# TORTURE 3 2022

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

VOLUME 32, NO 3, 2022, ISSN 1018-8185

**TORTURE**

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

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

**Volume 32, No 3, 2022**
**ISBN 1018-8185**

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



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Front page: Mogens Andersen, Denmark
Layout by Pedro López Andradas

# Content

# The 2022-revised version of the Istanbul Protocol: orientation kit for people in rush

**Pau Pérez-Sales**[1]

At last, after a seemingly endless wait, the second revision of the Istanbul Protocol (IP) has seen the light of day. Conceived in 1999, and revised 5 years later in 2004, it has taken another 15 years for there to be a much-needed updating and revision process (Haar et al., 2019).

Reference manuals in medical science need constant updating to stay alive, and this was the case with the IP. Yet, paradoxically, the main updates in this new version have not altered the medical or psychological science chapters (which remain essentially the same in their vast majority), but expanded the legal contents. While interdisciplinarity enrichens these processes, it entails complexity and need for clarification. The new protocol is not brief: 220 pages as compared to the 78 pages of the 2004 version. It is important that this extended version does not daze and dissuade health professionals who have been referring to the older version.

We summarise for those who frequently use the IP what they will find and where to invest their reading time.

The revised English version can be downloaded from the internet[2]. Although it is announced that it has already been translated into six languages, the official versions in other languages are not yet available.

**The debate behind the scenes: shorter or longer, simpler or more complex.**

There has always been a debate in the IP revision process between two doctrinal approaches. On the one hand, the position of those who, from their daily work on the front line and from the sometimes-complex training processes in environments where it is difficult to get qualified personnel, asked for a simpler, more agile instrument that would be less frightening in primary health care or in a hospital setting. This position was mainly represented by countries from the Global South and especially by practitioners from centres in Africa and Asia (Kelly et al., 2016). On the other hand, there was the position – mostly coming from forensic experts from the Global North - that the revision should point to a more comprehensive and highly specialised protocol, that would further develop, expand or clarify aspects of the 2004 version.

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2 https://www.ohchr.org/sites/default/files/documents/publications/2022-06-29/Istanbul-Protocol_Rev2_EN.pdf

https://doi.org/10.7146/torture.v32i3.133931

The new version of the IP triples its length. Quite a statement on what to expect when you unpack it for the first time. Without the new version of the IP being an exhaustive manual of forensic science (the medical and psychological parts include scarce changes), the final result is closer to the second model than to the first.

For those of you who live in a rush, let's not panic and, as Monty Phyton said in *Life of Brian*, look on the Bright Side of Life[3]: There is a lot of material in these pages that will be of great help to you.

**The Handbook becomes a reference tool.**

A good tip for integrating this revision of the IP into daily practice if you are a rushed worker is to change the way you understand and use the text. Whereas previously it was a text that could be read easily and quickly in a weekend or during a training workshop, today what we have is closer to a reference manual. All chapters have increased, not only in length, but also in density and complexity. The work of the dozens of experts who have collaborated in groups has entailed a process of addition and redundancies. The same ideas are offered to readers from multiple angles and each chapter now has its own entity and presents an all-encompassing perspective, as if it were a small independent piece. As always, this has advantages and disadvantages.

Therefore, a preliminary advice is that, from now on, carefully select what interests you and focus on an in-depth reading of that part, depending on your professional profile. The rest shall remain in your desk as excellent reference material.

And if you have very little time or you do not use the IP on a daily basis, wait until brief training guides are available for different professional profiles, something that surely will happen. The basics have not changed and you can continue working with your familiar version while progressively incorporating the changes. There is full compatibility of the core elements of the 2022 version with the 2004 version one, as it could not be any other way.

**The advantages of this text.**

A broader and more complex text also has unquestionable advantages and can make your life easier. Notably, it reduces the risk of erroneous and sometimes fraudulent interpretations of the text, as it has sometimes been the case with the 2004 version in certain jurisdictions (Moreno & Iacopino, 2008; Pérez-Sales et al., 2022). The revised version resolves and thoroughly anticipates most possible forms of manipulation or distortion of the IP, leaving a solid body of doctrine. The new version has incorporated clarifications and a shared normativity that leaves very narrow room for perverse interpretations that go against the victims.

It is also worth remembering that the Istanbul Protocol is not a closed formulary (in the worst sense of the word *formulary*) that must be completed point by point, but rather a set of guidelines and rules, some as a body of minimum standards of obligatory observance, and others as suggestions and indications of good practice. Those who erroneously untouchable claim that the IP should be followed as an ancient cooking recipe, overlook that what is important is to strictly apply the *principles and philosophy* underlying the protocol. Once these principles and philosophies are fulfilled, the margin of discretion and simplification or complexification that each evaluator wants to use is entirely up to him or her

3 https://www.youtube.com/watch?v=jHPOzQzk9Qo
https://www.youtube.com/watch?v=X_-q9xeOgG4

**Table 1**. Changes between the 2004 version and the current version

| Chapter | 2004 Version | | 2022 Version | | | |
|---|---|---|---|---|---|---|
| | Name | Length | Name | Length | Changes | Main audience |
| I | Relevant International Legal Standard | 8 | Relevant international legal norms and standards | 24 | Updated, more systematic and comprehensive | Legal experts |
| II | Relevant ethical codes | 4 | Relevant ethical codes | 14 | Reworked and expanded including new areas and professional profiles | Legal and Medical experts |
| III | Legal Investigation of Torture | 9 | Legal investigation of torture and illtreatment | 21 | Reworked. Clarified concepts and solved and addressed challenges. | Legal experts Policy makers |
| IV | General considerations for interviews | 7 | General considerations for interviews | 24 | Re-organised. Expanded by gathering parts that were distributed in chapter V and VI before. | Health professionals Some useful guidelines for other professions |
| V | Physical evidence of torture | 12 | Physical evidence of torture and illtreatment | 21 | Core elements unchanged. Expanded in specific new areas, specially sexual torture, gender and children | Health professionals |
| VI | Psychological evidence of torture | 13 | Psychological evidence of torture and illtreatment | 26 | Expanded, clarified concepts, more detailed descriptions and updated diagnostic categories | (Mental) Health Professionals |
| VII | Non-existent | | Role of health professionals in documenting torture and ill-treatment | 8 | NEW chapter – Gathers medical duties in non-custodial settings | Health professionals in everyday work or facing ethical dilemmas |
| VII | Non-existent | | Implementation of the Istanbul protocol | 9 | NEW chapter – Recommendations for the implementation of the IP at a global nationwide level. | Legal experts. NGO and HR groups. Policy Makers |
| Annex 1 | Principles on the Effective Investigation and Documentation of Torture and OCIDTP | 2 | Principles on the Effective Investigation and Documentation of Torture and OCIDTP | 2 | UNCHANGED | All professionals |
| Annex 2 | Diagnostic tests | Disappears | Guidelines for documenting torture and ill-treatment of children | 6 | NEW Annex – Summarises info related to children developed in chapters IV and VI | |
| Annex 3 | Anatomical drawings for the documentation of torture and ill-treatment | 8 | Anatomical drawings for the documentation of torture and ill-treatment | 27 | Completely reworked and Expanded with a special focus on gender issues and sexual torture. | Health Professionals |
| Annex 4 | Guidelines for the medical evaluation of torture and ill-treatment | 3 | Guidelines for the clinical evaluation of torture and ill-treatment | 3 | UNCHANGED | All professionals |

to decide according to the purposes and the framework of application of each case being evaluated. An IP should not be considered invalid because it does not comply with one or more of the sections in the suggested schema for the final report, as detailed in Annex IV of the 2004 (and 2022) versions, but rather because it violates any of the principles for this application.

In any case, if you are used to follow the Annex IV scheme step by step, here are the good news: The annex remains exactly the same as it was. In this, the coordination team wanted to give legal continuity to the previous version and did not want to jeopardise ongoing litigation by an erroneous or distorted interpretation that could challenge an IP based on the 2004 version on the grounds that the expertise provided no longer conformed to *contemporary* IP guidelines.

Table 1 summarises in a snapshot the changes between the 2004 version and the current version with reference to the number, name and content of the chapters, the differences in length and type of changes introduced, and the profile of the professional to whom the chapter is primarily addressed. In the remainder of this Editorial, we will go through the main changes section by section.

**Principle of loyalty and good faith.**

The first introductory pages provide some relevant preliminary notes to prevent the misuse of the Protocol. It is established that the IP should serve to document evidence of torture, but, in any case, to:

a. Exonerate perpetrators on the basis of the absence of physical or psychological findings of torture. Torture must be investigated by law enforcement authorities and expert forensic reports are a key supporting element, but not a substitute for investigation.
b. To arbitrarily disqualify or overrule independent expert opinions that conform to the principles of the IP by appealing to formalisms of structure or wording that are in no way in the spirit of the Protocol.

These have been historical frequent perverse practices in some countries while the Istanbul Protocol clearly states that principles of loyalty to the truth and good faith must prevail.

**Chapter I. Legal norms and international standards.**

The new Chapter I constitutes a comprehensive legal review of the concept of torture. Under the guidance and expert hand of Juan Méndez, we now have 25 pages that constitute a synthesis of international jurisprudence on the concept of torture, the interpretation of the main monitoring bodies and the mechanisms of international enforceability. If you need a brief yet comprehensive, authoritative and documented guide to conduct a training process with legal operators not used to the torture field, Chapter I of the IP may be a good place to start. It begins with the Convention's definition of torture (and admits no other) and then discusses its critical elements: direct and delegated State responsibility and how this should be understood in the expert process, the criteria of suffering, intentionality, purpose and application of sanctions in light of the doctrine of the Committee against Torture (CAT), as well as States' obligations for prevention, including the Optional Protocol (OPCAT) and visiting and monitoring mechanisms. It reviews the UN mechanisms that have jurisdiction in the field of torture, clarifying a map that may not always be easy for interpretation. It provides a brief doctrinal analysis of the specificities of the Inter-

American system and the jurisprudence of the Inter-American Court, the doctrine of the European and African Court of Human Rights and other regional instruments. Finally, it points out the most important aspects related to asylum and refugee law, international humanitarian law and the framework, and jurisdiction of international criminal tribunals in relation to torture.

**Chapter II. Ethical standards.**
The 2004 IP version established in its Chapter II the ethical principles that should govern the investigation of torture, and summarised in Annex 1 its most relevant elements. While the latter has not changed, Chapter II has been expanded to include ethical principles affecting judges, prosecutors and lawyers (see Table 2), especially in relation to the right to a fair trial. In addition, the principles of medical ethics are developed in greater depth (see Table 3). The dilemmas and conflicts of physicians, especially working under conditions of dual loyalty[4], are moved to a new specific chapter (Chapter VII) in which they are discussed in detail, besides other ethical conflicts in applied practice (Table 4).

**Chapter III. Investigation of torture.**
The new Chapter III explores how the investigation of torture should be conducted, and it is the chapter of the IP in which the reader will find more novelties. This new revised version does a thorough job of clarifying and expanding on the minimum conditions required for a proper investigation. Perhaps, for a reader coming from the medical and psychological forensic field, it may be perceived as an unnecessary chapter, too far away from the reality of the field worker. To understand its logic, one should have in mind that in the international - and especially the European - arena, there are more convictions of state parties for failing to investigate allegations of torture than for committing them. In an international environment of widespread impunity for torture cases, it is useful that the IP establishes what are the minimum conditions for a torture investigation to be considered acceptable. Besides that, some recommendations for monitoring visits on places of detention are also relevant to torture cases. This is the focus of this chapter.

