assessments Individual Feedback Survey

Email address:

1. Your (doctor's) name (first name and surname):
2. MFID number:
3. Name of the doctor who carried out the remote assessment:
4. Date of last remote appointment (if known):
5. Did the individual give their verbal consent to record and use their answers here for research, policy work, media / communications work, teaching & training, and fundraising (please click 'other' and provide details if only partial consent was given)?
6. How did you feel the assessment went? Is there any specific feedback you would like to give us?
7. Was there anything that particularly helped you communicate via video link/ phone? (e.g. something the doctor said?)
8. Was there anything in particular that made it difficult?
9. Were you able to say everything that you wanted to? If not, can you say why?
10. If you had been able to have a face to face appointment instead, in what way do you think that might have been different?
11. Anything else you would like to say?

MLRS Face-to-Face Individual Feedback Survey

Email address:

1. Your name (first name and surname):
2. MFID number:
3. Name of the doctor who carried out the assessment:
4. Date of last appointment (if known):
5. Did the individual give their verbal consent to record and use their answers here for research, policy work, media / communications work, teaching & training, and fundraising (please click 'other' and provide details if only partial consent was given)?
6. How did you feel the assessment went? Is there any specific feedback you would like to give us?
7. Was there anything that particularly

helped you to communicate at your appointments? (e.g. something the doctor said?)
8. Was there anything in particular that made it difficult?
9. Were you able to say everything that you wanted to? If not, can you say why?
10. If you had to have your appointment by video or by phone, in what way do you think that might have been different? [For part-face-to-face, part-remote individuals please indicate this was the case, and ask instead: "If you had to have your appointments only by video or by phone, or if you had been able to have face to face appointments, in what way to you think that might have been different?"]
11. Anything else you would like to say?

MLRS Remote Assessments Interpreters Survey

1. Your name (first name and second name):
2. Name of doctor you worked with:
3. Date of the last interpreting session with this MLR doctor (if known):
4. To what extent did you feel communication and rapport building were affected by the remote process?
5. Please provide further details if you can:
6. What could be done to improve the process of remote interviewing?
7. What challenges, if any, did you yourself face in providing interpreting services for the MLR service remotely?
8. Any other comments, concerns or suggestions?

MLRS Remote Assessments Medical Reviewers Survey

Email address:

1. Reviewer's name:
2. MFID number:
3. Date of last remote appointment (if known):
4. Was there a particular area of concern in the report on which you needed to comment?
5. Was the reviewing support required different to that of a face-to-face MLR - for example dealing with the limitations of a remote assessment?
6. To what extent has it been possible to link the person's psychological findings to torture?
7. To what extent has the doctor been able to address fabrication?
8. Apart from the physical examination, what points will need following up in a face to face assessment (please ensure you have included this in your review)?
9. Please outline any areas of best practice you picked up? (Please copy any good examples of wording into the 'good examples of wording' document after checking consent and appropriate redaction).
10. Anything else you would like to say?

MLRS Remote Assessments Legal Reviewers Survey

1. MFID
2. Name of legal reviewer
3. Is there a difference of opinion between the legal representative, doctor or legal reviewer about whether we can or cannot respond to instructions? If yes, please explain.
4. Was it necessary to feed back to the legal representative where we could only respond to some of the instructions, or could not complete the report? If yes, please explain.
5. Are there points in the legal case which remain unaddressed due to limitations

of remote evidence gathering or clinical concerns relating to the assessment being done remotely? If yes, please briefly explain the point/s and the limitations.

6. Are there any learning points to feed back to doctors, or any other issues to note? If yes, please briefly explain.

Patterns of torture among forcibly displaced Eritrean men in California: A cross-sectional study

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Key points of interest

- History of torture is common among male Eritrean asylum seekers; the most common forms are beating and forced positioning, and the most common sequelae include musculoskeletal problems and post-traumatic stress disorder.

Abstract

Introduction: This study was conducted to address a lack of information in the literature regarding the frequency and consequences of specific types of torture and abuse among Eritreans seeking asylum in the United States.

Methods: Cross-sectional study of Eritreans seeking asylum in the United States presenting to a human rights clinic for forensic medical and psychological evaluations based on Istanbul Protocol. Reports were eligible for inclusion if subjects: 1) immigrated from Eritrea 2) reported torture and abuse in Eritrea, 3) were 18 or older. 59 reports met inclusion criteria. Demographic features of individuals, reported history and specific types of torture, and physical and psychological sequelae were analyzed.

Results: Over 300 instances of torture were reported, an average of about 6 per person. The primary forms of torture reported were beating (87.7%) and forced positioning (57.9%). 90% of asylum seekers examined had physical findings which were consistent with the torture they reported, some of which had clinical as well as forensic significance. 86% of asylum seekers met diagnostic criteria for post-traumatic stress disorder.

Conclusion: Eritreans seeking asylum in the United States bear a high burden of post-traumatic physical and psychological morbidity.

Keywords: Asylum seekers, Tortures, Scars, Physical assessment, Eritrea

Introduction

The last decade has seen an inexorable rise in the global population of forcibly displaced people (Ignatieff, Keeley, Ribble, & McCammon, 2016; UNHCR, 2018). According to the United Nations High Commissioner for Refugees, the global refugee population is now at the highest level ever recorded and has approximately doubled since 2012 (UNHCR, 2018). Over the last two years, increasingly draconian political responses to forcibly displaced people (including travel bans, separation of children from their parents, and

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detention under inhumane conditions) have thrust dynamics of involuntary migration to the forefront of public consciousness.

Forcibly displaced people are likely to have witnessed and experienced deprivation, abuse, violence, and have suffered physical and psychological consequences. In a seminal study of adult outpatients in a Los Angeles primary care clinic, 6.6% were found to have experienced torture as defined by the United Nations (Eisenman, Keller, & Kim, 2000). A similar study of foreign-born but otherwise unselected outpatients conducted in New York found that 11% had also experienced torture (Crosby et al., 2006). These two studies, while hardly a comprehensive body of literature, nevertheless suggest the alarming possibility that, among immigrants in diverse urban communities in the United States, the prevalence of having been tortured may be comparable to that of low back pain or type 2 diabetes (Bullard et al., 2016; Freburger et al., 2009). While studies of unselected patients make this point dramatically, the prevalence of torture is much higher among forcibly displaced people. A recent systematic review found that the prevalence of torture (variably defined) among asylum seekers across 23 studies conducted in 10 high-income countries was 30% (Kalt, Hossain, Kiss, & Zimmerman 2013).

Primary care clinicians are typically ill-equipped by their training to recognize, evaluate, and treat forcibly displaced people who have survived torture and other traumatic experiences. Nonetheless, we find ourselves living in an unprecedented and global epidemic of enforced migration. As in any other epidemic, clinicians must understand the origins of the suffering they aim to alleviate, regardless of whether its sources are biological, psychosocial, or political (Virchow, 1985). Broad educational initiatives can help to address this and are indispensable to training the next generation of primary care clinicians (Metalios et al., 2008). Detailed studies of specific diaspora communities are equally important to practicing clinicians who work with members of these communities, because they improve clinicians' understanding of common experiences in specific groups. Clinicians' knowledge of displaced people must evolve with waves of migration; in an ever more connected and mobile world, local primary care must be responsive to global events. Moreover, clinicians have a clear, internationally recognized obligation to detect, describe, and decry human rights violations wherever they encounter them.

Despite its small population, Eritrea is currently one of the ten countries which produce the largest number of displaced people in the world (UNHCR, 2018).In 2017, the US Census Bureau estimated that over 38,000 people born in Eritrea live in the United States, although precise numbers are uncertain since prior to 2000, classified Eritreans as Ethiopians (U.S. Census Bureau, 2017). The largest proportion of Eritreans living in America are in California, primarily in Los Angeles and in the San Francisco Bay Area. Previous studies have described Eritrean immigrants' experiences with healthcare systems in destination countries (Walliman & Balthasar, 2019; Jonzon, Lindkvist, & Johansson, 2015) and examined post-traumatic mental health conditions (Getnet, Medhin, & Alem, 2019; Melamed, Chernet, Labhart, Probst-Hensch, and Pfeiffer, 2019) and their implications for health care utilization (Siman-Tov, Bodas, Wang, Alkan, & Adini, 2019). Searches of PubMed and Google Scholar (1975-2021) did not reveal any papers describing the epidemiology of torture among Eritrean asylum seekers in the United States, and this cross-sectional study was conducted to help resolve this gap in the literature.

Eritrea has experienced two large waves of outward migration in the last seventy years. The first began during the protracted and bloody war for independence from Ethiopia, which spanned from 1961 to 1991 and was accompanied by a civil war within Eritrea between rival nationalist factions. After independence there was a lull in emigration before the beginning of the present wave, which began when the ruling People's Front for Democracy and Justice party began an extensive program of militarization and repression in the wake of the 1998-2000 border war with Ethiopia (Hepner, 2009). Eritrea instituted a national service requirement for all citizens in 1995, excepting only veterans of the war for independence and the disabled, which prescribes an 18 month commitment with six months dedicated to military training followed by twelve months in military service or in work on civil infrastructure and agricultural projects under military discipline. Prior to the 1998-2000 border war, conscripts were discharged after completing this 18 month period of service. Since the war, however, national service has become open-ended for most conscripts. The universal liability to indefinite, barely paid service disrupts social and economic networks and curtails individuals' ability to pursue educational and economic advancement, and to provide for their families (Hirt & Mohammad, 2013). Harsh punishments, arbitrary detention under inhumane conditions, and torture are commonly employed by agents of the Eritrean state within and without the national service (United Nations, Human Rights Council, 2016). Those who attempt to avoid or desert from national service are subject to a shoot-to-kill policy if they flee across Eritrea's borders, and when apprehended are commonly detained for periods ranging from months to years and tortured (Kibreab, 2009). The indefinite nature of national service, its disruption of individual lives and family networks, its interference of the possibility of individual advancement and the ability to cultivate and provide for a family, and the prevalence of harsh conditions, arbitrary detention, and torture within national service have combined to make it the primary driver of the contemporary exodus of young Eritreans (Kibreab, 2014).

This study was conducted at a Human Rights Clinic (HRC) based in Northern California, which has served asylum seekers since 2003. HRC provides longitudinal primary care and forensic medical and psychological evaluations for use in asylum proceedings. These evaluations document physical and psychological stigmata of torture and other forms of abuse in order to assist immigration officials and judges who are responsible for granting or denying asylum. Forensic evaluations make a substantial difference in the likelihood of an asylum claim being granted, and can be performed by any trained primary care or mental health clinician (McKenzie, Bauer, & Reynolds, 2019).

Methods

Study Design

This is a cross-sectional survey of forensic medical reports prepared on behalf of Eritrean asylum seekers using retrospective qualitative and quantitative methods. Archived reports were anonymized before analysis to protect patient confidentiality, and treatment plans were not altered based on participation in the study. All procedures were approved by the Institutional Review Board at Highland Hospital.

Setting

All reports were drawn from HRC archives. Reports completed between 2012 and 2018 were reviewed. No patients were contacted as part of the data collection or analysis.

Participants

At the time of the study 438 evaluation reports were available for review, documenting various physical and psychological residua of torture in asylum seekers from a wide range of countries, predominately Guatemala, Honduras, El Salvador, and Eritrea. Reports were eligible for inclusion if the subjects: 1) immigrated from Eritrea 2) reported torture and abuse in Eritrea, 3) were 18 or older, and 4) were not evaluated solely for female genital cutting (FGC). 59 reports met inclusion criteria. Reports documenting FGC were excluded because at HRC patients with FGC typically do not undergo further extensive evaluation for forensic purposes (n=89). Anatomic evidence of FGC is legally recognized as sufficient grounds for asylum in the United States, and since the purpose of forensic evaluations is to provide information likely to bear on asylum decisions, a comprehensive trauma history and physical exam are typically not recorded for individuals who are evaluated for confirmation of FGC. Aside from forensic evaluations, clinical documentation of post-traumatic sequelae in patients evaluated for FGC was not always available, and in any case incommensurate with the detailed information obtained from individuals seeking asylum on grounds other than FGC. Finally, although technically illegal, FGC has been highly prevalent and continues to be practiced in many parts of Eritrea, and while it is viewed in many countries as a human rights violation equivalent to torture for the purposes of immigration policy, it is not so regarded by many who practice, sanction, and/or have experienced it in Eritrea (Zerai, 2003). There were no reports in which evaluators deemed that asylum claimants did not manifest findings that were consistent with some or all of their alleged history of trauma or found positive evidence of mendacity or malingering.

Data Collection

Coding frameworks were developed by the research team to identify and catalogue variables of interest in the narrative of the medical reports reviewed. The frameworks drew from the World Health Organization's 2002 *World Report on Violence and Health*, (Krug et al., 2002) and defined torture in accordance with the United Nations' *Convention Against Torture* (United Nations, General Assembly, 1984). Two research assistants, working separately, abstracted qualitative data from the narrative reports. Deductive content analysis was used to categorize demographic characteristics, number and place of detentions, types of abuse and torture described. Inter-rater reliability of the research assistants was 95%. Records reviewed by research assistants were anonymized by clinicians prior to review, and abstracted data were compiled under identifying numbers in a secure spreadsheet prior to analysis.