It is a chapter with a legal structure. It establishes the framework of obligations and rights of States and victims, delimits the legal and procedural framework of a commission of enquiry, as well as the role of prosecutors, judges and other actors in the investigation of torture allegations. In the previous 2004 version, these elements were cited and briefly reviewed. However, in the current 2022 version, there is an in-depth legal work that seeks to expand and clarify the mandate and obligations of each party in the light of its current jurisprudence.

Among the preliminary observations, the chapter highlights the obligation of states to

4 A conflict of dual loyalties is a situation in which the physician or mental health professional is faced with two legitimate and conflicting interests: the primary, which is the duty to the best interests of the patient, and the secondary, derived from obligations to the institution for which he or she works. There are many situations that are considered to be dual loyalties conflicts. For example, working for a religious institution whose principles of practice conflict with best medical practice; working as a prison physician being assigned by contract to tasks that collude with the principles of medical ethics described in the EP; facilities where the professional is required to provide access to confidential patient information on the basis of security concerns or other criteria; having to document situations of alleged mistreatment perpetrated by staff of the same institution that pays the health professional, and so on.

investigate allegations in all cases. The fact that there is a small number of criminal convictions of torture cases in the country should not be an excuse for not investigating, alleging that torture is "unlikely to happen". This small number of cases may be due to elements linked to the actual capacity of victims to disclose or complain or the lack of guarantees of a due process. The investigation may be conducted in the form of a criminal investigation, or a commission of enquiry, or a fact-finding visit. Governments are reminded of the obligation to include ill-treatment and torture in their national criminal code, as well as the need to have independent bodies monitoring the situation in places of detention.

There are seven aspects that a proper legal investigation of allegations of torture should fulfill (see table 5).

**Chapter IV. General considerations for the interview.**

The updated edition of the Istanbul Protocol has reorganised the recommendations for conducting the expert interview by centralising information which appeared in chapters V and VI in the previous version and providing a time-based structure that follows the steps of a traditional interview.

Unlike the previous version, now this chapter is addressed not only to health professionals but also to lawyers, prosecutors or members from human rights organisations who exercise monitoring functions or who are in direct contact with the victims. Therefore, the aim of the chapter is not only to support the medical-psychological evaluation, but also to give some general indications for the legal and juridical interview.

In the previous edition, the purpose of the IP was to collect a full account of the facts, to assess physical and psychological signs and symptoms, and to determine the degree of consistency between the findings and the victim's allegations. The current edition adds two new purposes: (a) to make a clinical interpretation of the findings and give an expert opinion on the possibility of ill-treatment or torture taking into account the psychosocial history, examinations, secondary evidence and knowledge of regional torture practices; (b) to make an assessment of the validity or reliability of these clinical findings.

Most experts already made both assessments, even if they were not explicitly included in the IP, but now, in the new formulation, they have become obligations.

The first part of Chapter IV is devoted to general recommendations, reiterating once again the need to comply with the ethical standards of the IP, as well as insisting on recommendations of good practice to create a trusting relationship between victim and interviewer and to minimise the risk of re-traumatisation. These aspects have already been developed in previous chapters. Some specific recommendations for interviewing victims of sexual and gender-related torture are now added in this chapter. The reader will also find recommendations for interviewing children and other vulnerable populations, especially those with severe post-traumatic stress disorder (PTSD) symptoms. In this regard, there is an analysis of transference and counter-transference reactions, as well as recommendations for the use of interpreters.

It is stressed in the text (as well as in other parts of the Protocol) that interviews with victims of torture should be conducted by trained and supervised personnel and, in the case of sexual torture and child sexual abuse, by persons with specific training in the field. In this sense, for example, it is strongly recommended that judicial authorities should not assume that every forensic expert is qualified to evaluate victims of torture, and a specific

analysis of the curriculum vitae as related to the assessment of torture victims is recommended. Regarding this, it is again reiterated that no greater value should be given to the reports of official forensic experts before independent examiners, without evaluating the level of qualification and merits of each of the different experts.

The 2022-IP insists, as in the previous version, on the need to integrate the assessments of the different professionals in a single report that includes the physical and psychological elements. In this version, another element is added: in the event that either the physical or psychological evidence strongly supports the allegations of torture, the report as a whole must reflect that there is strong evidence without erroneously contemplating that the physical evidence carries more weight than the psychological evidence, or that both types of evidence must be "positive", as had been observed on some occasions in the past.

**Table 2**. New ethical codes relevant to legal actors.

| | |
|---|---|
| Common Principles | • Duty to conduct themselves professionally and independently<br>• Duty to ensure equal treatment to all persons, including minimizing the risk of re-victimisation or trauma. |
| Judges | • Duty to promote and protect human rights – not concealing violations perpetrated by military, para-military or law-enforcement agents<br>• Duty to decide matters impartially in accordance with law according to the Basic Principles of the Independence of the Judiciary. Judges should have sufficient knowledge of the Istanbul Protocol and its Principles and ensure that they are applied by relevant parties.<br>• Promote protection from torture by (a) demanding that a suspect be brought before them at the earliest opportunity and check whether he or she is being properly treated (b) balancing acceptability of proof when there are allegations of torture, including suspension of the trial. No conviction should be done based solely on a confession obtained by means of duress or torture. |
| Prosecutors | • Duty to investigate and prosecute torture<br>• Duty to refuse evidence obtained through torture – exclusionary rule. The investigations of the allegations of torture should be performed by a prosecutor other than the one in charge of the initial criminal investigation.<br>• Duty of impartiality and objectivity, without pressures and with Independence from the State authorities<br>• Duty to ensure that State authorities respect the right to be free from torture, including guaranteeing that no illegal or improper method of obtaining evidence is used, monitoring places of detention requiring that interrogations are done before a judge, and prosecuting officials who are suspected of abuses. |
| Lawyers | • Duty to promote and protect human rights.<br>• Duty to treat their client's interests as paramount according to the Basic Principles of the Role of Lawyers<br>• Duty of Confidentiality |

**Table 3**. Review of ethical standards for health professionals.

| 2004 | 2022 |
|---|---|
| Global | |
| 1. Duty to act with independence.<br>2. Prioritise the interest of the patient above any other interest<br>3. Notify the authorities of all cases of abuse observed | 1. Not participate or collaborate actively or passively in acts of ill-treatment or torture, including participation in the interrogation of detainees or certification of the health status (fitness for interrogation).<br>2. Guarantee that people in detention centers are in conditions that do not deteriorate their physical or psychological health, including absolute respect for the Nelson Mandela Rules<br>3. Do not participate in situations of abuse that can be considered ill-treatment or torture specifically linked to the medical profession: forced-feeding of people on hunger strike, not providing analgesic treatment for coercive or punitive purposes, involuntary internment in medical or psychiatric institutions for unjustified reasons, medical or psychiatric interventions against the will of the patient, among others.<br>4. Obligation to report the observed abuses and to support fellow professionals (including subordinates) who carry out this reporting action. |
| During the exam | |
| 1. Informed Consent adequate in form and content and adapted to the capacity of understanding of the person, including mental capacity, age and culture.<br>2. Privacy – The right to examine and be examined in private, without limitations or restrictions.<br>3. Confidentiality – Report not delivered to detention or custody authorities. Obligation to notify the victim of restrictions on the duty of confidentiality when there are legal mandatory obligations.<br>4. Security assessment and prevention of the risk of retaliation | The same, plus:<br>5. Beneficence – In all the decisions that the health professional must make, act at all times in the best interest of the patient<br>6. Non-maleficence – Act following the criteria of above all, do no harm, especially in reference to the elements of relationship of trust, bond and minimizing the risk of re-traumatisation |

**Table 4**. Ethical dilemmas in situations of dual loyalty.

| 2004 | 2022 |
|---|---|
| Dual obligations | |
| | 1. Inform the patient of dual obligations<br>2. Maintain the primary obligation of the best interests of the victim and waive the assessment when this is not possible, providing alternatives.<br>3. Occasional exceptions to the duty of confidentiality when there is a risk to the life of the person being assessed or to third parties.<br>4. Document patterns of abuse anonymously and report such patterns to international or national human rights bodies |

New Chapter VII: Clarifying the role, duties and rights of doctors in primary care and hospitals (emergency room and others). Steps to follow:

1. Health professionals should seek to obtain the necessary training on the IP. Lack of necessary training is not an excuse to diminish ethical obligations. Lack of time, heavy workload or inadequate number of professionals is also not an excuse.
2. In non-legal contexts:
   c. Exclude any third parties from the evaluation room to ensure privacy, including any law-enforcement officer.
   d. Collect the account of events. Document the medical and psychological consequences.
   e. If previously trained, make a judgement of consistency and an opinion on the possibility of ill-treatment and torture.
   f. Provide a copy to the appropriate legal authorities and the patient, if requested. Do not provide a copy to law enforcement officials. Keep a copy in secure medical files.
   g. Make appropriate referrals and notify the authorities. If necessary, refer for new assessment with more experienced clinicians and specially when suspected sexual torture.

Chapter IV then establishes the necessary requirements regarding interview conditions: physical space, environmental conditions, position of the interviewer with regard to the victim and other elements relevant to building rapport. It also establishes the safeguard conditions in cases of assessment of persons in detention: the evaluation cannot be accepted by medical personnel who are attached to the same institution that carried out the detention unless there is a specific requirement from a judge. The transport and custody to the assessment room must not be conducted by the same persons who carried out the detention to avoid eventual intimidation and a lawyer must be present. The examination must be conducted in private and without the presence of third parties and the detainee shall be entitled to an independent assessment by a trusted medical or psychological personnel. The result of the assessment shall be given to the detainee or to the detainee's legal representative and a copy shall be kept by the clinician. Under no circumstances

**Table 5**. The seven principles of a proper investigation of torture allegations

1. Review the facts in detail to see if the criteria of the UN definition of torture are met, including severity of suffering, intentionality, alleged purpose and level of involvement of agents acting on behalf of the State. Special consideration should be given to facts that are based on a discriminatory motivation.
2. Timely, prompt, independent and effective investigation, even in the absence of an explicit complaint of the victim where there is sufficient grounds to suspect ill-treatment.
3. In the case of commissions of enquiry, having access to all sources of documentary information and having the legal capacity to interview witnesses and persons who may be implicated as perpetrators.
4. Ensuring measures of protection for the victims and witnesses.
5. Respecting victims' rights of complaint, information and hearing.
6. Acting with institutional independence from the alleged perpetrators.
7. Producing a proper forensic report in accordance with the principles of the Istanbul Protocol, including an opinion on the compatibility of the physical and psychological findings with a hypothetical situation of ill-treatment by torture.

shall it be given to custodial staff or to the institution where the person is detained in as far as they might be involved in the ill-treatment. The new Chapter IV also provides a detailed analysis of how security conditions and the risk of reprisals should be considered, with relevant guidance.

In short, the first part of the new Chapter IV is a practical and detailed translation of the ethical requirements set out in Chapter II.

The second part of this chapter deals with strategies for preparing the interview and building trust. It discusses the need to find a balance between a detailed account of allegations and the potential risk of re-traumatisation and, describes in more detail than in the previous version, the reasons why there may be inconsistencies. It also highlights the need for the clinician to make an analysis of the reasons for these inconsistencies based on the interview and the examination.

Finally, the structure of the interview is addressed in detail, following the same outline as detailed in the previous version of the Protocol. There are no substantial changes here, except for the list of potential methods of torture. The list has been updated to include in greater detail methods of torture with a mainly psychological component that were not previously covered in such detail.