Statistical Analyses

We examined demographics, features of detention, types of reported torture, geographical location of torture within Eritrea, and consistency of observed physical and/or psychological sequelae of torture (UNHCR, 1999).

Results

Of the 59 subjects, 91.5% were male with a mean age of 37 years (SD = 8.4). Nearly half were natives of the capital city of Asmara. 72.5% had completed a high school or higher education. About a third of subjects described themselves as business people (15.3%) or students/teachers (20.4%), although many other occupations were represented and some data were missing (11.9%). The overwhelming majority were monolingual Tigrinya speakers.

Asylum seekers reported between one and six separate instances of detention each, with

78.8% reporting three or fewer. Over 300 instances of torture were reported, with an average of six instances per person. Most individuals reported torture occurring while in a detention facility (82%). The most commonly reported sites of detention and torture were Sawa (20%), which is the central training site of national service conscripts and armed forces recruits, and Adi Abeto (19%), which is the primary detention facility for the capital Asmara and its vicinity. Other common sites included Wi'a (12%) and Assab (10%), both port cities on the Red Sea, and various jails and police stations within Asmara itself (10%). These findings correspond substantially to previous descriptions of the network of detention and torture centers in Eritrea by Amnesty International (Amnesty International, 2013), and the Office of the High Commissioner for Human Rights (United Nations, Human Rights Council, 2015; United Nations, Human Rights Council, 2016).

Asylum seekers reported inhumane conditions of detention; prevalence figures for common themes are given in Table 1. Most reported having been kept in overcrowded prisons without sufficient room for all detainees to lie down to sleep, which were generally described as windowless, unventilated, without artificial light, and constructed of concrete and sheet metal or made from re-purposed shipping containers. Detainees reported being confined to such spaces with only an open container as a toilet, inadequately fed, and let out only to defecate daily or participate in hard labor. Reports of epidemic diarrheal illness, skin infections, and arthropod infestations (e.g. lice and scabies) were common. Reports of exposure to extremes of temperature were also common, as would be expected in uninsulated and poorly ventilated buildings in the region; night time low temperatures in Asmara average < 10°C between September and March, whereas daytime highs average in Assab, on the southeastern coast, average > 35°C between April and October.

Table 1. Conditions of detention reported by Eritrean asylum seekers

Reported Conditions of Detention (n=57)	**n**	**%**
Inadequate sanitary facilities	44	74
Inadequate nutrition in detention	44	74
Exposure to extreme temperatures in detention	42	71
Lack of access to medical care	40	68
Overcrowding	31	53
Light deprivation	29	49
Prolonged sun exposure	22	37
Pests/arthropod infestations	20	33
Solitary confinement	11	18

Many forms of torture were reported, the most common being beating (with or without weapons) and forced positioning (Table 2). Falanga, (beating the soles of the feet) was a common sub-type of beating. Forced labor, rape, sexual humiliation, burning, electrocution, gunshot wounds, and simulated drowning were also reported. The most common form of forced positioning is known in Eritrea as "Otto," (after the Italian word for the number 8, which the bound victim supposedly resembles,) and consists of binding the elbows or wrists together behind the back, binding the ankles together, and then binding the ankles to the arms with an intervening rope. (Figure 1, United Nations, Human Rights Council, 2015).

A variant in which the victim is suspended by the intervening rope (Figure 2) is known as "Helicopter".

Table 2. Types of abuse reported by Eritrean asylum seekers

Reported Type of Abuse	n	%
Beating (with or without a weapon)	52	87.7
Binding and Forced Positioning	34	57.9
Forced Labor	23	39
Falanga	7	12.3
Substances applied to skin to attract insects	5	8.8
Rape/Sexual Assault	3	5.3

Asylum seekers indicated that torturers favored means which leave few permanent marks, such as beating with hoses or batons, and that they used the environment to their advantage. For example, torturers would withhold shoes to discourage escape over rough terrain, force prisoners to lie or roll on sharp rocks or gravel, expose prisoners to extremes of temperature, and apply substances such as milk or honey intended to attract insects to the skin of restrained victims.

Physical findings ranged from nonspecific abrasion and laceration scars to more specific lesions such as ligature scars, ligamentous injuries, compressive neuropathies, clinical and radiographic evidence of untreated fractures which healed with malunion, and neurocognitive impairment due to traumatic brain injury. Ligamentous laxity and peripheral nerve lesions were more common among patients who had been subjected to "Otto" and "Helicopter", because both forms of forced positioning involve circumferential compression of the extremities and (especially in the case of *Helicopter*) abnormal stress on the muscles and ligaments of the pelvic and shoulder girdles, particularly the shoulders since these are not

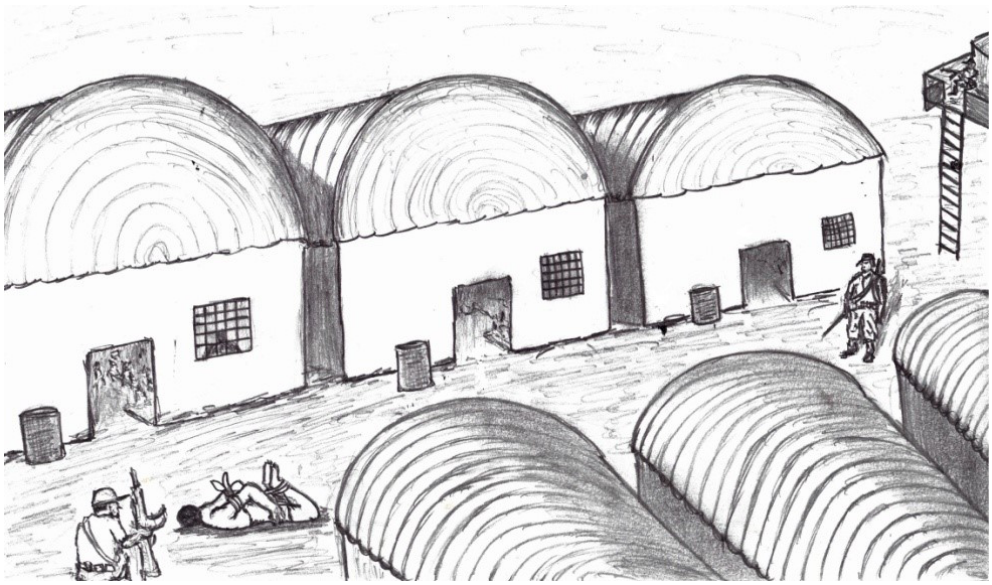

Figure 1: Drawing provided to the Office of the High Commissioner for Human Rights by an anonymous Eritrean torture survivor depicting "Otto," previously published with permission of the artist (Anonymous, United Nations, Human Rights Council, 2015, p286).

Figure 2: Drawing provided to the Office of the High Commissioner for Human Rights by an anonymous Eritrean torture survivor depicting "Helicopter," previously published with permission of the artist (United Nations, Human Rights Council, 2015, p286).

ordinarily weight-bearing joints. Findings were usually described by evaluators using the terms prescribed by the Istanbul Protocol (United Nations, Office of the High Commissioner for Human Rights, 1999), as summarized in Table 3.

No patterns of torture were identified which reliably differentiated detention centers within Eritrea, suggesting a relatively uniform culture of torture and abuse within the repressive elements of the Eritrean state (although our study was not designed statistically to evaluate this outcome and patterns might emerge from a larger dataset).

Table 3. Documented Physical and Psychological Sequelae of Torture

Physical Findings (Descriptors)	**n**	**%**
Typical	1	1.7
Highly Consistent	43	72.9
Consistent	9	15.3
Non-Istanbul Protocol Descriptors	6	10.2
Psychological Findings		
DSM-V Criteria Met for PTSD	51	86.4

Discussion

Eritreans seeking asylum in Northern California corroborate previous reports of widespread human rights violations. Their accounts concur with those of thousands of other Eritrean asylum seekers interviewed in many different countries (United Nations, Human Rights Council, 2016). Civilians describe arbitrary arrest, enforced disappearance, imprisonment under inhumane conditions, and torture. Conscripts describe compulsory and indefinite military service in which the slightest resistance to authority is punished by indefinite detention, forced labor, interrogation, and torture. In both the civilian and military contexts, conditions of detention included overcrowding, light deprivation, lack of access to medical care, unsanitary conditions, and endemic diseases of squalor and overcrowding including diarrheal illness, skin infections, and arthropod infestations. In both contexts, the most prevalent forms of torture reported were beatings and other forms of blunt trauma, followed by positional torture such as "Otto" and "Helicopter". Head injuries were also commonly reported (40%).

Our study had several limitations. We studied documents which were prepared for forensic rather than clinical or research purposes, and as such, they were structured to assist immigration officials in evaluating evidence rather than to conform to a prospective research protocol. For reasons stated above, FGC evaluations were excluded from this review, because they generally do not incorporate comprehensive trauma histories; however, because the prevalence of FGC in Eritrean women over 30 exceeds 90% (Zerai, 2003), the result was that almost no evaluations of Eritrean women were included. This study can therefore infer little about the experiences of forcibly displaced Eritrean women, although their experiences have elsewhere been described in detail (Gebreyesus et al., 2018; Gebreyesus et al., 2019; Lijnders, 2012). Additionally, because of cultural and religious factors, the incidence of sexual violence and rape reported for male asylum seekers is likely to be an underestimate.

Other geographic and socioeconomic biases exist in the data that could not have been avoided, even if the reports had been prepared with the present study in mind. All of the patients included in the study successfully escaped from Eritrea, survived their migration, and came to Northern California, a fact which implies a high average level of physical fitness, psychological resilience, and financial resources. It is possible that this subset of forcibly displaced Eritreans had systematically different experiences within Eritrea than other groups of compatriots, such as those who fled into neighboring countries and resettled there, attempted the Mediterranean crossing, or took the dangerous overland route through the Sinai to Israel, although larger studies than the present one suggest a chilling homogeneity of inhumanity (United Nations, Human Rights Council, 2016).

Nevertheless, some conclusions are possible. First, male Eritrean asylum seekers are very likely to have been imprisoned and tortured. Second, such torture, when experienced, is likely to have involved blunt trauma and forced positioning. Therefore, clinicians who serve communities in the Eritrean diaspora, or find themselves caring for an Eritrean immigrant for the first time, should be alert to the probability of PTSD and other trauma-related disorders of mood and cognition, and should look specifically for physical sequelae of commonly described forms of torture, including traumatic brain injury and associated disorders such as post-traumatic headache, temporomandibular dysfunction, and neurocognitive impairment; musculoskeletal in-

juries; and compressive neuropathies due to beating and forced positioning.

This study also illustrates the necessity for iterative epidemiological work in an era of increasing mobility and displacement to support clinicians' understanding of the background and shared experience of shifting diaspora communities.

Finally, the high prevalence of significant physical and psychological findings observed in the reports examined underscores the essential role of healthcare providers in documenting evidence of torture on behalf of asylum seekers, in order to assist immigration officials in deciding when to grant the protection of asylum (Dyer, 2019; McKenzie, Bauer & Reynolds, 2019). Clinicians probing Eritrean patients about possible torture or abuse should be aware that persecution is often linked to the patient's tribal, religious or political identity (Abu Suhaiban, Grasser, & Javanbakht, 2019).

Conclusion

This study adds epidemiological data to an existing international literature documenting a high prevalence of reported history of torture, and of physical and psychological manifestations which substantiate such reports, in Eritrean asylum seekers (Amnesty International, 2013; UNHCR, 1999; United Nations, Human Rights Council, 2016; United Nations, Human Rights Council, 2015). These findings should be situated within a broader understanding of the prevalence of torture and other traumatic experiences among forcibly displaced people who may seek help from primary care clinicians. Given the prevalence of torture and other forms of ill-treatment and their psychosomatic residua demonstrated in this and other studies of diaspora communities, it seems reasonable to recommend that all actors involved in asylum determinations and those who regularly care for displaced people be versed in the principles of trauma-informed care (Substance Abuse and Mental Health Services Administration, 2014). Clinicians must also endeavor to be responsive to distant events which create waves of displacement, and to become familiar with horrors that are difficult to comprehend in order to provide appropriate care to survivors.

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Experiences of survivors of commercial sexual exploitation availing rehabilitation at R&P homes in India

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Key points of interest

- Survivors of commercial sexual exploitation report physical, psychological, and economic victimisation. The long-lasting psychological trauma impacts the day-to-day lives of victims.
- Inclusion of various stakeholders through legal, medical, psychological, health, and financial assistance is vital in rehabilitation of survivors of commercial sexual exploitation.

Abstract

Background: Sex trafficking constitutes the primary form of human trafficking and involves predominantly young girls and women. Rehabilitation of victims rescued from commercial sexual exploitation is critical for efficient reintegration into society.

Aims: To explore the narratives of survivors of commercial sexual exploitation, analysing various factors associated with eventual rehabilitation in Rehabilitation & Protection (R&P) homes in India.