The chapter ends with recommendations for the interpretation of findings. It retains the same five levels of consistency and states that consistency should be made on the basis of an overall consideration of all physical and psychological evidence, as well as other evidentiary elements. Furthermore, it states that a protocol that does not include an opinion on the possibility of ill-treatment or torture should be considered deficient. In this regard, it recommends including a causality analysis that attempts to link the evidence, the symptoms and the conclusions.

Two additional recommendations are made here: one concerning the suspicion of simulation or self-harm, in which case the new version of the Protocol indicates that the opinion of a second clinician, independent of the first, should be sought and demands that both give a concurrent judgement. The second one, regarding the analysis of reliability and credibility, establishes that it must stick to the clinical elements. It is not the purpose of the Istanbul Protocol to establish the credibility

of the victim, but only the reliability of the account of events and the evidence. Finally, the chapter reiterates, once more, that the absence of physical or psychological evidence does not rule out torture. In this regard, the chapter notes that a deliberate misinterpretation of the absence of evidence as an indication of the absence of torture may constitute a form of collusion with the perpetrators.

**Chapter V. Physical evidence.**

The following chapters, the most relevant from a forensic point of view, are the ones that have changed the least. Chapter V, on physical evidence, remains substantially the same. It maintains the structure of the examination, emphasising that the anamnesis and medical examination of torture does not consist merely of the observation of external injuries, but of a complete and detailed medical examination by apparatus. The chapter indicates - in the same way as in the previous version - which elements should be searched for systematically and in depth, extending the indications with regard to some situations that were not well covered before, such as the detection of signs of dry and wet asphyxia and, in particular, signs of sexual torture. Within this part, a special section - not existing in the previous version - is dedicated to the forensic analysis of female genital mutilation and the examination of signs of sexual abuse in men.

In the rest, all the considerations of the previous version are maintained, including the five levels of consistency and, as we will see later, the anatomical drawings and graphs are substantially improved and continue to be included in the annexes.

**Chapter VI. Psychological evidence.**

This chapter also retains the same structure as the previous version. It emphasises the central role of a psychological assessment. On the one hand, because it is key to document the psychological suffering of the victims and, on the other hand, because psychological damage often lasts longer over time as opposed to physical injuries that may not exist or may disappear quickly. This is why - the IP emphasises- psychological examinations should never be excluded in the assessment of a torture victim. Exclusively, medical examinations would not be considered complete or adequate.

The text details how the ultimate aim of torture is the destruction of the personality, reducing the person to a position of helplessness and dehumanisation. It stresses that not every victim of torture has to present a clinical psychiatric diagnosis, but that the damage can be expressed in other non-clinical ways, and warns - as it did in the previous version - about the uncritical use of the concept of PTSD and the need to understand suffering from a perspective that integrates cultural and religious beliefs.

The text then reviews the main psychological symptoms and signs that can be expected.

Finally, there is a review of the most frequent psychiatric diagnoses, without this being interpreted as meaning that the absence of at least one of these diagnoses, or the absence of PTSD, is incompatible with the existence of torture.

The chapter significantly expands the indications for neuropsychological examination and gives specific indications for the assessment of children. The judgement of consistency in five levels remains also unchanged.

In short, it is a chapter that updates the previous version without substantial conceptual changes.

**The new Chapters VII and VIII.**

The Protocol includes two new chapters. We have already discussed Chapter VII on the role of health professionals in contexts beyond de-

tention (see Table 4). Issues that have already been addressed in chapters II, IV and V are regrouped here and reiterated once more.

The new Chapter VIII is a set of recommendations for the development of public policies and civil society actions for the implementation of the IP in a given country. It is a roadmap of aspects to be taken into account by each of the actors involved in the prevention and documentation of torture and is therefore addressed to a very specific audience.

**The new (and old) annexes.**

There are no changes to the two annexes that constitute the heart of the IP: Annex I on the principles of effective investigation and documentation and Annex IV containing the model of report. Here, the revision has opted not to take risks and introduced changes that could eventually question past or ongoing legal proceedings. Annex II on diagnostic tests disappears and is integrated into chapters V and VI on physical and psychological examination, and Annex III, which includes anatomical drawings, is expanded to include new areas and outlines specific to the documentation of sexual torture (see table 1).

**So, what are the headlines for a hurried reader?**

We could summarise the headlines as follows:

1. The new text is three times the length of the previous one. This does not necessarily mean new elements, but that each chapter is seen as a unit in itself which, on one hand, increases its potential but, on the other hand, makes the text at times somewhat redundant and a difficult read.
2. The minimum ethical and legal conditions are basically maintained, although some details are expanded:
   - The basic principles and minimum standards to conduct proper research are clarified and further developed.
   - Deontological and good practice requirements and duties for the physician are slightly expanded with two new requirements; and clarified, especially in contexts other than detention.
   - Ethical and deontological requirements for the legal professions are now included.
3. The clinical and forensic part is the least changed.
   - Annex IV remains the same and the guidelines for medical and psychological examination keep the conceptual core and structure.
   - The elements that were scattered in terms of interview recommendations are extracted and grouped together in a reinforced Chapter IV, which becomes essential for reading and may be the most important chapter for professionals who will use the Protocol in direct contact with victims.
   - The forensic expert in this new version must go further in his or her conclusions and must now (a) give an expert opinion on the possibility of the existence of ill-treatment or torture and (b) make, when required, an assessment of the validity or reliability of the clinical findings.

   In addition
   - Specifically included are guidelines for sexual and gender-based violence and for the assessment of children.
   - Diagnostic tests are updated, including recommendations for taking photographs, and forensic anatomical drawings are improved.

**Some final comments.**

As explained at the beginning, a first impression when confronted with the new Protocol can be overwhelming, but a closer examination shows that if the parts that each professional profile requires in their work are well selected, the update can be integrated with relatively easy for those accustomed to using the previous version of the Protocol. If you are a lawyer, you can focus on the initial two chapters and have a look at Chapter IV. If you are a medical doctor, keep Chapter IV and Chapter V on your desk for detailed reference, and if you work in primary care or a hospital practice, add Chapter VII. If you are a mental health professional, focus on reading Chapter IV and Chapter VI.

The text has undeniable redundancies. For example, the doctor's duty to report suspicions of ill-treatment or torture is explained or reminded on up to twelve occasions along the text[5]. And these redundancies can sometimes lead to minor dysfunctions: for example, we are informed in Chapter II (pg. 38) that it is better to interview minors alone so that they can speak freely, in Chapter IV (pg. 72), that it is better for the interviewer to decide on a case-by-case basis and in Annex II (pg. 133) that it is better for parents or guardians to be present if there are no solid reasons to the contrary. These, are in any case, small and detailed elements of minor relevance, and do not compromise the soundness of the new and long-awaited IP.

The potential of this new version is enormous. It is now up to us to take advantage of this huge effort of so many hundreds of people in work groups, and to spend hours squeezing it in and making the most of its 220 pages.

In conclusion, the field of torture documentation and prevention is in for a treat. With the publication of the new version of the IP, a giant step forward has been taken by capitalising on the experience of fifteen years of using it in a solid, strong and impressive text, destined to be the guiding light of work in the fight against torture for decades to come.

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**Other languages**

On-line versions available in French (*La version 2022-révisée du Protocole d'Istanbul: kit d'orientation pour les personnes en situation d'urgence*) and Spanish (*La versión revisada de 2022 del Protocolo de Estambul: kit de orientación para personas con prisa*).

5 Points 148, 149, 155, 162, 173, 177-182, 273, 603, 611, 622, 631 y 665.

# Hunger and torture. Assessing the adequacy of prison food under international law

**Ergun Cakal**[1]

**Abstract**

*Background*: Deprivation of prisoner food, in terms of its quality and quantity, has generally been accepted as violating the prohibition of torture and related ill-treatment, particularly when combined with other factors (i.e., harmful conditions and practices). Aspects relevant to assessing when and how food provision is considered inadequate, however, remain complex and confusing. This article presents a doctrinal review which consolidates normative understandings of adequate prisoner food.

*Method*: A systematic full-text search was made of international and regional normative standards, case-law and commentary in relevant databases. These were then selected based on their relevance for regulatory and explanatory specificity and pertinence to detention contexts.

*Findings*: International and regional bodies directly connect the adequacy of food to respect for dignity, freedom from torture and ill-treatment as well as the right to health – and particularly as depending on duration, quality, quantity and variety. What constitutes inadequate food remains complex as it is contingent on both material and non-material considerations, including its quality (content, nutritiousness, edibility, variety, wholesomeness), its quantity (calorie, substantiveness, balance), its preparation (hygiene, respect to the individual and community), its provision and consumption (when, how and where it is to be eaten, regularity, accessibility, warmth/cold), its socio-cultural suitability (to religious and cultural values) and its developmental suitability (for pregnant or breast-feeding mothers and children).

*Keywords*: denial, deprivation, manipulation, food, nutrition, hunger

> *Apart from sleep, the only time a prisoner lives for himself is ten minutes in the morning at breakfast, five minutes over dinner, and five at supper […] You got an extra six ounces of bread for your supper. A couple of ounces ruled your life.*
>
> Solzhenitsyn, 'One Day in the Life of Ivan Denisovich'

## Introduction

Food (or more broadly "nutrition")[1] is accepted as a basic human need next to water,

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https://doi.org/10.7146/torture.v32i3.128479



1 According to the International Committee for the Red Cross (hereafter: "ICRC") (2021: 31), "'[f]ood' refers to edible items, and the term 'nutrition' to the metabolic impact on individuals of what they eat".

sleep, health care, sanitation and accommodation under international law (Rule 42 of the UN *Standard Minimum Rules for the Treatment of Prisoners* (the Nelson Mandela Rules) (2015)). Put simply, the power to detain "comes with a corresponding responsibility to provide for basic needs, including food, adequate shelter and medical care, and to protect detainees from serious threats of harm" (UN Office of the High Commissioner for Human Rights (UNOHCHR) 2020: §18). Unsurprisingly, according to the World Health Organisation (WHO 2021), the "quality and quantity of food available in a prison has a major influence on the quality of a prisoner's life". The ICRC (2021:31) underscores it to be "an important and complex issue in prisons".

In practice, however, quality food and water are scarce in prisons around the world and usually have to be supplemented by prisoner families (Amnesty International 2016: 215-216). The UN Office of Drugs and Crime (UNODC 2016: 57) observes that "complaints about quality and/or quantity of food are among the most common" received (see e.g., UN Subcommittee for Prevention of Torture (SPT) Portugal 2019: §69: where complaints "ranged from food smelling rotten or being too greasy to reports of foreign bodies such as cockroaches and other insects in the food served"). As such, it is a standard aspect of life in detention that is attended to by monitoring bodies as a general rule. The ICRC (2018: 150) points out that "[s]carcity or perceived scarcity of food is a threat to detainee and staff safety, making reliable and fair access to food critical to the effective management of prisons". Therefore, the lack of food (whether intentional, incidental or structural) is generally taken to affect prison(er) life and health in a multitude of ways.

More directly, food has also long been a medium of "physiological influence during interrogation and detention" (DIGNITY 2018: 1). Deprivation (or withholding) and manipulation (or contamination) of prisoner food, therefore, in terms of its quality and quantity, and due to systemic and specific reasons, has generally been interpreted as amounting to ill-treatment, particularly when combined with other factors (conditions and methods). Mindful of the differences here, the UN *Istanbul Protocol* (UNOHCHR 1999/2004) refers to techniques involving food *as part of conditions of detention* (as "irregular or contaminated food") and *as deprivation of a basic need* (restriction of food) (§§145, (m)-(n)).

Additionally, this article adopts the conceptual approach outlined by Pérez-Sales (2020: 3), defining food deprivation as "food intake below the dietary required minimum energy level" and food manipulation as "the quality, aspect, taste or contamination of the food provided to an individual". These are understood by Pérez-Sales (2020: 6) to be "[s]hort-term or partial restrictions in food quantity, including food insecurity, or food of low quality or which is provided in a denigrating manner" compared to starvation and famine which are taken as "[p]rolonged and sustained restriction in the access to food that causes undernutrition and, ultimately, compromises life". As borne out by the literature, manipulation can amount to *de facto* deprivation due to the prisoner's inability and unwillingness to consume the inedible food on offer.

Despite such wide recognition of its significance to prisoner well-being, the normative understanding of adequacy remains to be consolidated in the literature. The following presents a comprehensive doctrinal review of the existing norms and commentary related to the regulation of food, primarily in detention settings. The use of food to harm in non-custodial contexts, such as mass starvation and famine, as well as force-feeding and

hunger strikes will not be covered here due to lack of space.

A systematic full-text search of international and regional normative standards, case-law and commentary was conducted using the UN Official Documentation System (UNODS), European Court of Human Rights' HUDOC and CEJIL's database on the Inter-American human rights system.with the keywords 'food', 'nutri*', 'diet*', 'calorie*', 'meal*', 'ration', 'eat*' and 'starv*'. These were then selected based on their relevance for regulatory and explanatory specificity and pertinence to detention contexts. Based on this search, part II compiles the international and regional hard and soft-law standards. Part III surveys the international and regional case-law. Part IV draws on the leading commentary towards offering a practically oriented discussion qualifying deprivation of food as torture or ill-treatment.

## Standards

This section provides an overview of the relevant international and regional standards which relate to the provision of food to prisoners. It draws heavily on international human rights law but also to some degree on international humanitarian law and historical developments wherever useful. At the most fundamental level, food is intrinsically linked to the right to health (and thus the right to life, though this has been underargued). Article 25 of the *Universal Declaration of Human Rights* states that "[e]veryone has the right to a standard of living adequate for the health and well-being of himself [...] including food". This is embodied in article 11 of the *International Covenant on Economic, Social and Cultural Rights.* UN Committee on Economic, Social and Cultural Rights' General Comment 12 on the right to adequate food (1999: §14) clarifies "minimum essential food" as "sufficient, nutritionally adequate and safe, to ensure their freedom from hunger".

The detention-specific point of departure here is Rule 22 (1) of the UN *Nelson Mandela Rules* which requires that "[e]very prisoner shall be provided by the prison administration at the usual hours with food of nutritional value adequate for health and strength, of wholesome quality and well prepared and served". The "quantity, quality, preparation and service of food" is also made subject to the inspection and advice of a physician or a competent public health body (Rule 35 (1)(a); see also *European Prison Rules,* Rule 44 (1)). These formulations have been maintained verbatim since the Rules were originally drafted in 1955 (as simply the *Standard Minimum Rules*). An important change has been that the "reduction of a prisoner's diet or drinking water" is now prohibited as a disciplinary sanction (Rule 43 (1)(d); see also Principle XI of the *Principles on Persons Deprived of Liberty in the Americas*). Additionally, whilst the prison administration remains the principal provider of food, the *Mandela Rules* also foresee that food can be obtained by prisoners from outside the prison at their own expense or through their family or friends (Rule 114; see also *European Prison Rules,* Rule 31.5 – although this cannot be said to absolve state of their obligations). The recently finalised *Principles on Effective Interviewing for Investigations and Information Gathering* ("the Mendez Principles", Association for the Prevention of Torture et al. 2021: Principles 70 and 111) also render "adequate food" as a necessary condition for an interviewee's mental and physical state throughout a police interview.

Particular attention is also drawn to dietary requirements according to developmental considerations (i.e., pregnant or breast-feeding women, children: Rule 48 of the UN *Bangkok*

*Rules* ("adequate and timely food"); Principle X ("nutritional services"; UN *Havana Rules*, Rule 37 requires that "every juvenile receives food that is suitably prepared and presented at normal meal times and of a quality and quantity to satisfy the standards of dietetics, hygiene and health"). Regional frameworks offer similar but more expansive formulations in these respects. The recently revised *European Prison Rules* require that prisoners be "provided with a nutritious diet that takes into account their age, health, physical condition, religion, culture and the nature of their work" (Council of Europe (CoE) 2020: Rule 22.1), with "its minimum energy and protein content" to be prescribed in national law (Rule 22.3) and that there must be "three meals a day with reasonable intervals between them" (Rule 22.4). Principle XI (1) of *Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas* for instance requires that food be "in such a quantity, quality, and hygienic condition so as to ensure adequate and sufficient nutrition, with due consideration to their cultural and religious concerns as well as to any special needs or diet determined by medical criteria".

International humanitarian law has also long been concerned with the provision of food to those deprived of liberty (See e.g., *Convention relative to the Treatment of Prisoners of War* 1929. article 11; *Geneva Convention IV*, article 89 ("Expectant and nursing mothers and children under fifteen years of age, shall be given additional food, in proportion to their physiological needs"); *Geneva Convention II*, article 5 (1)). Article 26 of *Geneva Convention III,* of particular note, requires that:

> *The basic daily food rations shall be sufficient in quantity, quality and variety to keep prisoners of war in good health and to prevent loss of weight or the development of nutritional deficiencies. Account shall also be taken of the habitual diet of the prisoners. The Detaining Power shall supply prisoners of war who work with such additional rations as are necessary for the labour on which they are employed. […] Prisoners of war shall, as far as possible, be associated with the preparation of their meals; they may be employed for that purpose in the kitchens. Furthermore, they shall be given the means of preparing, themselves, the additional food in their possession. Adequate premises shall be provided for messing. Collective disciplinary measures affecting food are prohibited.*

This jurisprudence adds to the discussion in three important respects: work-related and socio-cultural individuation as well as general notions of calorie consumption. To take calorie consumption first, "basic daily rations", according to the ICRC Commentary (2020: §2112), must be sufficient as to prevent weight loss or nutritional deficiencies. The Commentary (§2113) goes onto outline that a balanced diet considers climactic conditions as well as age and health needs and to consist of:

> *ingredients from each of the main food groups: staples (such as grains, cereals, roots or tubers), protein sources (such as pulses, beans, dairy products, meat, fish, etc.); fats and oils (such as butter, vegetable oils, oily seeds, etc.); and vegetables and fruit (such as spinach, tomatoes, carrots, broccoli, oranges, mangoes, berries, etc.). These food groups provide the required energy, protein, fibre and micronutrients for optimum health.*

Beyond its material importance for physical health, food is laden with values and beliefs. The ICRC Commentary (§2106) states that, instead of thinking strictly in terms of equality, the detaining power should take into account the "habitual diet" of prisoners of war. The term "habitual diet" is taken to mean food

that is consistent with prisoners of war's usual diet given that, although the food provided by detention authorities may ostensibly be adequate, it may reasonably the refused by detainees due to "cultural or religious practices" (ICRC 2020: §2121). This entails detaining authorities consulting on and understanding what the prisoners usually eat and how they eat (including acceptable mealtimes particularly when associated with religious values) (ICRC 2020: §§2121-2123). Such requirements to adequate food are also part of customary international humanitarian law (ICRC 2005: Rule 118). Such non-material considerations will be returned to.

By way of illustration, the requirement around rations and consideration of work tasks came into play in the *Duch Case* (ECCC 2010: §§268-269, 278, 457), where the Extraordinary Chambers in the Courts of Cambodia (ECCC) linked the inadequacy of food to expectations which arose from "arduous physical work involved in digging dykes and canals, and transplanting rice" (§229) as

> *Food rations were extremely scarce and usually consisted of rice gruel, rice soup or banana stalk served twice a day. Guards would scoop the food from a bowl into mugs or plates and order the detainees in the common rooms to distribute it among themselves. Due to the scarcity of food, detainees resorted to eating insects that fell on the floor, for which they could be beaten if a guard saw them. [One witness] described being so hungry that if he had been offered human flesh, he would have eaten it. […] Consequently, detainees suffered severe weight loss and became extremely weak. The Accused acknowledged that the deprivation of adequate and sufficient food was deliberate and meant to debilitate the detainees in order to maintain control over the prison population, prevent riots and facilitate the generation of confessions.*

Moreover, the European Committee for the Prevention of Torture (CPT) has been a distinctly close and consistent observer of food in places of detention. Its recommendations have added a degree of clarity to what is meant by adequacy, including that: it means "at least one full meal (i.e. something more substantial than a sandwich) every day" (CPT 2015: §§42 and 47); that pregnant "women prisoners […] should be offered a high protein diet, rich in fresh fruit and vegetables" (CPT 2002, §26); that inadequacy relates to "lack of variety and low protein content" (CPT Italy 2020: §1); that where detainees are restrained they should be "enabled to eat and drink autonomously" (CPT Bulgaria 2020, §40); that "food is served to inmates using appropriate equipment (such as food containers and trolleys" and that "residents are provided with proper cutlery to eat their meals and are encouraged and, if necessary, assisted by staff to use it" (CPT Moldova 2020, §§69 and 166); and that "meals should be eaten communally" and not so early in the afternoon that prisoners have "to wait almost 16 hours before their next meal" (CPT Ireland 2020, §67; see also CPT England 2020: §173).

Whilst this all seems context-specific, qualified and considerate enough, there is still a clear lack of operational clarity. How are we to assess adequate quality, quantity, substantial, nutritional value, especially that which avoids the violating the prohibition of torture and ill-treatment? Do we for instance take it as meaning *optimum* for well-being or as the *minimal* for survival? From a legal perspective, there are two complications. One complication is that violations of these prison rules, whilst indicative (as soft-law standards), are not automatically constitutive of torture or another

form of ill-treatment. The CPT, it should be acknowledged, does not hold its standards as being absolute and rejects any assessment, given the possibility of alleviating factors, that a "minor deviation from its minimum standards may in itself be considered as amounting to inhuman and degrading treatment of the prisoner(s) concerned" (CPT 2015: §21). The second is that deprivation of food is often associated with prison conditions or as part of a combination of other techniques (nowhere so clearly witnessed as in the European Court case of *Ireland v. UK* where the so-called "five techniques" consisted subjecting "detainees to a reduced diet during their stay at the centre and pending interrogations" (§96) (specifically "a diet of one round of bread and one pint of water at six-hourly intervals": Separate Opinion of Judge Zekia). With these qualifications, what more can be said (if anything)? This will be asked of the reviewed case-law.