*Method***:** The study involves mixed method qualitative study at R&P Homes in India. In total, 30 victims of commercial sexual exploitation, aged 29-50 years, participated in the study. Conversational interviews guided the data collection through a dedicated interview protocol.

Results: Thematic analysis explored factors promoting or inhibiting rehabilitation in R&P Homes. The results reflected positive change in respondents' individual and social behaviour and identified facilitators for rehabilitation through R&P Homes. The result highlighted various barriers to rehabilitation, including lack of dedicated focus on psychological assistance, financial stability, and sense of safety and security within society. The analysis also reflected various internal and external factors contributing to effective rehabilitation.

Conclusion: The results provide insight into creating an inclusive model of rehabilitation for victims of commercial sexual exploitation.

Keywords: Coping Strategies, Protective Homes, Rehabilitation, Victims of Commercial Sexual Exploitation, Ujjawala Homes.

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Introduction

The United Nations (2000) Protocol to Prevent, Suppress, and Punish Trafficking in Persons, especially Women and Children, define Human Trafficking as: »*the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation*«. The term 'Trafficking' implies the involvement of movement, but in fact, the victim of trafficking could be transported across borders or remain close to their home (U.S. Department of State, 2006). Table 1 details various definitions provided by multilateral organisations, The United States, and India associated around human trafficking. The terminology within India's Immoral Traffic (Prevention) Act (1956) has received consistent criticism from various social workers and organisations working with commercial sex workers. Various judicial judgments in India have refuted the terminology, but the legislature remains unamended.

Internationally, 98% of Commercial Sexual Exploitation (CSE) victims are women and girls (International Labour Organization, 2012). CSE involves both human trafficking and sexual violence. The International Labour Organization (2005) estimates that 43% of all human trafficked survivors are trafficked for sexual exploitation, and a further 32% are exploited for commercial purposes. UNICEF (2012) reported nearly 2.5 million individuals as survivors of human trafficking, with

Table 1. Key Definitions around Commercial Sexual Exploitation (CSE)

Organisation/ Institution	Indicators	Definition
World Health Organisation (2002)	Sexual Violence	*Any sexual act, attempt to obtain a sexual act advances, sexual comments, directed against a person's sexuality by coercion, by any individual irrespective of the relationship with the survivor, including but not limited to workplace or home*
United Nations High Commissioner for Refugees (2003)	Sexual Violence	*Any act, attempted or a threat of sexual nature that results or is likely to result in physical, emotional or psychological harm*
U.S Trafficking Survivors Protection Act (2000)	Commercial Sexual Act	*Any sexual act on account of which anything of value is given or received by a person*
First World Congress Against Commercial Sexual exploitation of Children (1996)	Sexual Exploitation	*Sexual abuse by an adult and remuneration paid in cash or kind to a child or a third person or persons*.
The Immoral Traffic (Prevention) Act (1956) - India	Prostitution	*Sexual exploitation or abuse of individual for commercial purposes or remuneration in cash or kind*

children representing as many as 22-50%. The number of individuals trafficked in Asia is nearly half of the global trend (Rasheed, 2004). Large countries like India and China have reported that a greater number of children are trafficked for sexual exploitation within the country than are trafficked abroad (Dottridge, 2008). A Coalition Against Trafficking in Women (CATW) - Asia Pacific study (1997) identifies Asia as a focus of sex tourism, prostitution, and females trafficked for marriage. The expanding sex trade industry in Asia grows through the mobility of the population, migration policies, lack of employment, and growing infrastructure for sexual tourism

Individuals recruited into commercial sexual exploitation through trafficking face repeated physical and sexual victimisation from their trafficker (Raymond et al., 2001). A mixed method study with 31 child welfare-involved children highlighted that one-third (35.5%, n=11) underwent psychiatric hospitalisation, and that most of the sexually exploited participants (80.1%, n=25) suffered Post-Traumatic Stress Disorder (PTSD) (Sprang & Cole, 2018, p. 189). Due to prolonged physical and sexual victimisation, survivors experience significant psychological trauma and adverse effects varying from depression, to stress, trauma, PTSD, and suicidal thoughts (Zimmerman et al., 2006). Survivors also develop mistrust (Smith et al., 2009), suffer stigmatisation (Curtis et al., 2008), and social isolation (Klain, 1999). These psychological harms restrict survivors from normal life and thus limit the scope of rehabilitation, supported by psychologists, social workers, and other mental health professionals. Lederer and Wetzel (2014) focused on awareness and involvement of efficient medical and mental health professionals to provide requisite care.

Effective rehabilitation programs and initiatives are essential to help survivors of commercial exploitation cope better with past victimisation. Wilson & Butler's (2014) systematic review of literature reaffirmed challenges faced by survivors of CSE in pre- and post- entry to, and post exit from, the commercial sexual exploitation scenarios. A study utilizing semi-structured in-depth interviews of 61 teens emphasised various facilitators and barriers towards the escape of children from commercial sexual exploitation. The facilitators stressed proper food and basic amenities, social support, and emotional support. The challenges faced by children to escape commercial sexual exploitation were isolation, drug dependency, and financial necessity (Williams & Frederick, 2009). Coping mechanisms of female adults with a history of commercial sexual exploitation include substance misuse and self-harm (Barnert et al., 2020). Loza et al. (2010) found that the vulnerabilities of adult female sex workers becoming survivors of commercial sexual exploitation were based on the need for basic amenities, and lack of education and skill.

The aim of this study is to explore and understand the lived experiences of survivors who reside in Rehabilitation & Protective (R&P) homes in India. The research examined factors contributing to the restoration of normalcy in the lives of survivors of commercial sexual exploitation and any inhibiting factors to rehabilitation, to inform the foundation of a holistic model of rehabilitation

Methods

Research Design

The research utilised mix methods and was conducted at R&P Homes[1]. The R&P

1 R&P Homes are institutions partly sponsored by the Ministry of Women and Child Development, Government of India & UN Office on Drug and Crime under the Ujjwala Scheme:

Homes are a Non-Governmental Organisation (NGO) that focuses on rehabilitating survivors of commercial sexual exploitation referred by local police anti-trafficking units. Each R&P home in India includes 5-25 female-only beneficiaries, based on various legal and circumstantial factors. The research structure considered the beliefs, values, culture, and environment of the participants. The study incorporated suggestions from participants from the earliest stage of research to the analysis of the data. Active participation promoted effective data collection for the qualitative research through continuous engagement with the participants. A comprehensive meeting with respective R&P home coordinators was arranged to clarify and establish the premise of the research. The research objectives were shared and discussed with all beneficiaries of the R&P Homes and informed consent was acquired. The research utilised conversational interviews as the data collection tool. The data collected was analysed through content and thematic analysis.

Ethics

O. P. Jindal Global University approved the study through its JGU Research & Ethics Review Board (JGU RERB)

Sampling

The study participants were survivors of commercial sexual exploitation residing at R&P homes. The inclusion criteria for the R&P Homes were: a) R&P Homes in or near a metropolitan zone; b) functional R&P Homes for at least past 5 years; c) opportunity for interactions of various stakeholders of R&P Homes with the beneficiaries of R&P Homes in past. The inclusion criteria for the participants of study was a) Female beneficiary of R&P Homes; b) participants should be above the age of 18; c) participant should be a full-time beneficiary of the R&P Homes.

The purposive sampling was indicative of providing opportunity to relevant beneficiaries of various R&P Homes across India. Sampling continued through interviews of agreed participants till saturation, and 30 beneficiaries (i.e., survivors of commercial sexual exploitation) from 12 R&P Homes across seven states in India were interviewed for the study. Multiple locations were chosen to avoid biased participation of respondents across R&P Home locations in India.

Procedure

In accordance with mixed method study design, consent and active engagement of participants were obtained. Emails were sent to R&P Homes coordinators to ascertain participant availability, and meetings with beneficiaries were scheduled as per participants' consent, obtained by the coordinators. During the meeting, consent was obtained from participants to take part in the conversational interview. Conversational interviews were audio-recorded for 18 participants and meticulous journal entries were made with the remaining participants in an interview journal. The coordinator of each respective R&P Home was available for moral and psychological support of the respondent with minimum involvement during the interviews.

Comprehensive Scheme for Prevention of Trafficking and Rescue, Rehabilitation, and Reintegration of the survivor of trafficking for commercial sexual exploitation . The Ujjwala scheme focus on rehabilitation as essential amenities, legal aid, medical care, and educational provisions for restoration of the beneficiaries . (Ministry of Women and Child Development, Government of India & UN Office on Drug and Crime, 2008)

Data Analysis

Data generated through interviews were analysed simultaneously by the principal investigator, and sampling continued until no new themes were generated. The analysis was conducted in three stages. First, the entire data was utilised to generate codes through content analysis. Second, the codes were categorised, aligned with the coding framework generated through the literature review. Finally, the generated categories were assigned with relevant themes answering the research question.

Findings

Socio-demographic Characteristics

Participants (n=30) were between 29-50 years old (M= 40.16, SD= 5.15). Four participants were illiterate, seven had enrolled in primary schooling, and around two-third (n=19) were literate at varying levels. 90% participants (n= 27) were involved in commercial sex work as survivors of trafficking for more than 15 years. 93% participants (n=28) deliberately kept themselves out of contact with their family members before arrival at the R&P Homes to avoid social stigma or negative labels for their family.

Table 2. Socio-demographic data of Commercial Sexual Exploitation survivors in R&P Homes

Indicators	n	M	SD
Age		40.16	5.15
Education • Literate • Illiterate	 26 4		
Education • Primary Schooling • Uneducated	 7 23		
Years survived in Commercial Sexual Exploitation (12-29 years)		20.54	6.18
Prior Family Contact • Yes • No	 2 28		

Factors affecting Rehabilitation of Survivors of Commercial Sexual Exploitation

The factors determined to affect the rehabilitation of survivors of Commercial Sexual Exploitation (CSE) are categorised under two headings: facilitators and barriers of rehabilitation. As shown in Table 3 and Table 4, each category contains themes supported by participant statements.

Facilitators towards effective rehabilitation: Rehabilitation can be initiated with the empowerment and development of individuals and their social, professional, and personal lives. Categories and themes for the above are reflected in Table 3.

Getting back into a normal routine: All participants felt that following the daily routine in the R&P Home would instil structure and help them return to a productive life:

I like waking up early…. (P7)
We follow the daily timetable set by our teacher…they help us get back on feet… (P12)
…. I complete my daily work as allocated and then perform other tasks… (P20)
I enjoy performing activities assigned…. each day we have different activities to do…. we do ask for different routine for different week to keep ourselves occupied… (P13)

Working on individual behaviourism: participants were united to work on their attitude and behaviour to instil optimism, determination, confidence, and other positive characteristics:

…Earlier I was afraid to put my opinion out or share anything but now with my friends around, it's easier for me to communicate and share things…it has given me further confidence in me (P22)
I believe, I can face the cruel world outside… I am a strong woman now…time here has provided me with a positive attitude…it feels good here (P11)
I think of a better future now…it gives me a sense of positivity… (P26)
We are safe here…people here are good…they make me believe in humanity (P9)

Improving social behaviourism: Interaction with other individuals of similar backgrounds developed a sense of unity and belonging in respondents. Social bonding within the R&P Home created a family-like environment, fostering the process of rehabilitation and return to life:

I have made few friends here, who understand me…. (P27)
We play a lot of team activities in our free time…. It's fun time more us… all of us together... I like to spend time with all of them (P30)
We always make time to sit together and discuss with each other…. This helps is to know each other better and support each other in case of any difficulties faced by anyone… even our coordinator (Didi) sits with us occasionally and listens to our problems…. (P14)

Working on ones' personal growth: Participants mentioned that they focus on working on themselves and wish to see a better and improved version of themselves in a few years. They have developed a few habits and hobbies for self-development at R&P Home:

Table 3. Identified themes and codes of facilitators in effective rehabilitation at R&P Homes

1. Getting into normal routine
- Waking up early
- Maintaining timetable
- Getting work done on time
- Participation in activity
- Daily routine

2. Improving individual behaviourism
- Positive outlook
- Decision making
- Adaptability
- Determined
- Optimistic
- Good human being

3. Improving social behaviourism
- Interaction with others
- Participation in group activity
- Discussion with friends
- Team games
- Healthy group dynamics

4. Contribution to ones' self-growth
- Learning new things
- Reading books
- Listening to the news and current affairs
- Enrolling for courses
- Solving puzzles

5. Contribution to financial independence
- Vocational course
- Skill development
- Training
- Workshops
- Job opportunity
- Remuneration from crafts

6. Focus on individual needs
- Safety
- Food & clothing
- Health & hygiene

I couldn't complete my schooling but here I had chance to study different subject and I wish to continue it even further…. (P19)
We have so many books here…I love reading books…. (27)
I spend my morning time in watching news or reading newspaper… (P29)

Working towards financial independence: Participants have stated that they have been trained in various vocational programs that have boosted their confidence in financial freedom:

We are trained in various skills like embroidery, stitching, diya making, painting, beautician course etc…it has helped us make clients that would be helpful for future…(P10)
I learned painting and I love doing it…last month we have small exhibition and I earned money by selling my painting… (P17)

We take small orders for festivals and make money that help us survive better… I believe that this would help me in future as a skill (P3)

We have been told that there would be many other modern day training that would help us get better jobs like computer training, car driving etc…. (P5)

Focus on individual needs: Participants disclosed that R&P Home gives them a sense of belongingness and a family environment fulfilling their basic needs without any selfish motive attach to their past experiences:

I feel safe here, and people here are very helpful…(P11)
We are given food in regular basic, and we make the food on rolling basic as per our roster…. (P28)
We all maintain healthy habits, and I have also complained about a girl, who did not take a bath that day… So, cleanliness is very important here, or we all would get sick… (P6)

Barriers towards effective Rehabilitation: Rehabilitation can be obstructed by various individual choices, behaviours, and societal responses. The roles of various stakeholders play

Table 4. Identified themes and codes of barriers in effective Rehabilitation at R&P Homes

1. Maladaptive practice
- Drug Use
- Alcohol use
- Self-Isolation
- Self-Blame

2. Issues in psychological assistance
- Counselling needs
- Occasional triggers
- Slow improvement

3. Issues in financial assistance
- More food & resources required
- Money for education
- Equipment for training
- Lack of funds

4. Issues in social security
- Lack of respect
- Labelling in society
- lack of support

5. Doubts about future
- Lack of acceptance
- Future aim not clear
- past to haunt
- family life jeopardised

a significant role in steering an efficient rehabilitation approach. Related categories and themes are shown in Table 4.

Addictive maladaptive practices*:* The majority of the participants have reported to have a habit of either drug (inclusive of smoking or tobacco) or alcohol use. These negative coping mechanisms may help victims avoid past trauma temporarily but are associated with severe health issues:

I am addicted to tobacco, and I cannot help it…it gives me instant satisfaction…(P24)
I need alcohol occasionally… I have overcome the addiction part…but I still crave for it, and they have it in little amount…. (P20)
I feel good here, but sometimes it feels so painful inside that I feel like hurting myself…. it all feels that everything in past is my mistake…. (P13)

Need for psychological assistance*:* Mental health has been a prime focus in holistic rehabilitation. Most participants stated that time spent with the counsellor was beneficial in a the short-term but does not entirely resolve the problem:

Counsellor didi helps us but then next day its all the same…. (P5)
I still get those painful flashbacks, and then I wake up and sleep net to my friend. Counsellor didi tries to help me out but it does not go…she said we will go to bigger doctor… but…we have not gone yet…. (P21)
I feel sad at times and next day even more sad and then all fine…I discuss this with counsellor didi and it gets better, but then again, after a few days, it's all the same…maybe it will get better in sometime…. (P6)

Lack of sufficient financial resources*:* Both participants and R&P coordinators pointed out the shortage of funds, leading to compromise on various necessities and resources:

*At times we want to celebrate some festival, but we know that sir (coordinator) does not have money…(*P8)
We need a lot of items at our centre, so that we can learn a lot of new things…but the purchase is taking a lot of time as there is money problem…(P1)
*Didi and Sir gets us new dress and gifts from their money…we know that centre doesn't have enough money…. (*P10)

Fear of societal reaction*:* Society plays a crucial part in rehabilitation. Participants were stressed about their reintegration to society and were afraid of the reaction of society when they go back:

They see us in such a bad way….it seems like we get polluted, every time we step outside… (P7)
I am afraid, if my family members and relative would accept me back…if not I would have to stay alone and survive on my own… (P15)
We were called with such bad names before…I am afraid if the same would continue after we go back to the society…(P18)

Uncertainty in future events*:* A secure future suggests the best possible way of rehabilitation. Participants were doubtful over the next actions as they return to society:

I feel I would not be able to settle down in my life…. (P14)
I pray to god that I never have to return to my past life or never come in contact with me ever (P11)

We are trained here on number of things but I doubt if anyone would be willing to give us jobs without any ulterior motive…. (P26)

Discussion

The research explored various narratives of people who survived CSE and now reside at R&P Homes, identifying various contributing and inhibiting factors to efficient rehabilitation. The study investigated pertinent factors including individual development, social support, financial freedom, educational facilities supporting rehabilitation, and subsequent reintegration into society. It is imperative to re-establish and impart a sense of belonging and support through the process of rehabilitation. This study also explored certain negative factors impeding the rehabilitation of CSE survivors. These factors can be categorised into individual characteristics (maladaptive coping, self-harm) and social structure (acceptance, labelling, respect). Adolescents with a maladaptive substance abuse or any health and behavioural conditions are at higher risk of sexual victimisation (Smith et al., 2009). This study highlighted that dedicated efforts to overcome the obstacles to rehabilitation would aid effective reintegration into society. Smith et al. (2009) note that traffickers use a combination of assault and acts of kindness to control the victim, making it more difficult to escape the abuser.

This study also finds a critical need for regular psychological and medical assistance for survivors of commercial sexual exploitation. The participant narratives demonstrate that experience of past trauma triggers issues in physical and mental well-being at times. Traffickers cause psychological trauma through terror and destroy the sense of self in the survivor (Herman, 1997). Lederer & Wetzel's (2014) previous study on 107 survivors of sex trafficking in the United States documents adverse physical and emotional effects, including depression, weight loss, and PTSD. Another study indicated that survivors reported insomnia, worthlessness, shame, trapped, and fear (Raymond et al., 2001). Lederer & Wetzel's (2014) study supports the current findings, reflecting the need for frequent medical assistance towards survivors of CSE. Medical professionals should be adequately trained to identify high-risk patients, treat them with respect and without bias, limit secondary victimisation, develop trust, overcome language impediments, and prevent any revelation of their victimisation (Baldwin et al., 2011; Estes & Weiner, 2002; Institute of Medicine and National Research Council, 2013).

The role of Non-Governmental Organisations (NGOs) is crucial to the rehabilitation of survivors of sexual exploitation. The current study suggests the active participation of stakeholders of NGOs through various initiatives employed by the Rehabilitation & protective homes. UNICEF (2003) suggested that the most effective preventive and proactive measures to prevent sexual exploitation and deter sexual revictimisation are conducted by organisations which are close to the source of the problem and connected to the community. Barnert et al. (2020) emphasise the role of care providers through behavioural health treatments to overcome various psychological traumas related to experience. This study focused on extensive vocational and employment training for the beneficiaries to increase financial independence. These services towards survivors of CSE are vital towards their reintegration towards society. Many service providers and NGOs insist that trafficked survivors' need is of far greater importance than other marginalised groups due to past trauma and environmental experiences (Herman, 1997). Mendonca (2014) discussed the importance

of a survivor-centric approach to the crime of CSE at every stage. The current study, consistent with Mendonca (2014), focusses on emphasis on survivors within the R&P homes for efficient rehabilitation.

Limitation

R&P Homes in India are limited to 19 states. The sample was predominantly collected from the R&P Homes around metropolitan cities of seven states. The limited sample of R&P Homes was due to the shortage in resources and manpower. Further research should document experiences of beneficiaries at R&P Homes in other states, primarily rural settings, with bare minimum facilities and resources. This approach would increase diversity of the sample and would better represent India as a whole, for generalisation. The refusal rate of participants across the 12 R&P Homes was 83%. The most common cause of refusal to participate in part of study was lack of interest in engaging with the study. A further limitation of the research is the lack of intercoder reliability in the extensive qualitative data collected in conversational interview.

Conclusion

The current study provides insight into the experiences of survivors of CSE at Rehabilitation & Protection (R&P) Homes in India. The study highlighted various barriers to effective rehabilitation including a lack of psychological and financial assistance, issues in societal acceptance, and survivors doubt over their future. The study investigated the experience of survivors of CSE and expressed factors like development of individual and social behaviourism, self-growth, focus on financial independence and individual needs that facilitated effective rehabilitation through R&P Homes. With this foundation, the study envisions an inclusive model of rehabilitation with diligent partnership with various stakeholders. It guides mental health professionals and medical practitioners with strategies to overcome the risks to rehabilitation, especially psychological and physical care. It will enhance the knowledge base of social workers and practitioners in creating interventions, developing research, and formulating effective policy towards rehabilitation. The facilitators and barriers of adequate rehabilitation, as suggested by the study, provide various factors for a strong foundation towards the efficient rehabilitation of CSE survivors.

The research findings suggest cumulative efforts from various stakeholders in anti-human trafficking to enhance the rehabilitation experience of the survivors. The various organisations in allied fields such as Boat People S. O. S. (2009), have helped various trafficking survivors towards refuge through their initiatives. Similarly, other organisations can integrate their knowledge and experience and contribute with available resources to achieve more effective rehabilitation. Consistent with Barnert et al., (2020) and Mendonca (2014), the findings of the current study recommend an inclusive rehabilitation model for the survivor of CSE involving every stakeholder that acts as a pillar of efficient rehabilitation, namely the legal profession, criminal justice professionals, mental health professionals, social workers, medical practitioners, NGOs, government representatives, and volunteers from the general public. This would promote the involvement of all relevant stakeholders, reducing the risk of any lapse in attaining the goal of R&P Homes. Such combined efforts will provide a firm foundation in the field of anti-human trafficking. The research advocates the inclusion of participants especially from critical and marginalised populations. This research contributes a rich, descriptive narrative, paving the way for further

research on survivors of sex trafficking. Furthermore, this research provides a voice to CSE survivors through active participation in each stage of research.

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Trauma Psycho Social Support Plus® and EMDR therapy for children and adolescents in a post-conflict setting: Mental health training in Kurdistan

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Key points of interest

- Trauma Psycho Social Support Plus (TPSS+®) is a stabilisation approach using EMDR therapy elements and designed for social workers. The methods taught can be used as standalone interventions as preparation for EMDR therapy interventions. The training program focuses on fostering resilience by means of resource installation and psychoeducation about trauma.

Abstract

Introduction: This paper describes the implementation of a pilot project in Kurdistan / Northern Iraq on the use of EMDR in children in post-conflict settings.

Methods: A 4-field scheme aimed at patient stabilisation was taught to social workers for the application with children and adolescents in Northern Iraq. If possible, the stabilisation was followed by procedures aimed at memory reprocessing or modification within the eight-phase EMDR protocol and (in all cases) with further care.

Results: An initial assessment of the children and adolescents themselves revealed significant traumatic burden. The subjective distress was reduced when the rescue and the present situation were reflected age-appropriately with the help of pictures and sketches. For six children and adolescents, a post-stabilisation treatment within EMDR therapy was offered.

The first results in this very small sample were encouraging providing support for a full-scale controlled study.

Keywords: Posttraumatic stress disorder, Eye Movement Desensitization and Reprocessing, resource installation, psychological first response, intervention.

Introduction

In 2017 TraumaAid collected information and data in different Kurdish refugee camps regarding priority needs. Parents complained about problems in raising their children after the war events and their escape – problems that in a professional's view result from the traumatic quality of the incidents. In parallel,

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a questionnaire was created and later handed out to social workers and mental health professionals in two camps in Kurdistan by Terre des Hommes (TdH) Italy (personal communication, June 16, 2017) to assess the needs of the employees in better serving the refugee population. The answers from the staff (N=21) showed as top priority being trained on "case management and dealing with different types of child abuse", followed by "psychosocial support" in general, "dealing with trauma", "psychological first aid", and "awareness raising in families". This was the basis for a training program that included trauma recognition, methods of stabilisation and working with grief and loss as part of an EMDR education program. The program included a novel focus, the so-called EMDR-Plus, which prepares for EMDR psychotherapy.

EMDR therapy is a psychotherapeutic approach focusing on stressful memories that a patient has made in a traumatic or otherwise adverse event (Shapiro, 1992, 2001). The therapy features an eight-phase approach in which the earliest or most stressful event is identified and reprocessed under bilateral stimulation. Stabilisation is an essential part of the eight-phase approach (Phase 2). EMDR has proven effective for the treatment of PTSD in various studies and is accepted as a standard treatment for PTSD by the WHO (Bisson & Andrew 2007; Lee & Cuijpers, 2013, World Health Organization, 2013). EMDR therapy is currently offered by Jiyan-Foundation across six counselling centres in Kurdistan. There are few scientific research articles about refugees especially in the Eastern Mediterranean Region. One of them highlights the therapeutic work with victims of the Syrian war and describes EMDR therapy with traumatic material (Zaghrout-Hodali, 2014). As training a therapist in EMDR therapy is considered to take too much time under an emergency situation, the seminar "Trauma Psycho Social Support Plus" (TPSS+®) was supposed to widen the options of the professionals who work in this field with EMDR therapy-based methods of psychosocial support.