### Case-law

This section presents the most representative case-law illustrations where deprivation or manipulation of food amounted to torture or ill-treatment. Systematic full-text searches were conducted in electronic official databases of the UN Human Rights Committee (HRC), UN Committee Against Torture (CAT), European Court of Human Rights (ECtHR), the International Tribunal for the Former Yugoslavia (ICTY) and the Inter-American Court of Human Rights (IACtHR).[2]

As with the standards compiled above, there is no shortage of case-law alluding to food deprivation, starvation and hunger as torture or ill-treatment. Such instances are almost always remarked upon in combination with other factors. They are mentioned briefly as the "lack of food" (HRC, *Sendic v. Uruguay*, §§2.3, 2.4, 20), that "the food [provided was] deficient" (HRC, *Polay Campos v. Peru*, §§2.1, 8.7), that the prisoner was "denied food and water" (CAT, *Danilo Dimitrijevic v. Serbia and Montenegro*, §§2.2, 7.1, CAT, *Abdulrahman Kabura v. Burundi*, §7.8; HRC, *Franck Kitenge Baruani v. Democratic Republic of Congo*, §2.4), or that the food was "sparse and spoiled" (ICTY, *Nikolic*, §57). There are numerous cases in which adjudicatory bodies describe the content of the food a bit more spaciously. In *Cariboni v. Uruguay* (HRC, 1987: §10), the victim was provided with "usually a very hot clear soup with hardly anything in it […] and nothing else". In *Déogratias Niyonzima v. Burundi* (CAT, 2014: §9), the victim was "served disgusting food consisting of beans and rice crawling with insects". In *Juvenile Reeducation Institute v. Paraguay,* the IACtHR found that the food was: "not fit for human consumption because it was prepared on the bathroom floor", "horrible", "almost always beans with stew", "pig's slop" causing illness (see §§16, 18, 25, 147). In another widely cited case from the IACtHR of *Miguel Castro Castro Prison v. Peru*, "kerosene, camphor and rat skin", "small rocks" and "grounded glass, urine... rat parts [were in the food, which was not provided] warm or at adequate hours" (§§37, 51, 105). The way detainees were forced to eat attracted similar levels of judicial attention: that the prisoner had to eat "by kneeling on the floor and using the same chair as a table [and using their] fingers to eat soup" (HRC, *Cariboni v. Uruguay,* §4); with "three minutes to eat, then one minute to return to their quarters (ICTY, *Kvocka*, §§15, 64, see also ICTY, *Prlić*); "all detainees had to eat standing up"

2 The IACtHR does not provide detailed guidance (as compared to other regimes) beyond recognising (in *Pacheco Teruel v. Honduras*, para. 67 (d)) that "the food provided in prisons must be of good quality and sufficient nutritional value".

(ECtHR, *Istratii and Others v. Moldova*, §62); or blind-folded (HRC, *Giri v. Nepal,* §2.4). The HRC has also considered on occasion the deprivation of food to violate article 10 (respect for dignity of detained persons) of the *International Covenant on Civil and Political Rights* (see HRC, *Basnet v. Nepal* 2014: §8.6; HRC, *Aber v. Algeria* 2007: §3.4).

The ECtHR has also handed down a number of judgments concerning food and article 3 (prohibition of torture and ill-treatment). In the case of *Kadiķis v. Lithuania* (no 2), the ECtHR explicated the connection between the right to health and the right to food stating that the obligation of national authorities to ensure the health and well-being of a general detainee implies, among others, the obligation to provide adequate nutrition (wherein the Court also called into question the frequency of meals, §55; see also *Stepuleac v. Moldova*, § 55). In the case of *Moisejevs v. Latvia,* which concerned a pre-trial detainee who was denied adequate food on days he was transported to court hearings (being offered only a slice of bread, onion and a piece of fish or meatball or simply a bread roll), the ECtHR found this to be insufficient to meet the body's functional needs and having increased his psychological tension, holding it to amount to inhuman and degrading treatment under article 3 (see also *Starokadomskiy v. Russia*, § 58). In *Ebedin Abi v. Turkey*, the diabetic applicant was not provided with meals compatible with the diet that doctors had prescribed for him and experienced a deterioration in his health as a result. Rejecting the state's argument on economic grounds, this was held to amount to inhuman or degrading treatment (see §§31-54).

Outside the detention setting, in *MSS v. Belgium and Greece*, the ECtHR confirmed that the scope of article 3 (prohibition of torture and ill-treatment) also extended to a state's failure to act in "a situation of extreme material poverty" or "serious deprivation of [most] basic human needs" including food, hygiene and shelter (§254). In *Modârcaˇ v. Moldova*, which concerned an application where numerous basic necessities such as heating, ventilation, bedding and space were not adequate as well as daily expenses for food limited to 28 Euro cents for each prisoner, referring to a CPT report which described food at the same prison as "repulsive and virtually inedible" (§67), the ECtHR ruled that the treatment amounted to a violation of article 3 (unspecified). In *Ciorap v. the Republic of Moldova* (§36), the ECtHR interestingly ruled that:

> *while the absence of specific [meat and dairy] products from the menu does not, of itself, amount to treatment contrary to Article 3 of the Convention, it is to be noted that the nutritional tables and menus in prisons already represent the minimum of food as determined by the domestic authorities. Failure to provide even that minimum, and doing so for prolonged periods of time as in the present case, puts at risk the health of detainees […] and is incompatible with the State's obligations under Article 3 of the Convention. [inhuman treatment]*

The danger of food allergies have also been argued to raise significant issues (albeit unsuccessfully before the European Commission of Human Rights (ECommHR) in *Nevaro v. Finland* (see also the death of Michael Saffioti due to food allergies in prison, Washington Post (2014)). Nutrition needs of breastfeeding mother in prison have also been recognised (*Korneykova and Korneykov v. Ukraine*, § 141). Prisoner requests for a special diet based on religions considerations and motivations were accepted as reasonable in *Jakóbski v. Poland* (see § 45-55) (where it was linked to

the freedom of religion under article 9) and *Vartic v. Romania* (no. 2) (see §35). In the case of a Jewish prisoner requesting kosher meals, in *Erlich and Kastro v. Romania*, however, the Court assessed the demands that kosher food preparation entailed as onerous to the state and found no violation of article 9. In sum, special dietary and nutritional needs due to religion, health or contextual circumstances (transportation as discussed) have been attended to by the ECtHR at some length.

Yet, in most other cases where the quality, quantity and variety of the food is fleetingly remarked upon (e.g. *Mozer v. Moldova and Russia*: "the food was scarce and inedible […] full of worms and made from rotten produce", see §§29-31) or the manner in which it is served is noted (*Todorov v. Bulgaria:* "without cutlery" and that prisoners were forced to eat with their fingers: §52) a useful elaboration of how these were weighed in the overall finding does not exactly follow. How similar factual scenarios diverge in being found to either violate the prohibition of torture and ill-treatment or the respect to dignity is also unclear. Such opaque reasoning is not particular to food violations. We are left to deduce the implicit reasoning, as is attempted in the following discussion.

## Commentary and discussion

There are tens of additional cases involving comparable factual scenarios ending with similar vague reasoning as to how significantly the deprivation of food weighed in the overall decision-making. Hunger is a complex matter and contingent on numerous factors beyond a simple calorific intake. How does one therefore quantify 'adequate', 'appropriate', 'usual', 'timely', 'sufficient' and 'edible'? Legal prescriptions are often detached from practical realities and experiences of prisoners. Laws and standards have "largely been drafted without considering their meaning in terms of architecture and design" (ICRC 2018: 9), or implementation for that matter. Needless to say, this is not restricted to food but also applies to conceivably any issue relating to prison regime. By one prominent take, generality in legal language performs the function of bringing in "principles or policies lying beyond the rule" (Dworkin 1977: 28). As the research here suggests, prescriptions of "adequate" operate in a similar manner. Legal practitioners are left with homework in explicating specifics. Harm inflicted through food, whether in terms of its deprivation or manipulation, in the context of an assessment of torture and ill-treatment runs through two main elements of the international definition of torture in article 1 of the UN *Convention Against Torture:* namely, *severity* and *intentionality*. In other words, deprivation of food in prison will clearly satisfy other elements of the definition (namely, official involvement and purpose) but be challenged on these two. In the following, a critical discussion is offered in better appreciating these interpretative terrains.

### *Severity (and duration)*

Mindful to avoid an iron-clad causality, we can safely say that deprivation is indicative of harm, especially when what is deprived is as basic as the nutrients to physically and cognitively function as a human. Harm is also contingent on prevailing societal expectations of dignity. Harms inflicted through the deprivation or manipulation of food, therefore, centre on both physiological and non-physiological aspects. Physiological harms entail considerations of content, calories, quality, quantity, variety and regularity, whilst non-physiological harms entail emotional reactions borne out of socio-cultural-political-religious disregard and discrimination in how food is prepared, served and consumed, and its symbolic

(and psychic) impact on prisoner autonomy and identity.

The physiological considerations focus on the material nourishment a human body requires to function physically and cognitively. From a physiological perspective, a recent systematic review of medical literature (DIGNITY, 2018: 1, *references omitted*) on food deprivation clearly links adequate nutrition and health consequences as follows:

> *A diet that repeatedly lacks adequate nutrition intake leads to malnutrition which can weaken the immune system, delay wound healing, cause pain, and disorientation. Symptoms of malnutrition include dry and scaly skin, swollen gums, weight loss, thinned hair, and decaying teeth. Consistent food deprivation results in starvation which can lead to profound weakness, the inability to sustain even the smallest physical efforts, frailty, depression, apathy, increased urination, brady- cardia (slowed heart rate), hypertension, constant chills, fatigue, reduction in circulation and cardiac function, and increased risk of infections e.g., pneumonia, tuberculosis and gastrointestinal infections. Ongoing food deprivation may lead to death in 8-12 weeks. Studies examining the effects of food deprivation have found that food restrictions under circumstances of stress causes deficits in cognitive functions, impairs short-term memory and can lead to depression. Furthermore, poor diet coupled with lack of hygiene can lead to vitamin deficiency syndromes, a host of malnutrition diseases and death due to dysentery.*

Calorific intake has been one lens through which adequacy (and severity) has been approached. This discussion remains unsettled. Pérez-Sales (2020: 15) proposes that prolonged food deprivation, which he defines as "less than 2000 calories/day for more than two weeks" that "produces severe suffering in almost all human beings and that should, in most if not all cases, at least from a medical point of view, amount to torture". More recently, the ICRC (2021: 43) has promoted the understanding that the

> *human body needs a diet of adequate quantity (sufficient amount of kilocalories, or kcal) and quality (balance among the various food groups) in order to maintain health. […] Because all the nutritional requirements cannot be met by only one meal, a minimum of two meals should be served each day. The energy content of detainees ration should be 2,400Kcal at least.*

The ICRC *Commentary to Geneva Convention IV*, relatedly, notes that the 1947 Government Experts assembled to debate the possibility "to refer to the calorific value of the food […] rejected [such a solution] because of the difficulty of fixing a value which would be suitable in all latitudes and also because of the difficulty of giving sufficient details regarding the distribution of the calories to meet all cases". Furthermore, according to the Commentary to the *Model Detention Act* (van Zyl Smit 2011), a detaining authority:

> *… should take appropriate advice from international agencies (such as the ICRC and United Nations bodies) on what constitutes a nutritious diet. The UN Food and Agriculture Organisation (FAO) recommends 1800 kcal per person per day as a minimum energy intake. A diet which drops below this minimum requirement cannot be justified by lack of resources.*

The standards and caselaw above also consider the non-material aspects of food which, though related to material physical needs, un-

derscore the potent harms which can arise from the disregard of a prisoner's social, cultural, religious values and beliefs. This can be experienced "as a form of dehumanisation, humiliation and denigration" thus constituting "a powerful method to produce severe suffering and break identity" (Pérez-Sales 2020: 14). Non-physiological harms focus on the non-material meaning attributed to food, in terms of prisoner perceptions of fairness and experiences of punishment. As such, food becomes central to punishment, underscoring a prisoner's powerlessness, which can easily amount to degradation at the very least.