At the end of the seminar, social workers and other health professionals should be able to teach parents and other family members how they could use resource installation with their children. In the unlikely case of later access to EMDR therapy, this would be a helpful preparation (Gattinara and Pallini, 2017). Most likely, children will have to cope without the chance of therapy – for those, the resource installation procedure could be an important chance to gain more emotional stability. Bilateral stimulation (BLS) is for example administered by alternate tapping on the knees or shoulders, which can be offered by the therapist or as therapist guided self-stimulation. We hypothesised that this approach would support emotional balance and thus stabilisation of the person as a whole. In contrast to advanced techniques like resource development and installation for children (RDI) (Adler-Tapia et al., 2008, p. 77-79), in EMDR-Plus it is not necessary to activate negative memories. That requires advanced experience in psychotrauma therapy. After war or long-lasting crisis, instead of focusing on trauma confrontation, the way to reinforce personal resources is to focus on symptom relief (Steinert et al., 2016).

Trauma Psycho Social Support Plus: Description of its position in the support pyramid

The model of a pyramid may explain the position of TPSS+® in the system of refugee camp-based health care (see Figure 1). At the bottom of the pyramid, the work of different caretakers who provide Psychological First Aid for all refugees in the first hours and days is displayed. Later during the stay in the

camp, there is a program specifically for children: The Child Friendly Spaces (Snider & Ager, 2018). At the next level, professionals provide support for families and groups, who are able to develop a structured help for the unique situation of living in a refugee camp. The problems of families are as specific as family structures are themselves. Therefore, working with groups proves to be just as challenging: Group members can be of different ages and gender; they face different problems and strive for different goals.

At the second level, this is what TPSS+® has to offer: A complete training for psychologists, social workers and similar professionals to install a positive and solution-orientated attitude. This attitude and understanding sets the baseline for this approach completed by the training of resource installation. The top of the pyramid is reserved for the work of specialists; fully trained trauma therapists are providing EMDR therapy for individual persons (children, adolescents, adults) and groups.

Data concerning children affected by war events and suffering from psychopathological symptoms

Syria has suffered civil war since 2011. Quosh et al. (2013) summarises that "*three out of four Syrian children have lost a loved one in the fighting, more than 60% experienced events where they felt their lives were in danger, and 50% had been exposed to 6 or more traumatic events. However, 71% of the girls and 61% of the boys also had strong close relationships to trusted persons for help and support. At the same time, 30% reported that they had been separated from their families. Also, around 60% of the children reported symptoms of depression (significantly higher among girls), 45% reported symptoms of PTSD, 22% aggression and 65% psychosomatic symptoms to a degree that seriously reduced the children's level of functioning* (Özer et al., 2013, 36)" (p. 287).

Figure 1. *Graphic Description of Trauma Psycho Social Support Plus (TPSS+®)*

Children are especially vulnerable as they are still in the process of developing their working model of the world and how they define human relationships, their own perspective and meaning in this world. It is essential to help them find a way to deal with their experiences.

Therapists and health workers in the Eastern Mediterranean region

The World Health Organization (2016) stated in the recently published Mental Health Atlas that "across the Eastern Mediterranean region, nurses (including both psychiatric nurses and general nurses working in mental health facilities) make up the largest professional group among the mental health workforce, followed by psychiatrists, psychologists and social workers". (…). The average total mental health workforce in the Eastern Mediterranean Region is 14.6 per 100 000 population. This is less than half the comparable global rate of 33.8 per 100 000 population. The number of psychologists, social workers and occupational therapists per 100 000 population is less than a quarter of the global average". In Europe, training in EMDR therapy will only be offered to therapists who have completed at least their first level psychotherapeutic education (Farrell & Keenan, 2013). Even for those therapists, it is a challenge to adopt EMDR into the daily routine depending on institutional conditions.

Trauma and resource related social support training

Based on this element, TPSS+® is a program based on a training on "Pre-therapeutic EMDR" (Phase 1 and 2 of the eight-phase EMDR therapy approach): only slow tactile bilateral stimulation and resource installation. According to available evidence, the impact of slow bilateral stimulation (therapist directed eye movements or tactile stimulation) during presentation or activation of a resource can facilitate the access to positive memories (Amano & Toichi, 2016). The proposal was to train in a short but daily ritual that help parents and children to build positive relationships again. The intervention intends to create and install a memory network of safety in the child which will help to cope with fear responses in a long-term view. Tactile bilateral stimulation was preferred as it is considered less activating in a memory network compared to the use of eye movements. Additionally, one can also use a resource installation technique in a group setting and the overall biological principles of information processing in front of shocking and stressful events seems to be transculturally acceptable.

According to the Adaptive Information Processing (AIP) model (Shapiro, 1995, 2001), the model of pathogenesis and change in EMDR therapy, an intrinsic information processing system is responsible for the way that memories are stored in the brain (Solomon & Shapiro, 2008). If the information processing system is impaired, a stressful life event is assumed to be stored and isolated in the networks as "frozen in time": "Attitude, emotions, and sensations are not considered simple reactions to a past event; they are seen as manifestations of the physiologically encoded perceptions in memory and the reactions to them" (Solomon & Shapiro, 2008, p. 316). Even if encoded a long time ago, this dysfunctional encoded, maladaptive memory can be triggered by similar events or similar parts of it: sounds, smells, pictures, etc. This memory will then totally or partially invade into consciousness and influence perception of the present as well as action.

Particularly children will be confused about their reactions to daily experiences: During their daily routine they might find themselves

slipping into quick and highly arousing emotions of fear or anger they cannot control. Psychoeducation is necessary to understand this inner process and can prevent children and adolescents from feeling insane. Furthermore, the intention of the training was to show and train methods to deal with those confusing reactions before they occur again.

As a first step, the lap of the parent representing a safe environment was used to install a sense of safety in the present following the TPSS+® and Resource-Oriented Trauma Therapy with Elements of EMDR (ROTATE) treatment manual (Wöller & Mattheß, 2020).

Parenting in a refugee camp

One of the most important factors of getting a positive view of the future for children and teenagers is education and that parents in general have the central desire to be able to cope with their educational tasks even under the circumstances of a refugee camp. They are motivated to understand how best to parent in this context and are keen to receive parenting advice and thought that this would improve their children's welfare" (El-Khani et al., 2018, p. 26). The importance of a good education might be an aspect which helps parents and children to accept a therapeutic approach: if a child is willing to learn but he or she is not able to focus, to concentrate and to control his or her feelings, it becomes an obstacle to education (Hase & Bublak, 2015). Children can learn better and be more successful in school if they learn to stabilise themselves by resource installation and begin to manage their emotions. This is the objective of the TPSS+® program. If trained by professionals how to use resource installation parents should be able to apply resource installation with their children on their lap like a ritual even outside a therapeutic setting. Even if there is no higher level of education or knowledge about psychology it should be possible to explain to parents that this method is helpful for the children to recover from the effects of traumatic events. Of course, this applies to such a post conflict setting where trauma has hit the family and cannot be transferred to a setting where a child is victimized by parents. To assist the parents of integrating resource installation in their daily routines of raising their children the Android-App "TraumaAid" (available for Android systems in German, English and Arabic) was developed. The app provides a fixed rhythm including a sound, a point or dot that moves left- right on the screen of the mobile phone and parents only have to do the tapping on the knees of their children, sitting on their laps (Figure 2) in the same rhythm.

From a trainer's point of view, it is important to keep it simple: Parents should be instructed to find positive memories, abilities, capacities, strengths etc. Children and adolescents should draw pictures or look for symbols that represent a personal resource. This practice aims to activate positive memories. To emphasize the difference to more advanced techniques of problem-solving methods originating from EMDR therapy: It is not necessary to focus on problematic current life situations or traumatic events here. In this setting, it seemed reasonable just to focus on the positive experiences.

Figure 2 summarises the treatment for children led by their parents to develop a daily ritual. Initial practicing with the help of a health professional is recommended.

The age of children receiving resource installation in this way can range from three to eight years. Younger children may receive the tactile stimulation (taps) on their knees or shoulders but without watching the point of the mobile phone which goes left-right and back 5 times (up to 40 times in total) – the

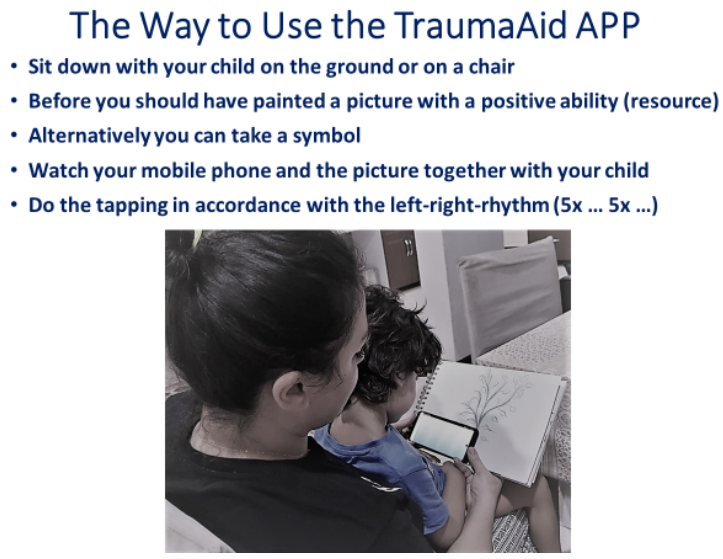

Figure 2. *Resource Installation for Parents*
Note. The child is watching the screen without earphones (optional) at the same time as tapping by the mother.

sound may be enough to underline the necessary rhythm of tapping. Older children may avoid sitting on the lap of an adult. A solution recommended is applying the tactile stimulation themselves, supported by a warm voice and possibly being held by parents. This was described as the butterfly hug (Jarero, 2002). Two effects are expected: Children calm down which is helpful for the widespread hyperarousal and the brain is stimulated in a special way that will not trigger traumatic material but implement feelings of safety. Research on bilateral stimulation to enhance positive elements supports this assumption (Amano & Toichi, 2016).

The present exploratory uncontrolled study. The aim of the programme was to provide mental health staff with background knowledge of the dynamics of traumatization and to teach resource installation for mental health staff to work responsibly with children, adolescents, and their parents. Part of the TPSS+® series of seminars was the application of 4-Field-Procedure, a procedure in EMDR therapy close to the IGTP procedure (Jarero et al., 2006) which offers a structured confrontation of traumatic memories in group and single settings. As educated EMDR therapists were not available in the refugee camp setting this procedure was adapted to the field conditions as described in the procedure section. About half a year after the training seminar, there was a post-training meeting at which two EMDR therapists would visit the refugee camp and treat sufficiently prepared children and adolescents with EMDR.

Methods

Participants
The 4-Field Procedure was conducted with 37 local children and adolescents (mean age of 11 years, approximately balanced distribu-

tion of girls and boys), who provided pictures with stress assessments or stress assessments only at a post-training meeting about half a year after the initial training seminar. No cases were excluded. Six patients were sufficiently stable to receive EMDR at the post-training meeting.

Materials

Apart from the impressions from the patients' pictures and sketches, self-report data concerning the subjective stress level were recorded in terms of subjective units of distress (SUD). The widely used SUD scale (Wolpe, 1990) asks the perceived momentary stress in a simplified form from 0 as the least distress imaginable to 10 as the most distress imaginable. SUD were gathered as a measure of the current stress level when remembering the escape compared to the stress level when remembering the rescue.

Procedure

Immediately after the first training, the social workers who were responsible for the counselling process applied a 4-field scheme to children and adolescents. As a gentle method with minimal moments of confrontation, it aims to stabilise.

The procedure only required two sheets of writing paper and pens.

1. Children were asked to paint a picture of a resource on the first paper
2. Children were asked to fold the second paper twice to get four fields
3. Four questions / topics were explained to children and in accordance with the answers four pictures or sketches should be drawn in the four squares from right to left (countries where Arabic writing is common) and from top to bottom.
   - "What happened to me?"
   - "I'm in safety again."
   - "It was helpful to me."
   - "Getting simple but realistic help (in the future)."
4. For each picture, children should assess the distress that they felt in the moment ("now") on the SUD scale from 0 (*neutral*) and 10 (*maximum imaginable distress*). The group or child should then use tactile bilateral stimulation and a kind of ritual to deal with bad memories. This ritual was described in a standard way with the words: "Let's drum away the bad pictures together – knock on your knees as loud, fast and strong as possible".

According to clinical judgment, 3 children needed further stabilisation measures. Therefore, they could not participate in further EMDR therapy. The previous interventions of their counsellors were continued and supplemented by the external consultants. Three children had received sufficient preparation (i.e., they exhibited sufficient stability), giving reason to assume they were ready for an EMDR 8-phases approach intervention. Even though for one adolescent drawing the traumatizing events and leaving it in an imaginary container was the appropriate measure at that time. Two children could be treated successfully according to the 8-phases of EMDR therapy using the protocol adaptated for children. They were prepared well (phase 1, history taking and phase 2, preparation) and could move on to phase 3, assessment of the traumatic event. Phase 3 includes figuring out the worst image as part of this event, the negative cognition about oneself associated with it, and its counterpart - the positive and desired cognition. How true this positive cognition feels is scored on a scale ("Validity of Cognition") as well as the degree of distress

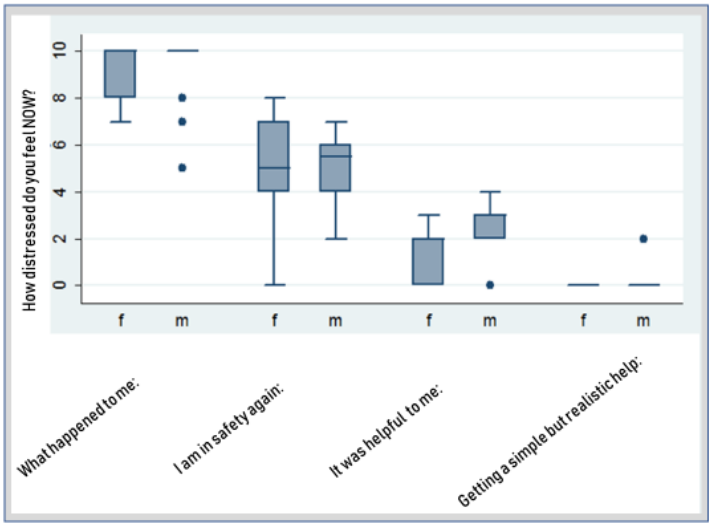

Figure 3. Boxplots of SUDs in a 4-Field-Scheme (Field-IGTP)
Note. $N = 37$. SUD = Subjective Units of Distress.

(SUD). Emerging emotions and bodily feelings during this processing work are part of the assessment. Phases 4 serves - accompanied by bilateral stimulation - for desensitization and if successful the therapist can anchor the positive cognition in phase 5 ("Installation"). A body scan - phase 6 - that assesses the tension in the body is followed by the conclusion of the session (phase 7, closure). Phase 8 reviews the previous process at the beginning of the next session.

All children received two (case 1, 2 and 3) or three (case 4, 5 and 6) sessions of 60 to 75 minutes each. Further care after the sessions by the responsible social workers was ensured.

Results

Application 4-field-scheme

The average SUD was 8.6 for the critical event, 4.6 for the moment of rescue, 1.8 for the thought about helpful things (also persons), and 0.2 for the phantasy about a simple but realistic future help. Figure 3 graphically illustrates these developments as a function of gender. Thus, there was a near-maximal level of subjective distress when children painted their pictures and remembered the incidents. After being rescued and remembering that moment, subjective distress decreased notably but still exhibited a considerable amount of distress in the children's memory. The subjective distress in connection with the pictures of helpful things and persons seemed to be bearable for a child in the camp situation, and the subjective distress in connection with imagining getting simple but realistic help was near-zero.

Results of EMDR therapy application

The results of the interventions with the six children served by the therapists on visit are summarised in Table 1. Safe and reliable stabilisation is a prerequisite for processing therapy such as EMDR. This could not be determined with certainty by the therapists

Table 1. The Interface Between TPSS+® and EMDR – Six Cases

Patient / Gender	**Traumatic Event(s)**	**Main Symptoms**	**Intervention: Phase 1 & 2 (preparation) or 8-phase EMDR protocol**	**SUD 1 - SUD 2**	**Positive Cognition / Symptom Relief?**
Case 1: Girl aged 7	Saw dead bodies and beheaded people	Flashbacks, beating siblings heavily	1 & 2– not stable enough for confrontation	Not available	Visibly better concentration, less aggressive
Case 2: Boy aged 9	Lost his father during escape	Severely confused, self-harming	1 & 2– not stable enough for confrontation. But: Sketching house and rescue, mentioning bombing	Not available	Able to pick up contact during sessions
Case 3: Boy aged 16	Captured by ISIS	Flashbacks, flooded by memories	1 & 2– not stable enough for confrontation; minimal first confrontation step: Pendulation technique, events sorted along a time-line	Not available	Relaxation during sessions
Case 4: Boy aged 17	Group rape and tortured continuously	Bed wetting every night	1 & 2– not stable enough for confrontation. But: Draw four hidden images of traumatic experiences – put them into a container made of a paper envelop	Not available	No bedwetting the next two nights. "I have achieved it and will continue to achieve it!"
Case 5: Girl aged 10	Saw the dead body of her mother killed by ISIS	Depressive, always crying, burn-out on a child level	8-phase-EMDR-protocol for children: Phase 3 - 8	10 – 0	"I always do my very best!" More open during sessions, interested in playing and dancing in therapy container
Case 6: Boy aged 7	Bomb attack, thrown behind a rock, survived together with his father	Bed wetting	8-phase-EMDR-protocol for children: Phase 3 - 8	10 – 0	"I am safe, in safety!" No bed wetting the next two nights

Note. SUD = Subjective Units of Distress.

for all participants. It was always decided towards the safe side in order not to burden anyone additionally. However, for two of the children in question, the decision for a processing session could be made safely.

Discussion

The TPSS+® training presented here aims to encourage social workers to integrate trauma-informed interventions into their daily work. The interventions should be easy to use and adaptable for children and adolescents according to their age. These are based on the EMDR trauma therapy procedures. For the individuals in the therapeutic process, a main goal is to create windows for relief. This is all the more important the more stressful the life situation is.

The results of this pilot project showed that if an adequate preparation is offered, therapy sessions with children in refugee camps can be conducted in a safe and efficient way.

Using the example of a 4-field-scheme, the first findings showed how much children and adolescents in question suffer with their memories. Their self-assessment was close to the most subjective distress possible when they were asked to outline their traumatic experiences.

After focusing on the rescue situation and on the current situation in the camp, the perceived stress level decreased. The goal of these interventions was to provide relief and help those seeking advice to perceive it accurately. Feeling this relief was seen as the basis for coping with daily life under considerable stress and threat. The answers in the last field of the scheme (step 3 / topic 4) shows that children don't know about the circumstances they would meet coming home. It seems important for social workers to inform children and youth about the reality of their home in a case of return to prevent them to live with illusions.

Additional processing

TPSS+® and EMDR have the same theoretical basis but are performed by different professionals. If a social worker is well trained in the methods of TPSS+®, it should be possible to refer traumatised children and adolescents to an EMDR therapist. Among a very small number of six individuals, the clinical judgment for four of them was that more stabilisation was needed before the next step of trauma processing could be offered. Two individuals were given a full EMDR intervention, which they seemed to benefit well from on the behavioural level. A focused approach of preparing children and adolescents for EMDR with TPSS+® might help increase the number of sufficiently stable patients in refugee camps to be treated with EMDR.

Though the results are promising, there are a few notable limitations to the present pilot uncontrolled preliminary study. The sample size was very small. The research work was difficult due to the often-pressurized working conditions in the refugee camp, in which the daily crisis management of refugees is the main priority. There was no follow-up measurement to examine how patients were doing several weeks after the initial measurement. There was no control group of patients (waiting list) or a treatment as usual intervention. Finally, the study design did not involve blinding, which could have prevented the possibility of experimenter or expectancy effects.

Conclusion

With reference to the intervention pyramid shown above, TPSS+® could fill the gap between the first respectively second level (supplying basic needs for people in the refugee camps) and the top of the pyramid (psychotrauma therapy). Resource installation and modified EMDR procedures as provided by TPSS+® can meet these demands in

a way that is culturally appropriate. The results suggest that resource installation is a feasible option according to clinical impression and staff capacity. This combination, supported by a referral system to an EMDR therapist would provide a therapeutic basis without language barriers. Larger-scale research should test this preliminary conclusion.

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Engaging torture survivors in the global fight against torture

Berta Soley[1]

In front of the current ongoing debate on the need to actively engaging torture survivors in the global fight against torture, IRCT held a webinar at the request of IRCT member centres. The webinar examined torture survivor engagement in the rehabilitation process of rebuilding lives, seeking justice and torture prevention.

Lived experience can be emancipating and also paralysing, but foremost, it is precious to combat what has been suffered in the first person (Henry, 2021). How to recognise that contribution and engage torture survivors in the global fight against torture? What role do survivors play in society? How to involve survivors in advocacy and policy-making processes? What are the existing power (in)balances at play? Who gets to decide whether a survivor should speak up or not? Acknowledging that it can prompt some organisational, therapeutic, and professional considerations, what are the limits? How do we ensure that the survivor's well-being is protected along the process? To what extend should survivors be engaged in our organisation's decision-making?

Léonce Byimana[1], Feride Rushiti[2], Kolbassia Haoussou[3] and Vasfije Karsniqi-Goodman[4] walked us through these questions. The discussion was enhanced with inputs from other IRCT-members.

Why should we engage survivors?

To understand the relevance of engaging survivors in the global anti-torture work, one could t reflect on the following question: «*Between the person who cooks the cake, and the person who eats the cake – who is the best one to answer the question on 'how does the cake taste'?*» - Kolbassia Haoussou

This strong-willed question places the survivors as ultimate experts and reflects their relevance in the global work on torture prevention and rehabilitation. Torture survivors are masters of their own experience and deeply understand other survivors' mindsets. Consequently, they are powerful entities for advocating and contributing to the global fight against torture (Byimana, 2021; Haoussou, 2021).

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4 Survivor and member of the Kosovan parliament

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At a macro-level, survivors' stories can have a massive impact on the social perception and knowledge of torture and policy-making related to the practice of torture and the culture of impunity. By speaking up and telling their stories, survivors can sometimes be more powerful than statistics or research, even with policy-makers, since it brings the human aspect behind the data (Byimana, 2021).

One good example of this is the case of Vasfije Krasniqi-Goodman, who got her case re-opened only after sharing her story publicly. Ever since she became an activist, she has given testimony at the US congress for the Kosovo war crimes done by Serbians and at the UN in NewYork and Geneva, among other places. This gave survivors some hope that justice could be reached, she claimed (Karsniqi-Goodman, 2021). Her case demonstrates the immense impact of speaking up publicly, while it also reflects the institutional negligence of justice in assessing her case:

> *"After the war ended, the UN came to Kosovo. I believed so much in their justice and their right-doing that I reported my case to them. Unfortunately, the UN did not do anything for my case – I am not sure they looked at it. […] when my case reached the supreme court in Kosovo, I was denied justice. To me, it felt worse than being tortured because when justice is denied, that is something that hurts you even more after the crime is done."* - Vasfije Krasniqi-Goodman

She now continues to advocate for justice, combating stigma and empowering other survivors. As a current Member of the Kosovan Parliament, she hopes to bring justice to the more than 20.000 survivors of the Kosovan war by holding the perpetrators accountable for their war crimes (Karsniqi-Goodman, 2021).

Another good example is Sister Diana Ortiz, who decided to share her story and founded TASSC to provide a platform for other survivors to speak up (Byimana, 2021).

At a meso-level, survivors can help identify other survivors among their communities and serve as a robust referral mechanism, encouraging reluctant and fearful survivors. They can also form a strong support network at a community level, which guarantees ongoing and long-term support even in the most challenging contexts (Walker, 2021).

Some of the IRCT-member centres already serve as an example of a well-functioning, survivor-led and survivor-implemented organisation. Survivor empowerment is now central to the strategic functioning of Freedom from Torture, 60% of the Tree for Life team are survivors, and all directors from TASSC and half of its board are survivors. This shows the direct access to and impacts the organisations' decision-making regarding the services provided and advocacy (Byimana, 2021; Haoussou, 2021; Rushiti, 2021; Walker, 2021).

At a micro-level, engaging survivors can have a double-valuable therapeutic effect. Survivors can play a crucial role in helping and supporting other survivors throughout their healing process. Sharing their own traumatic experiences engenders a sense of closeness between them. They also embody the sense of hope that their lives will be rebuilt. Simultaneously, helping others heal is an integral part of the therapeutic process for the survivors who deliver such support. This gives them a sense of agency, self-worth and empowerment (Walker, 2021).

> *"Working with survivors of torture has helped me to heal from my trauma, and the process has helped to understand that the journey of healing is not a one-day thing, but it is a process"* - Tree of Life Field Officer

They also claim that it has contributed considerably to their resilience, and some have decided to become politically active again, despite the risks (Walker, 2021).

Similarly, being engaged in advocacy positively contributes to their mental health and self-esteem, as their feeling of usefulness in influencing policy-making and social perception of torture increases. 70% of the torture survivors who access TASSC were previously activists, whistle-blowers, human right defenders and advocates back in their countries and tortured for this reason. After being tortured to be silenced, having the platform to speak up and share their stories is a powerful opportunity for them. Supporting these individuals continue to advocate is only natural for them (Byimana, 2021).

Building the bridge and creating the platform

In survivor engagement, we must create a platform that will allow survivors to reach and contribute to the anti-torture world, functioning as a *bridge* to connect them with the broader society and institutions (Byimana, 2021; Haoussou, 2021; Rushiti, 2021).

Following the survivor engagement model, attention is given to integrating a survivor-centric approach in rehabilitation services. It entails adopting an individual approach by looking at the survivor as a unique entity, listening carefully to her or his needs and promote her or his rights in their best interest. In this process, it is of utmost importance to set joint goals with the survivor. Survivors may have different goals (protection, therapy, rehabilitation, justice, etc.), and the service should help them achieve these goals. It is equally important to fully understand these objectives and assess their feasibility against the centre's capacity to provide the necessary means to accomplish them and manage the survivor's expectations. Sometimes the capacity of the centre cannot cover all their requests, and this needs to be clarified (Rushiti, 2021).