Related to the discussion here is the use of "minimum level of severity" test to assess whether the alleged conduct falls in the scope of the prohibition against torture and inhuman and degrading treatment. What role does this actually involve or serve? This serves as a lower threshold that encompasses a broader assessment than that simply of pain, though that too is included. It draws in considerations of "duration of the treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim" (*Ireland v. UK:* §162). For the ECtHR, it also serves a role analogous to article 1 of UNCAT's "lawful sanctions clause" – in that it seeks to exclude altogether forms of treatment that are viewed by adjudicators as being lawfully inherent to criminal justice practice. The Court has interpreted this in various ways as something other than difficult or "undoubtedly unpleasant or even irksome" (*Guzzardi v. Italy*, §107) requiring the conduct in question to be "discreditable and reprehensible", "distressing and humiliating" or "interfering with human dignity" (*Raninen v. Finland*: §50). When determining degrading acts, the Court has looked for treatment which "grossly humiliates [the victim] before others or drives to act against his will or conscience" (*Greek Case* 1969: §186) or "showing a lack of respect for or diminishing his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance" (*Strelets v. Russia*: §54).

From a legal perspective which holds fast to case-by-case analysis, there can of course be no hard and fast rules given the differences in individual needs based on age, sex, health etc. Given that a relative assessment is always needed, we can only take calorific numbers as guidance, albeit needed and useful for a practitioner. What can be confidently said is that the severity of pain arising from the deprivation of food can be based on duration (ICTY, *Prosecutor v. Krnojelac*, 2002: §183). The unclarity of the duration (also in terms of whether the deprivation was total or partial) has been commented on in a number of cases (including HRC, *Mika Miha v Equatorial Guinea*, 1994, §§6.4 and HRC, 1997, *Hill v Spain*, §13). The duration of deprivation is reasoned to therefore be associated with deterioration of well-being and, in turn, the accumulation of prisoner's pain. The case-law generally supports the reading that prolonged denial of an adequate quality or quantity of food enters the domain of at least ill-treatment. There is no requirement that there is total deprivation though that will likely move decision-makers towards a finding of torture – as severity and intentionality can be more strongly established in such a scenario. Complexity abounds.

*Intentionality (and omission)*

Standard discussions related to assessing food deprivation as torture also relate to intentionality and omission, as article 1 of the UN *Convention Against Torture* requires that severe pain must be inflicted intentionally for an act to constitute torture. An omission (a negative act) is likely to amount to torture as is a commission (a positive act), as it is

widely accepted that nothing in the drafting would indicate that "the drafters intended a narrow interpretation that would exclude conduct such as intentional deprivation of food, water, and medical treatment from the definition of torture" (Nowak 2006: 819; see also Nowak and McArthur 2008: 66). Boulesbaa (1999: 14) similarly finds that it would be "absurd to conclude that the prohibition of torture in the context of Article 1 does not extend to conduct by way of omission" (see also Rodley and Pollard 2006: 120). This was derived from the ECommHR's finding in the *Greek Case* (1969: 461) that "the failure of the Government of Greece to provide food, water, heating in winter, proper washing facilities, clothing, medical and dental care to prisoners constitutes an 'act' of torture".

Despite these understandings, the element of intent underscores action and commission in contrast to omission as that is in some ways associated with negligence. The ICTY has itself pointed this out where it stated that "the most characteristic cases of torture involve positive acts" (see *Prosecutor v. Delalić et al.*: §468; *Prosecutor v. Kunarac*: §483; *Prosecutor v. Brđanin*: §481). Following the Greek Case, it was only in 1998, in *Kurt v. Turkey*, where the Turkish state failed to investigate the applicant's son's disappearance that the ECtHR found that an omission amounted to an article 3 violation (and not torture at that).

The conventional understanding has it that intentionality can be easily discerned. The differentiation between intentionality (and towards torture) and negligence (and towards another form of ill-treatment) is often illustrated in the following scenario (UN Special Rapporteur on Torture (SRT) 2010: §34):

> *A detainee who is forgotten by the prison officials and suffers from severe pain due to the lack of food is without doubt the victim of a severe human rights violation. However, this treatment does not amount to torture given the lack of intent by the authorities. On the other hand, if the detainee is deprived of food for the purpose of extracting certain information, that ordeal, in accordance with article 1, would qualify as torture.*

When referring to intentionality, Boulesbaa (1999: 20) argues:

> *The term, however, serves a very important function because it implies the exclusion of negligent conduct from the application of Article 1. The question then becomes: When does a particular conduct cease to be considered merely negligent. There is no reference to the particular conduct ceasing to be considered merely negligent. There is no reference to the question at any stage in the drafting of the Convention. In many systems of law, however, 'intent' is defined in terms of 'specific' and 'general intent', and negligence is determined by the reasonable standard under the circumstances. Thus, when a State fails to provide food and water to prisoners in its custody and is accused of torture by way of omission, such State would not be able to escape liability by claiming that its conduct was not intentional but was merely negligent outside the scope of Article 1.*

This is further complicated from a macro perspective as there are clear systemic sources of the deprivation of food implicating resource limitations due to lack of funding, overcrowding and corruption (including where food is taken out of prison by staff and sold for profit (see, e.g., SPT Paraguay 2011: §60)). There is no question that "[s]ignificant financial resources are required in order to ensure its regular supply" (ICRC 2021: 31). Furthermore, the characterisation of the right to food

as a fundamental economic and social right also contributes to distorting the deprivation of food in detention contexts. This is due to the right to health being understood through a developmental prism and as less than justiciable and enforceable. When violations of such rights are pervasive, the law tends to attend to specific cases that are somehow aggravated and thus individuated. Otherwise, individual perpetrators and victims become difficult to identify. Whilst there is nothing in article 1 of the UNCAT that explicitly requires identifying an individual, this emerges as an implicit yet important processual requirement. More attention to the circumstantial and contextual is warranted.

A case-study on starvation in Haitian prisons, over a period where the prison population doubled without any increase in funding, directly implicates governmental decisions concerning prison food budgets in the ensuing harms (Schechter 2003: 1255-1256). Schechter thus argues that this can only be characterised as acquiescence, intentional and purposeful as it facilitates additional punishment and coerces prisoners to pay prison officials. She argues that intent is established as

> *the government knows that its budget is inadequate to meet the needs of the prison population. The prison administrators satisfy general intent either by tolerating the guards' thievery of the food with willful blindness or by stealing along with the prison guards. The guards fulfill the intent requirement by keeping the food from the prisoners, an act that clearly deprives the inmates of food and results in their suffering.*

This cannot be said to be limited to Haiti as the UNODC (2010: 13) has observed that the prison food budget

> *… will rarely increase sufficiently to meet the nutritional requirements of the growing number of prisoners. Indeed especially in low-resource countries there will be no change in the budget allocated for food, thus prisoners will need to rely on additional food from their families and/or suffer the consequences of inadequate and low quality food. This will severely compromise prisoners' health. In the worst cases it can lead to prison deaths due to malnutrition.*

A notable international authority who has paid special attention to prison food has been the UN SRT whose reports, particularly those from Manfred Nowak's tenure, are dotted with remarks on inadequacy of food. Beyond individual complaints about inadequacy of food, one way of quantifying quality for the SRT has also been through examining the state budget allocated to prison food as well as possibility of agricultural initiatives to allow for prisons to grow their own food – following it up on a number of country visits (SRT 2012: 334; SRT 2014: 9-10; SRT 2015: 22; SRT 2008: §546; see also budgetary discussion around food in *Segheti v. the Republic of Moldova*, and *Ciorap v. the Republic of Moldova* (No. 3), where violations were found). Expenditure on prisoner food has also been a point of scrutiny by the CPT and SPT in certain contexts (eg. CPT Greece 2020: §117; CPT North Macedonia 2021; SPT Poland 2020: §§100-101).

Slow and systemic harm has long been an issue for decision-makers, who tend to look upon individual, intense and spectacular events as torture and those which are born out of the detention regime and environment as other forms of ill-treatment (on this point see Başoğlu 2017: 140-144 and see generally Berlant 2007). Under Article 20 of the UNCAT, the CAT is empowered to conduct a confidential inquiry of a member state (who

has opted into this provision) upon receipt of "reliable information which appears to it to contain well-founded indications that torture is being systematically practised in the territory of a State Party". The CAT (1993: §39) has advanced a working definition of systematic torture as where:

> *Torture may in fact be of a systematic character without resulting from the direct intention of a Government. It may be the consequence of factors which the Government has difficulty in controlling, and its existence may indicate a discrepancy between policy as determined by the central Government and its implementation by the local administration. Inadequate legislation which in practice allows room for the use of torture may also add to the systematic nature of this practice.*

We must bear in mind that this procedure does not look at individual cases per article 1 but at the systemic conditions prevailing in a state. The working definition, as it looks away from intent, has proven relatively expansive. Monina (in Nowak 2019: 554) finds that the ten inquiries to date on the whole (though not consistently) have not required an "explicit Government policy instructing intelligence or law enforcement bodies to use torture". The perspective on offer here may be usefully reading intentionality into specific assessments of deprivation of food where it is also systematic.

According to conventional interpretive orientations, deprivation of food has been assessed by decision- and policy-makers alike as follows: i. planned and prolonged deprivation of food in an interrogation context to force a confession or as punishment of a prisoner resulting in severe health consequences (physical or psychological) would conceivably amount to torture (not that a single international or regional case has conclusively decided so); ii. the provision of insufficient, inedible or non-nutritious food leading to severe pain (as elements of intention and purpose per article 1 remain questionable) adds or amounts to inhuman treatment or punishment; and, iii. deprivation of food due to systemic shortages, or being forced to eat in a humiliating manner (where intention, purpose, severity are questionable) may amount to degrading treatment.

## Conclusion

International and regional bodies directly connect the adequacy of food to respect for dignity, freedom from torture and ill-treatment as well as the right to health – and particularly as depending on duration, quality, quantity and variety. What constitutes inadequate food remains complex as it is contingent on both material and non-material considerations, including its quality (content, nutritiousness, edibility, variety, wholesomeness), its quantity (calorie, substantiveness, balance), its preparation (hygiene, respect to the individual and community), its provision and consumption (when, how and where it is to be eaten, regularity, accessibility, warmth/cold), its socio-cultural suitability (to religious and cultural values) and its developmental suitability (for pregnant or breast-feeding mothers and children). Furthermore, its restriction is prohibited as a disciplinary punishment, and the adequacy of food is to be supervised by a competent professional. The assessment of food deprivation as torture or ill-treatment is further complicated by obscurity of severity and narrow readings of intentionality.

So, what are the implications here? The complexity of food provision is indeed complex – as it draws in a multitude of considerations. Yet, there is sufficient information and regulation to allow for a clear and criti-

cal reflection in practice (detection, documentation, adjudication) – perhaps even more so with the systematic review presented by this article. Whilst there is no question about how often food is complained about by prisoners, the paramount challenge here is to be more attentive to the suffering it can produce – that it is not simply a background factor because it is a basic need, that its inadequacy not only exacerbates other suffering but that it can produce real suffering in and of itself.

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# Identifying resilience-promoting factors for refugee survivors of torture

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**Key points of interest**

- There is a strong association between torture and mental health such that the greater the number of torture experiences, the greater severity of depression, anxiety, and PTSD symptoms reported.
- Refugee resilience should be conceptualised from multisystemic lens which include both psychological constructs as well as environmental factors that promote refugee mental health (e.g., resources that enable individuals to learn English, gain employment, and receive legal services).
- One promising psychological construct to further study that promote resilience is psychological flexibility, which can be clinically targeted through evidence-based treatments like Acceptance and Commitment Therapy.