This model must be founded on the survivors' *willingness* to be engaged without pressure on them to do so. Likewise, the *purpose* for engaging should be well outlined. The objectives can differ from empowering other survivors to seek justice to break myths and stereotypes or be role models for other survivors (Haoussou, 2021; Rushiti, 2021). Most survivors decide to advocate, do it for their communities' safety back home, empower other survivors to do the same, and seek justice (Byimana, 2021).

The presenters also highlighted the importance of creating a *safe space* for the survivors to engage. Torture survivors, especially those who have suffered from sexual violence, are fragile and sensitive. It is crucial to provide a protected space and ensure confidentiality throughout the process (Haoussou, 2021; Rushiti, 2021). Feride Rushiti shared her organisations' experience supporting Vasfije Karsniqi- Goodman as the first survivor to appear in public and share her story in Kosovo. Aspects such as soft light and direct eye contact with her family and psychologist while testifying in the courtroom were considered to ensure a safe space where she could feel comfortable in telling her story. Moreover, the momentum chosen for the survivor to speak up can also increase and maximise its impact. The exposure of Vasfije's case was a breaking point for Kosovan society and mobilised high institutions (Rushiti, 2021).

Engaging torture survivors also requires re-visiting the question of *power (im)balance* at an organisational level. As service providers, we hold significant power, influencing how the safe and confident space is shaped. In the process of engaging torture survivors, power needs to be shared with survivors. They are a reliable source of knowledge regarding the

quality of the services provided, and power imbalance might affect the confidence of survivors to provide trustworthy feedback on the rehabilitation process, fearing they might be denied those services if the feedback is negative. Hence, together with a safe space, cultivating balanced power relationships with survivors will help us build a sense of trust and confidence, bring us closer to their reality and recognise their capacities (Haoussou, 2021).

> *"You need to understand that you need to share power, create the space for people to engage, and when it comes down to your services, the people that are using your services are the real experts, nobody else."* – Kolbassia Houssou

Challenges to engaging survivors

Engaging torture survivors may be challenging for several reasons. On the one hand, telling your story as a survivor is always painful and may bring distressing memories. If revealing their identity may also put their families back home in danger. Moreover, it may jeopardise their legal asylum process if their story is not fully compliant with the one stated on the application (Byimana, 2021). There is also the concern that it may be an obstacle for survivors to digress from the 'survivor identity'. This is why it is relevant to assess the survivor's maturity, resilience, and potential psychosocial consequences (Rushiti, 2021). Likewise, the panellists insist on the voluntary aspect of survivor engagement, ultimately making their own decision to speak up and face these risks (Byimana, 2021; Haoussou, 2021; Karsniqi-Goodman, 2021; Rushiti, 2021).

Lynn Walker explains that, given the Zimbabwean context of ongoing use of torture, collective violence and impunity for the perpetrators, survivors in their organisation do not engage in advocacy actions since it would be overly dangerous. Nevertheless, for survivors helping other survivors throughout their healing process, self-care and survivors' well-being are critical. In that sense, care for the caregivers and monitoring the well-being of the survivors must be an integral aspect of our work (Walker, 2021).

On the other hand, engaging survivors also represents a challenge at an organisational level. It involves changes in the organisational structures, internal procedures and decision-making processes, implying power imbalance. Nonetheless, solid leadership and a theory of change that puts survivor engagement at the centre may facilitate this transition. In any case, re-formulating the organisational structure and power balance is paramount to allow survivors to assume leadership (Haoussou, 2021).

Conclusion

Successful survivor engagement entails identifying challenges at a personal and organisational level and adjusting tactics to respond to the challenges and provide opportunities to overcome them. If managed successfully within an organisation, survivor engagement can contribute positively to the prevention and rehabilitation of torture. When a torture survivor shares her or his story, it can strongly impact advocacy, policy-making, and their rehabilitation journey. When a torture survivor engages in helping other survivors throughout their healing process, it can positively affect both. Given that each survivor's care and well-being is of paramount importance, the tactics used will differ in each context. However, the overriding message from the IRCT webinar is that more survivor engagement will improve torture rehabilitation services and, therefore, more member centres should consider this and take action.

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The dark face of Chilean democracy: the Catrillanca case and the Temucuicui community arrest

Jesús Antona[1]

Dear Editor-in-Chief:

Following the failed strategy of linking the Mapuche with international terrorism, another crude ruse has been concocted to propagate the image of the 'Mapuche narco' in public opinion to hide the shameful actions of state security forces and justify practices which harm human rights. For some, the operation set up to justify this hoax surpasses anything seen in the south of Chile in the thirty years since the return of democracy (Lavozdelosquesobran.cl, enero 2021).

On the 7th of January, special militarised national police forces, *Carabineros*, deployed 800 police equipped with weapons of war and air support to raid the communities of Temucuicui using an unusual level of violence. The pretext for this action was to neutralise drug trafficking networks and combat organised crime in the Araucanía region. In this unfortunate intervention, in addition to the damage inflicted on the Mapuche community members, the Inspector of the Investigative Police (PDI), Luis Morales Balcazar, lost his life in circumstances that have not yet been clarified.

One would have to be very naïve to think that the raid was accidental, as it occurred on the very same day the sentence of the 'Catrillanca case' was announced. This case established the responsibility of the Chilean State in the death of Camilo Catrillanca, convicting members of the Special Operations Group (GOPE) of Carabineros from Chile for this homicide and to various crimes related to the same case; obstruction of justice, frustrated homicide, and the illegal kidnapping of the unnamed minor known by his initials 'MACP'.

On the same day of the raid, the Oral Court of Angol convicted the former GOPE sergeant, Carlos Alarcón, as responsible for the murder of Camilo Catrillanca and the attempted murder of his companion, the minor MACP. Six other former police officers and a civilian lawyer were also convicted, to varying degrees, of obstruction of justice, illegal detention and frustrated homicide. On the same day, police raided the community of Temucuicui, arresting the wife and mother of the deceased Catrillanca and separating them from their 7-year-old daughter Wakolda, who was held by uniformed officers for several hours. This intervention had the immediate consequence of making it impossible for his family and friends to attend the reading of the verdict.

Camilo Catrillanca was the grandson of the *logko* (Mapuche leader) of the combative community of Temucuicui (commune of Ercilla). The proven facts indicate that he was shot by members of the GOPE on 14 November 2018. On the day in question, the Car-

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abineros from the Malleco communications centre received a report that three individuals, with covered faces and carrying weapons, had stolen three vehicles from the Santa Rosa rural school. This information prompted the deployment of a Carabineros Special Forces operation composed of »several [armoured] police cars and a helicopter to locate the vehicles«[1]. On finding the road blocked, the GOPE patrol involved descended from the armoured car and advanced on foot, encountering on the road a tractor driven by Camilo Catrillanca and in which the 15-year-old MACP was also travelling. Catrillanca, on seeing the uniformed officers, went backwards and turned around, at which point the police stopped him and, according to the Carabineros, when he ignored the order, they fired several shots at the occupants of the tractor. One of these shots hit Camilo Catrillanca in the back, killing him; other projectiles aimed at his companion missed the target, hitting the mudguard where he was sitting. The minor went down with his hands up without offering any resistance, but was violently subdued, tied up, beaten, and taken to the police station.

On returning to the police station, the Carabineros' commanders concocted a false account of the events with the help of the corps' lawyer, Cristian Eduardo Inostroza, aimed at blaming the Mapuche involved for the crimes of vehicle theft - claiming that they were carrying weapons and resisted detention, leading to an exchange of gunfire in which the victim was shot by chance. However, the proven facts in the trial made it clear that:

> *»(…) the version of events presented as having occurred on the afternoon of 14 November 2018 given by the accused [carabineros] (…) was devised prior to giving evidence to the prosecution and instructed by the accused Inostroza Quiñinir and Valdivieso Terán [Carabineros Major and group leader] providing false information«* [2].

In addition, the verdict also ruled that the statements made by members of the Carabineros group to the local prosecutor's office in Collipulli in the early hours of 15 November were false:

> *»The members of the GOPE patrol had not been attacked with firearms and had fired in response to Camilo Catrillanca's action to elude the Carabineros officers he encountered during his movement«*[3].

A key aspect in this case was the video cameras that are usually part of the officers' personal equipment. Those involved declared to the prosecutor that they were not carrying cameras or in possession of images of the events, a version that was accepted by the Prosecutor's Office despite the fact that one of the members of the group had handed over a camera, although without the memory card because, according to its bearer, it had been destroyed because »it contained intimate images«. Finally, despite pressure from the high command and the passivity of the Prosecutor's Office, the GOPE agents began to break their initial silence, revealing the fallacy of the police story.

The judicial reality demonstrated that Camilo Catrillanca was killed from behind and that the teenager who accompanied him was saved by chance, as well as making it clear that neither of the young men were armed. However, the sentence left a bittersweet taste among Mapuche and human rights organisations because, although the truth about the circumstances of the young Mapuche's death

1 Verdict, 7 January 2021, Rit-80-2019-1.

2 Ídem

3 Ídem

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and the improper and criminal actions of the rest of the accused had been established, the sentences were below what was expected. This was due to an underestimation of the seriousness of the crimes charged: instead of aggravated homicide (which would have implied a heavier sentence), simple homicide was applied and the accusation of torture inflicted against the minor MACP was dismissed, as were the the accusations of false documentation and dishonest schemes concocted by the Carabineros' advisor lawyer in collusion with his commanders.

The truth is that the GOPE Tactical Reaction Group, also known as the »Jungle Command« had been targeting the young leader of the Temucuicui community since at least 2017. Camilo Catrillanca was identified as one of the leaders of the Mapuche Territorial Alliance (Alianza Territorial Mapuche), according to a document leaked by the Centro de Investigación Periodística de Chile (CIPER) and released on 27 November 2018 called: »Exposición coordinación zona de control orden público« from the Unit of Special Operational Intelligence Unit (Unidad de Inteligencia Operativa Especializada) from Carabineros (UIOE). This unit was dismantled after the scandal known as Operation Huracán, when different offences were attributed to them, such as falsification of public instruments, obstruction of investigation, and illicit association.

The communication strategy aimed at tarnishing the image of the murdered Mapuche spread the idea that he was a habitual offender. On the day of Catrillanca's death, the Intendant of the region, Luis Mayol, argued that the victim had a record for car theft, implying this was a clear case of common crime. However, it was shown that Camilo Catrillanca had no criminal record, although the Minister of the Interior, Andrés Chadwick, propagated this theory, arguing that he certainly did not yet have a criminal record, but only because he had not yet been charged, as his case was still in the procedural phase.

For the Mapuche organisations, this case shows the darkest side of Chilean democracy in Mapuche territory, where militarisation, disproportionate use of force and police set-ups are the response of successive governments to the territorial demands and aspirations for self-determination of the communities, especially the most combative, such as those in the province of Malleco. Raids ("Allanamientos"), a kind of military operation that sweeps away everything that gets in the way of the uniformed officers' boot, are the most frequent form of indiscriminate suppression applied to Mapuche communities targeted by police intelligence. This form of collective punishment is frequently used and sometimes does nothing more than reflect the impotence of the police to locate the persecuted activists. However, it is also a strategy to instil terror in the collective mind, penalise solidarity, and encourage collaboration. These actions, which are clearly warlike, seek to establish the image of the overwhelming force of the state in the face of any attempt at subversion in the Waj Mapu (Mapuche territory).

The militarised and synchronised nature of these lightning-fast actions allows them to be carried out with maximum impunity as they take place in a relatively short time, outside urban settings, far from the uncomfortable gaze of the press and behind the backs of the everyday life of urban centres. All of this allows them to perpetrate aggression unscrupulously, taking children, women, the elderly, and all those community members or sympathisers who consciously, or involuntarily, get in their way.

In the »Report on the human rights situation of the Mapuche people« prepared by dif-

ferent organisations to be considered in the »Universal Periodic Review« of the State of Chile, it is pointed out that raids and excessive police violence are a common practice in Mapuche communities, Mapuche Students' Homes, as well as harassment of their traditional authorities.

This type of action has mobilised national and international public opinion, condemning these practices as abusive and contrary to the fundamental rights of the Mapuche. The Coordination of Human Rights Organisations of the Araucanía Region issued a communiqué unequivocally condemning the raids on the aforementioned communities and the excessive use of violence:

> *»These events are indescribable due to their gravity and the re-victimisation they cause to those who suffered the loss of a loved one at the hands of agents of the State (…)«* (CODH, 2021).

The same communiqué points out that far from being isolated acts (and much less attributable to common crimes) these actions are framed in the context of the so-called »Mapuche conflict« and the historical debt that the State of Chile owes them for the »violent invasion« of their territory, which »has been maintained over the last centuries through political, economic and social exclusion, criminalisation and the excessive use of force« (Ídem).