**Abstract**

*Introduction*: There are 1.3 million refugee survivors of torture living in the United States today. An existing body of research with refugees has largely examined mental health, but few of these studies focused on resilience. *Objective*: Using a clinical sample of refugee survivors of torture, we tested the resilience-promoting factors of community engagement, employment, English fluency, and psychological flexibility. We conducted moderation and mediation analyses to investigate how these resilience-promoting factors impact the torture-mental health relationship. *Results*: Torture severity had significant positive associations with all mental health symptoms including PTSD (post-traumatic stress disorder), depression, and anxiety. Conversely, psychological flexibility had significant negative associations with all mental health symptoms. Additionally, psychological flexibility was a significant mediator of the torture-mental health relationship, highlighting its potential as a causal mechanism between torture and mental health. This evidence suggested that experiencing greater torture severity led to greater mental health problems in part via difficulties in psychological flexibility. Separately, English fluency and employment status were negatively correlated with mental health symptoms. *Conclusion*: The findings from this study identified potentially resilience-promoting factors for

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https://doi.org/10.7146/torture.v32i3.128843

refugee survivors of torture and contributed to both research and clinical insights in better serving this vulnerable population.

*Keywords*: psychological flexibility, Acceptance and Commitment Therapy, PTSD, depression, anxiety, refugee resilience

## Introduction

According to the United Nations Convention Against Torture (UNCAT, 1984), torture is "defined as any act that intentionally inflicts severe pain or suffering—physical or psychological—for specific purposes such as obtaining information or a confession, punishment, or as an act of intimidation or coercion, or discrimination of any kind" (UNGA, p. 1, 1984). Although the practice of torture has been prohibited and condemned under international law, torture and other inhumane acts are still widely present in at least 141 countries, which represents three-quarters of the world (Amnesty International, 2014). Research estimates that the overall prevalence of torture survivors in the refugee population is around 44% (Higson-Smith, 2015), and up to 1.3 million survivors of torture currently live in the United States (Center for Victims of Torture, 2015).

The experience of torture has consistently been shown to be a strong predictor of various long-lasting physical and psychological difficulties (Quiroga & Jaranson, 2005). The psychological problems that torture survivors are most frequently diagnosed with include posttraumatic stress disorder (PTSD), generalised anxiety disorder, depression, and somatic disorders (Elklit et al., 2012). Due to the heterogeneous samples and measures presented across studies, it is challenging to conclude the exact prevalence of various psychological disorders among refugee survivors of torture. However, refugee torture survivors are consistently shown to have elevated mental health risks. For example, refugee torture survivors are approximately four times more likely to suffer from PTSD than other refugees and about two-and-a-half times more likely to suffer from depression than non-tortured refugees (Steel et al., 2009). Refugee torture survivors also tend to report significantly greater symptoms of other mental disorders such as anxiety than non-tortured refugees (Shrestha et al., 1998).

On the other hand, not all refugees with a trauma history present with mental health symptoms. For example, in a study with Ugandan former child soldiers, 27.6% of the sample who experienced high trauma at least six months prior to the study did not report clinically significant behavioral or emotional problems, indicating posttraumatic resilience (Klasen et al., 2010). Moreover, in two community studies with Iraqi refugees, although torture survivors reported worse physical health outcomes, they reported signs of greater psychological resilience (i.e., stronger post-traumatic growth attitude, better sociocultural adjustment, and a higher practice of religion as coping) than a non-tortured refugee group with other types of trauma history (Kira, 2014).

There may be many mechanisms to explain why there are differences in *symptomology and resilience* among refugee survivors of torture. The Chronic Traumatic Stress (CTS) Framework (Fondacaro & Mazzulla, 2018) proposes that the interplay between individuals and the environment is critical to consider. Specifically, this framework proposes that one's mental health outcomes can be affected by both protective and risk factors exhibited at the various levels of individual, family, community, and culture. The CTS Framework conceptualises differences in refugee trauma outcomes based on the interaction between

risk and protective factors and stressful events, and this interaction can increase mental health risks or promote resilience (Fondacaro & Mazzulla, 2018). Therefore, the Chronic Traumatic Stress (CTS) Framework emphasises the importance of viewing mental health outcomes through a multisystemic lens and aligns with resilience conceptualisations (Fondacaro & Mazzulla, 2018).

While a strong body of research has investigated refugee mental health, few studies have examined refugee resilience (Watters, 2001). Broadly, resilience describes the process where an individual can bounce back and adapt positively to move forward in life in the face of significant adversity and challenging experiences (Edward et al., 2005). It is important to note that various theories and definitions in the literature conceptualise *resilience*. Among these, a prominent view is that resilience is not restricted within the level of individuals but is a byproduct of the interactions within multi-level systems. For example, Masten and colleagues (2011) proposed that resilience is "the capacity of a dynamic system (individual, family, school, community, society) to withstand or recover from significant challenges that threaten its stability, viability, or development" (p. 494). This definition of resilience also aligns with the Chronic Traumatic Stress (CTS) Framework which emphasises the importance of viewing mental health outcomes through a multisystemic lens including the levels of individual, family, community, and culture (Fondacaro & Mazzulla, 2018).

Therefore, guided by the Chronic Traumatic Stress (CTS) Framework, the present study conceptualised resilience as the positive adaptation of refugee torture survivors despite having experienced significant adversity and is viewed through multiple internal and external protective factors. Evidence from previous studies has demonstrated several resilience-promoting factors for refugees, some of which include social/community engagement, English fluency, employment, and psychological flexibility.

*Specific protective factor: social/community engagement*

Social or community engagement in refugee populations seems an important source of resilience, perhaps due to the majority of refugee communities holding high values on collectivism and social cohesion (Bemak et al., 2002). Evidence suggests that refugee individuals and families who utilise and engage with community resources display higher levels of resilience under adverse situations (Sonn & Fisher, 1998). Additionally, community engagement brings social support, buffering the harmful consequences of trauma, loss, and other challenging life events. For example, Allden and colleagues (1996) found that former Burmese political dissidents described camaraderie and support from the community as an important protective factor against the psychological effect of imprisonment and torture. Social participation within the community also alleviates immigration-related psychological distress, as indicated in a study with Iraqi refugees in Sweden (Lecerof et al., 2015). Guided by these findings, community engagement was considered a protective factor for refugees in the current study.

*Specific protective factor: employment*

Employment can also be a source of resilience for refugee survivors of trauma. Employment offers income opportunities and a stronger sense of self-fulfillment, social connections, and belonging (Mollica, 2008). A study conducted among African refugees in Australia showed that employment was significantly linked to positive physical and psychological outcomes and facilitated successful integration into a new

community (Wood et al., 2019). Additionally, employment allows refugees to have improved healthcare access and promotes healthy lifestyle behaviors, both of which ameliorate mental health problems (Wood et al., 2019).

Refugees typically face systematic barriers when securing employment, such as immigration documentation, language, and cultural differences, in addition to managing physical and mental health issues. Despite these significant barriers, many refugees participate in the labor market, which demonstrates a sign of positive adaptation in the face of adversity. Therefore, the participant's employment status was considered a protective factor in the current study.

*Specific protective factor: english language acquisition*

Language barriers after resettlement often pose significant risk factors for mental health among refugees since language barriers may prevent access, utilisation, and effectiveness of mental health services (Murray et al., 2010). Therefore, supporting refugees interested in learning the languages of their new communities can foster psychological resilience. For example, research has shown that better acquisition of the new country's language is associated with significantly lower PTSD symptoms among Iraqi refugees in Sweden. Refugee mothers with significantly higher English proficiency also reported receiving greater social support than their counterparts (Scott & Johnson, 1997). Similarly, among refugee youths, competence with the host country's language is significantly associated with a reduced risk of depression and internalizing problems (Fazel et al., 2012).

In the U.S., knowing English can be a particular challenge for refugee adults compared with refugee children and youths who may receive more opportunities to learn English and benefit from greater plasticity in cognitive development. In the current study of refugee adults resettled in the U.S., basic English fluency was considered an important resilience-promoting factor since it demonstrates positive adaptation in this population.

*Specific protective factor: psychological flexibility as an internal protective factor*

The literature presented thus far focused on factors mainly external to the individual, but it is equally important to consider internal protective factors. Among several internal protective factors, one promising candidate to examine is psychological flexibility. The construct of psychological flexibility (PF) is defined as the process of fully connecting with the present moment and persisting in or changing behavior to be in line with identified values (Hayes et al., 1999). Opposite of this construct is *psychological inflexibility* (PI) which relates to the concept of "experiential avoidance" and represents a common factor in many mental health problems (Gray et al., 2020; Kashdan & Rottenberg, 2010). Psychological inflexibility is an–unwillingness to experience distressing emotions by avoiding them or remaining attached to unhelpful cognitive or behavioral patterns and avoiding engaging in values-based activities that all cause psychological harm in the long run (Hayes et al., 1999). Psychological flexibility is a central concept in an evidence-based psychotherapy known as *Acceptance and Commitment Therapy* (Hayes et al., 1999). This treatment conceptualises psychological flexibility as comprised of six main components: acceptance, cognitive defusion (i.e., changing one's relationship to thoughts), contact with the present moment, conceptualisation of the self within context, identification and clarification of values, and committed action (Hayes et al., 1999).

Clinical studies with refugees have begun to explore the role of psychological flexibility in moderating treatment outcomes. For instance, evidence shows that interventions focused on psychological flexibility (through mindfulness and acceptance strategies) can significantly decrease somatic distress and rumination (Hinton, Pich, Hofmann, & Otto, 2013). Promoting psychological flexibility is also an important skill for refugees who learn to adapt to living in a novel and multicultural environment (SAMHSA, 2013). According to a study conducted with Tibetan refugees, psychological flexibility was described as a learned and active process of "making the mind more spacious and flexible," which abated psychological distress among refugee survivors of political violence (Lewis et al., 2013, p. 314). Additionally, a previous study from our research team showed that psychological *in*flexibility is a cognitive *mediator* of the torture and mental health relationship, highlighting its important clinical value (Gray et al., 2020). Based on growing evidence of the role of psychological flexibility in refugee resilience, this construct was included as an important internal protective factor in this study.

*The current study*

In the current study, interviews were conducted with a clinical sample of refugee torture survivors who sought services at an outpatient mental health clinic in the Northeast United States with a specialised refugee and asylum seekers program. Specifically, the current study investigated whether and how resilience-promoting factors moderate or mediate the relationship between torture history and mental health outcomes. Therefore, analyses focused on torture severity as the independent variable, the level of mental health symptomology (PTSD, depression, and anxiety) as dependent variables, and various resilience-promoting factors as the moderators and mediators in this study.

The specific hypotheses for the current study were as follows:

- Hypothesis 1: Torture severity and mental health symptoms would be positively correlated.
- Hypothesis 2: Resilience-promoting factors would moderate the torture-mental health association. The torture severity-mental health symptoms association will be larger when resilience is low, but smaller when resilience is high.
- Hypothesis 3: Resilience promoting factors would mediate the torture-mental health association, such that resilience promoting factors would emerge as one potential mechanism through which torture impacts mental health.

In addition, the study examined whether these dynamics among the main constructs were observed differently when covariates were included in the models. Covariates in this study included broad demographic factors such as age, gender, marital status, education level, housing status, and immigration status.

## Methods

*Participants*

The current study is a secondary data analysis on two combined datasets. The study includes a total of 75 adult refugee survivors of torture who received mental health services between the period of August 2007 and July 2019. At the time of data collection, participants gave consent to participate in future studies after their information was completely deidentified. Ages for participants ranged from 19-88 years ($M$ = 41.1, $SD$ = 15.4) and 52% of the sample identified as female. The participants reported to be from 13 different countries

of origin and self-identified as 27 different groups of ethnicities. All use of data and other study procedures were approved by the Institutional Review Board (IRB) at the University of Vermont (IRB code STUDY00000608).