The Mapuche organisations emphasised the traumatic consequences that accompany these police operations, especially the psychological damage to the communities, which particularly affects children and the elderly. In this sense, there is a clear violation of children's rights protected by international law. In this case, there is also the aggravating circumstance that the daughter and the direct family of Camilo Catrillanca were involved in the raid, for this reason it was argued that Chile had also violated the right to reparation of victims of human rights violations4.

The psychosocial damage to Mapuche children is neither trivial nor new. Various reports from researchers in Araucanía (CIDSUR, 2018) point with concern to the serious consequences of police interventions on the health of children in the Mapuche communities that have been raided. Specifically, in Temucuicui, one of the most seriously affected communities with more than a dozen raids in recent years, more than 30 children and adolescents have suffered the consequences of these brutal police operations. The catalogue of damage caused to Mapuche children and adolescents includes symptoms of asphyxia caused by tear gas, injuries from the impact of pellets, bruises of varying degrees from blows, manifestations of shock, and nervous breakdowns. According to experts, the psychosocial effects of this type of action on the development of Mapuche children and young people have serious consequences for Mapuche families and constitute a long-standing punishment.

The concluding observations of the Periodic Review of Chile in 2015, within the framework of the United Nations Committee on the Rights of the Child:

»(...) urges the State party to modify those aspects that generate structurally violent conditions (…) [the Committee also urges the Chilean State to] act immediately to put an end to police violence of all kinds against indigenous children and their families (...)« (Committee on the Rights of the Child, 2015: 19, in CIDSUR, 2018: 57).

The overexposure of Mapuche children and young people to the territorial conflict is

4 Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law (2005).

seriously detrimental to their development. The stress generated by the images of violence and the fear that their parents, relatives, or friends could be harmed, creates a permanent state of emergency in children, as they fear that at any moment there could be another action by the police, which leads to the normalisation of violence in their daily lives. Moreover, the experience of violence at such an early age, during cognitive development, creates disturbing associations that will be fixed in the collective subconscious of those who constitute the future of the community.

The testimony of a Mapuche child shows the emotional and psychological impact of violent police operations on Mapuche children. The six-year-old girl interviewed by specialised professionals said that she did not know what the people who had forced their way into her community looked like. She could not even imagine what was behind those clothes and helmets, even expressing disbelief that there were people behind those 'masks' (CIDSUR, 2018 pp.57 y ss.). Das noted that the subjectivity of terror produces phantasmagorical images that become realities for those who experience them, and these terrors are somehow expressed through these images in an attempt to rationalise inexplicable facts that escape language and reason (2008, p. 346).

On the other hand, if this repressive strategy fulfils the function, intentionally or not, of instilling terror, it also reaffirms the idea of a continuum of violence from the Chilean state against the Mapuche, which is why it often has the opposite effect. This has been demonstrated in cases of children of repressed traditional leaders and authorities who have now taken over Mapuche activism, setting themselves up as the new *weichafe* (Mapuche activists or fighters) and generally wielding more radical approaches than those before them. This collective intergenerational damage, far from putting an end to Mapuche resistance, becomes a factor of intergenerational resilience in the face of the occupation of their lands by Chileans. As Das has rightly pointed out, sometimes memory is created by inflicting pain, indeed, the direction of memory is not the past, but the future (2008, pp. 95-144).

However, the damage to the new generations has already been done. The fate of many young people exposed to these traumatic situations, or belonging to criminalised communities, tends to be irreparable, as they are forced to follow a path full of suffering and sacrifice by opting for political strategies that often result in arrest, imprisonment or flight and hiding, dictating their potential at a very early age, as their future will already be marked by the stigma of 'terrorism'. In this way, the authorities are writing off the new Mapuche generations in order to engage in a political dialogue that will allow them to find fair and peaceful solutions to the conflict, avoiding undesirable outcomes.

20 March 2021

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Tribute and Homage to those who left us

In recent months, during a year when organisations that provide services for survivors of torture faced new challenges during the global COVID-19 pandemic, some of the people who have been leading the anti-torture movement for years have passed. We would like to remember and pay tribute here to some of these figures. This list is by no means exhaustive. Through the names it contains, it is intended to serve as a tribute to the many workers, survivors, and friends who have left us.

Remembrance is the only paradise from which we cannot be expelled.

Javier Enriquez Sam (1960-2021). Surgeon and Master in Social Medicine were one of the founders of the Colectivo Contra la Tortura y la Impunidad A.C. (CCTI) and its General Coordinator for several years. He was also the driving force behind the implementation of the Istanbul Protocol in Mexico since 2002, together with experts in documenting cases of torture in this country. As part of the CCTI team, he coordinated the area of Therapy and Rehabilitation. Javier was the leading expert in carrying out multiple reports. He co-authored training materials and research that were the expression of 16 years of experience. He received the Tata Vasco Award from the Ibero-American University in 2018. Promoted training on the Istanbul Protocol in the most prestigious universities in Mexico. A tireless and untiring social fighter against the practice of torture, he died by COVID when providing care to his parents, being consistent with the solidarity that characterised him as a person and as a doctor throughout his life in the face of a health system dismantled by voracious capitalism.

Gerald "Jerry" Gray (1935-2020), a psychotherapist and licensed clinical social worker, founded and played a leading role in a number of lasting organisations devoted to the treatment of torture survivors and other organisations devoted to accountability for torture, trauma, and abuse of power. In the 1980's, his private practice clinical experience with torture survivors motivated him to found Survivors International, one of the first torture treatment centers in the U.S. In 2001, Jerry directed the Center for Survivors of Torture in San Jose, affiliated with Asian Americans for Community Involvement. He

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played a key role in establishing other treatment centers in the U.S. and Canada. In 1998, he founded the Center for Justice and Accountability (CJA), an organisation in the United States that works to hold torturers accountable. He served on the initial steering committee and inaugural Board of Directors of the Canadian Centre for International Justice, founded in 2000. Other engagements included co-founding the Institute for the Study of Psycho-political Trauma, work with the Stanford Human Rights in Trauma Mental Health Laboratory, and consultation with the International Criminal Court and the International Institute for Criminal Investigation (The Hague). Thereafter, he founded and directed the Institute for Redress & Recovery at Santa Clara University. In his last years, Jerry co-founded and funded projects in El Paso, supporting legal and advocacy workers to recognise and manage vicarious trauma, connecting mental health evaluators with immigration attorneys to prepare reports supporting asylum seekers in immigration court. Furthermore, he provided video-therapy to Mexican journalists living in danger due to their coverage of corruption and violence, and funding observers documenting proceedings in immigration court.

Sister Jean Abbott (1943-2021) After taking a vow of poverty with the Sisters of St. Joseph of Carondelet in 1961, Sister Jean lived her vocation to support the most vulnerable in our society. It was her work in Central America in the 1980's and later involvement with the Sanctuary Movement that brought her focus to working with survivors of state-sanctioned torture. A clinical social worker by trade, Sister Jean was painfully aware of the legal, physical, and emotional needs of these refugees, and worked tirelessly to secure funding and pro bono services to help meet them. This advocacy culminated in the founding of the Center for Survivors. Sister Jean served as Clinical Director of the Center for many years, providing direct service to those in need and training younger clinicians in working with vulnerable

refugee populations. While Sister Jean ultimately stepped back from day-to-day operations, she never really stepped back from the work, travelling to Uganda for six months in her seventies to teach students there stress reduction and coping techniques and travelling several times to Mississippi in her later years to work with victims of human trafficking.

Jose María "Chato" Galante (1948-2020) was a leading member of the Association of Former Political Prisoners La Comuna, Presos del franquismo, which fought against the crimes perpetrated during Franco's dictatorship.

He was a member of the Revolutionary Communist League during his youth. At the age of 20 he was arrested, tortured and imprisoned for participating in student protests.

A militant on the underground, he was actively in the Ecologist and Human Rights movements until his death, at 71. He led the movement to fight against impunity for torture in Spain and to reverse the amnesty laws approved during the so-called Spanish "democratic transition" that allowed crimes to be unpunished. Gifted with a gentle disposition, he was one of those leaders who naturally managed to gather people around him, drawn by his charisma and his tireless work. In a sort of poetic justice, a few days after his death, Antonio Gonzalez Pacheco, alias Billy the Kid, his torturer that was never judged, passed away also from COVID.

Gianfranco De Maio (1963-2020). Graduated from the Università Cattolica del Sacro Cuore in Rome, he was a medical doctor specialising in neurology and tropical medicine. He has always been involved in social volunteering and joined MSF in 2001, initially as a field doctor, carrying out various missions in the Democratic Republic of Congo, Ivory Coast, Haiti, Brazil, Niger, Central African Republic, Bulgaria and Italy. He was project leader for the MSF Rehabilitation Centre for Torture Survivors in Rome, Athens, Mexico City and other places along the migration routes. Gianfranco was a free, bold, courageous and ironic man. His life and work have been a lesson in intelligence, passion, professional and ethical commitment and an enormous enrichment for anyone who has met him, even for a short time. Gianfranco contributed with his analytical capacity, his critical spirit, his expertise, to consolidate and enrich the international movement of Doctors Without Borders.

Sister Dianna Ortiz (1958-2021). Founder and former Director, survivor-led Torture Abolition and Survivors Support Coalition (TASSC) International. She inspired so many by her courage and fortitude, and her quest to reveal the truth.

An excerpt from a March 29, 2021 email statement from The Hopi Foundation and the Barbara Chester Award Community honoring Sister Dianna: "*As a torture survivor, she modeled compassion, humility, and service which instilled hope in other survivors. Sister Dianna was abducted and tortured while teaching Mayan chil-*

dren in Guatemala. After her return to the U.S., she . . . worked with the Guatemalan Human Rights Commission in Washington, DC. In 1997 she co-founded Torture Abolition and Survivors Support Coalition International (TASSC) in Washington, DC with the mission to give voice to torture survivors and gently support their healing. Every year on June 26th TASSC gathers survivors from around the world to commemorate the signing of the UN Treaty Against Torture. This event created opportunities for survivors to advocate directly with members of Congress, to educate the public during an organised vigil, and to share with each other, to heal together and make strong connections. She took the horrible experience of torture and created opportunities for collaborative healing with other torture survivors."

Call for papers. Special section of Torture Journal: Journal on Rehabilitation of Torture Victims and Prevention of Torture

Racism, ethnocentrism and torture by police and security services

Guest Editor: John Schiemann, Professor of Government and Politics, Fairleigh Dickinson University
Pau Pérez-Sales - Editor-in-Chief, Torture Journal

Background

Since the early summer of 2020, the world has seen a wave of protests against shootings and brutality by police and other law enforcement and security services across the world. As the focus of many of those protests make clear, it is an unfortunate truism that racism and ethnocentrism often play an important but complicated role in violence and torture, including at demonstrations and in other non-custodial settings. What connections between racism on the one hand and torture and inhumane treatment on the other have endured. What are new or dramatically changed and transformed relationships? What are the implications?

Objective

The UN Convention against Torture specifically identifies "discrimination of any kind" as one of the examples it prohibits. In the spirit of a 2020 resolution of the UN Human Rights Council calling attention to excessive use of force and other human rights violations by law enforcement officers against Africans and of people of African descent against and the Journal's own recent special section on migration and torture, the Torture Journal seeks to gather and disseminate legal, social scientific, psychological, and historical perspectives on the relationship between racism and ethnocentrism broadly defined and torture and inhumane treatment by police and other law enforcement and security services in order to better understand and reduce their prevalence.

Call for papers

Torture Journal encourages international and national studies with a social scientific, historical, psychological, or legal orientation, particularly those that are interdisciplinary with other fields of knowledge. We particularly encourage submissions from the Global South. We welcome papers taking a variety of perspectives and approaches, including, but not limited to, the following:

a. Identification of the conditions under which police and other law enforcement and security agencies are more likely to selectively target members of specific racial or ethnic groups for

torture and inhumane treatment;

b. Study of the social psychological links between prejudice, racism and torture generally, as well as the influence of prejudice and racism on the criminal interviewing methods and coercive interrogations;
c. Exploration of how racism and ethnocentrism affects the type or nature or supposed purpose of torture and inhumane treatment by police and other law enforcement and security service units who engage in torture;
d. Investigation of how the above patterns have changed over time within and across regions, countries, political regimes, socio-economic conditions, and other sources of variation;
e. Examination of the relationship, if any, between social protest movements and reform efforts, and the effectiveness of torture prevention in contexts of racialized and ethnicised torture and inhumane treatment;
f. Analysis of the broader social effects, widely construed, of systematic racialized and ethnicised torture and inhumane treatment by police and other law enforcement and security services;
g. Inquiry into whether there are physical and/or psychological sequelae specific to racialized and ethnicised torture and inhumane treatment by police and security services on torture victims and what, if any, implications they have for victim rehabilitation treatment.

Deadline for submissions
30th December 2021

For more information
Contact Editor-in-chief (pauperez@runbox.com) and Guest-Editor (jws@fdu.edu) 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/2eefc4b785f87c7c3028a1c-59ccd06ed.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.

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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.

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