*Measures*

*Demographic questionnaire:* Participants were asked to complete a 26-item questionnaire which includes demographic information such as age, gender, employment, highest education level, English fluency, and community engagement (See Appendix 1). The external protective factors were coded as dichotomized variables, based on the participants' responses on the relevant demographic question items. Specifically, community engagement was coded as a 0/1 dichotomized variable such that any level of community engagement was coded 1, and none as 0. English fluency was coded as a 0/1 variable based on whether participants endorsed English as one of their top 3 languages that they were most fluent in. Employment was coded as a 0/1 dichotomous variable (not employed /employed) based on the participants' self-report in describing their employment status at the time of the interview.

*Harvard Trauma Questionnaire (HTQ; Mollica et al., 1992):* The Harvard Trauma Questionnaire is a validated cross-cultural screening instrument designed to assess torture, trauma exposure, and trauma-related symptoms in refugees. The HTQ has been reported to have high test-retest reliability ($\alpha = .89$) internal consistency ($\alpha = .90$; Mollica et al., 1992); and it has been recommended for assessing PTSD symptoms across non-Western populations (Gagnon, Tuck, & Barkun, 2004). The measure consists of four sections; the two relevant sections for this study were part I and part IV. Part I includes the questions which identify traumatic life events including torture experiences and part IV is a list of PTSD symptoms according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV, American Psychiatric Association, 2000). In this study, the participant's history of torture severity was calculated by a sum of the experiences of torture endorsed in the part I of the HTQ. Events reported as "witnessed' or "heard about" were not included within torture severity to be consistent with existing literature on similar studies which utilised the HTQ (e.g., Arnetz et al., 2014; Wanna et al., 2019). For the PTSD variable in this study, the mean score of trauma symptoms reported by the participant on the part (IV) of the HTQ was used, as guided by the scoring manual.

*Hopkins Symptoms Checklist (HSCL-25; Derogatis et al., 1974)*: The Hopkins Symptoms Checklist is a cross-culturally validated screening tool designed to detect symptoms of anxiety and depression. The HSCL includes a 10-item subscale for anxiety symptoms as well as a 15-item subscale for depression symptoms experienced within the past week, with each question item scored on a Likert scale from 1 (not at all) to 4 (extremely). Sample anxiety items include "being scared for no reason" or "heart racing," and sample depression items include "feeling hopeless" or "feeling no interest". For anxiety and depression variables in this study, the mean scores of symptoms reported by the participant were used, as guided by the HSCL scoring manual. The HSCL-25 is reported to have the high internal consistency with Cronbach's α values of .93 for the overall scale, .90 for the depression subscale, and .85 for anxiety subscales respectively (Kaaya et al., 2002). The test-retest reliability of the HSCL was also high ($\alpha = .86$; Derogatis et al., 1974). Interrater reliability for the total and subscale across groups of the HSCL was higher than .98 (Mollica et al., 1987, p. 499).

*The Acceptance and Action Questionnaire - II (AAQ II; Bond et al. 2011):* The AAQ-II is a self-report scale with seven items that assess levels of psychological flexibility. Psychological flexibility is measured as a continuous construct. In the original scoring, participants' scores lie on a continuum with higher scores indicating higher psychological **in**flexibility. For our purpose, the psychological flexibility score was reversed such that higher total scores represented greater psychological flexibility, to be consistent with the rest of resilience-promoting factors in this study. Participants were asked to rate items on the questionnaire from 1 (*never true*) to 7 (*always true*). Sample questions include "I'm afraid of my feelings" and "My painful memories prevent me from living a fulfilling life." The AAQ-II has demonstrated good internal consistency with a mean alpha coefficient of .84, strong test-retest reliability ($r$ = .81 at 3-months and $r$ = .79 at 12-months) in clinical samples (Bond et al., 2011).

*Procedure*

As noted above, this project used previously collected data. A clinician obtained informed consent from participants after explaining the nature of research, confidentiality, privacy, and that participation in this project was completely voluntary. Next, the clinician conducted self-report questionnaires and measures through an in-person interview. The questionnaires were completed in English through an in-person or telephone interpreter who spoke the participant's language when needed. After each interview, the clinician or a research team member entered the participant's information into a centralised database without containing any identifiable information.

*Data analytic plan*

First, correlational analyses among primary study variables were conducted to test hypotheses about associations between torture history, resilience, mental health symptoms and to determine the magnitude, direction, and statistical significance of associations among these variables. Moderation and mediation analyses were conducted using SPSS statistical software version 25 (IBM Corp, 2017) through the PROCESS program in

**Table 1**. *Descriptive statistics for primary study variables (n=75)*

| | M | SD | Range |
|---|---|---|---|
| Torture severity (Number of torture events endorsed) | 5.37 | 3.98 | 0-15 |
| Posttraumatic stress symptoms (HTQ) | 2.34 | 0.81 | 1.06 – 3.90 |
| Depression symptoms (HSC-D) | 2.39 | 0.74 | 1.00 - 3.67 |
| Anxiety symptoms (HSC-A) | 2.30 | 0.81 | 1.00 - 3.80 |
| Psychological flexibility (AAQ) | 23.67 | 13.24 | 7 - 49 |
| | Yes | No | |
| Endorsed English as one of top 3 most proficient languages | 38.7% | 61.3% | |
| Endorsed employed status | 41.3% | 58.7% | |
| Endorsed community involvement | 44.4% | 55.6% | |

**Table 2**. *Correlations among primary study variables(n=75)*

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| 1. Torture severity | – | | | | | | | |
| 2. Average PTSD symptoms | .71** | – | | | | | | |
| 3. Average depression symptoms | .41** | .65** | – | | | | | |
| 4. Average anxiety symptoms | .40** | .69** | .73** | – | | | | |
| 5. Psychological flexibility | –.44** | –.72** | –.50** | –.54** | – | | | |
| 6. Self-reported English fluency | –.14 | –.31** | –.26* | –.35** | .23* | _ | | |
| 7. Self-reported employment status | .04 | –.26* | –.15 | –.16 | .12 | .28 | _ | |
| 8. Self-reported community involvement | .01 | –.05 | –.11 | –.12 | –.05 | .00 | .13 | _ |

$N = 75$. * $p < .05$; ** $p < .001$

SPSS (Hayes, 2013). Analyses were also rerun in the presence of covariates such as gender, age, marital, housing, and immigration status.

## Results

*Descriptive Statistics and Zero-Order Correlations*

In the current sample ($N = 75$), 48% of the participants self-identified as male and 52% as female. The mean age of the participants was 41.1 years old with considerable variability ($SD = 15.4$) such that the youngest participant was 19, and the oldest was 88. About 67% of the participants indicated that they were married, 20% were single, and the rest reported as either divorced or widowed. Over 85% of the sample reported having one or more children. Only 6% of the sample reported having become either U.S. citizens or green card holders, with the rest reporting their current immigration status as refugees, asylees, or asylum seekers.

Table 1 presents the sample mean, standard deviation, and range for the main study variables.

The findings from the correlational analyses among primary study variables are summarised in Table 2. Torture severity was significantly and highly correlated with the participant's reported mental health symptoms. Specifically, participants with a history of higher torture severity reported greater PTSD symptoms, $r = .71$, $p < .001$, greater depression symptoms, $r = .41$, $p < .001$, and greater anxiety symptoms, $r = .40$, $p < .001$. Therefore, the study's first hypothesis was supported; torture severity and mental health distress was positively associated in this sample of refugee torture survivors.

Participants with higher torture severity history also reported significantly lower

psychological flexibility, $r = -.44$, $p < .001$. However, torture severity was not significantly associated with any of the external resilience-promoting factors.

Among resilience-promoting factors, psychological flexibility and English fluency had significant negative correlations with all mental health symptoms. There was also a significant negative correlation between employment status and PTSD symptoms. Self-reported community involvement was not significantly associated with any of the main study variables.

Using the PROCESS program (Hayes, 2013), linear regression analyses were conducted to test the study's hypotheses of moderating and mediating effects of resilience-promoting factors on torture-mental health associations.

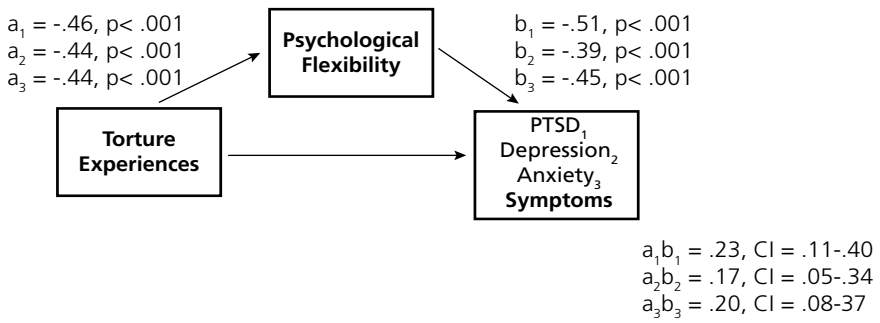
*Psychological flexibility's impact on the torture-mental health relationship*

Moderation analyses were conducted separately for each outcome measure of PTSD, depression, and anxiety symptoms. In all of these models, there were no statistically significant interactions between torture severity and any of the resilience-promoting factors predicting mental health symptoms. Therefore, these findings did not support Hypothesis 2.

However, it is noteworthy that psychological flexibility emerged as a significant predictor in all of the moderation analyses, even with a greater predictive value than torture severity, for PTSD, depression, and anxiety symptoms. For the PTSD symptoms, psychological flexibility ($\beta = -.53$, $p < .001$) and torture severity ($\beta = .46$, $p < .001$) were both significant predictors. Similarly, for depression symptoms, both psychological flexibility ($\beta = -.41$, $p < .001$) and torture severity ($\beta = .23$, $p = .04$) were significant predictors. For anxiety symptoms, only psychological flexibility ($\beta = -.49$, $p < .001$), but not torture severity ($\beta = .19$, $p = .09$), was a significant predictor.

Next, given the important role of psychological flexibility, we ran mediation analyses to test its impact on the torture-mental health relationship using the PROCESS program (Hayes, 2013). The findings from the mediation analysis demonstrated that higher torture severity indirectly led to greater PTSD symptoms through challenges in psychological flexibility ($ab = .23$, CI = .11 – .40, $p < .001$). Specifically, participants with the history of greater torture sever-

**Figure 1**: Summary of Mediation Analyses



ity reported lower psychological flexibility ($a$ = –.46, $p$ < .001), and individuals with lesser degrees of psychological flexibility reported higher PTSD symptoms ($b$ = –.51, $p$ < .001).

Similarly, the experience of higher torture severity indirectly led to increasing both depression and anxiety symptoms through difficulties in psychological flexibility respectively ($ab$ = .17, CI = .05–.34, $p$ < .001; $ab$ = .20, CI = .08–.37, $p$ < .001). Specifically, higher experience of torture severity was linked to lower psychological flexibility ($a$ = –.44, $p$ < .001), and lower degrees of psychological flexibility predicted higher depression symptoms ($b$ = –.39, $p$ < .001) and higher anxiety symptoms ($b$ = –.45, $p$ < .001). Therefore, Hypothesis 3 was supported; psychological flexibility was a significant mediator of torture-mental health relationships. These findings from mediation analyses for the models of PTSD, depression, and anxiety altogether are shown in Figure 1.

*The impact of external resilience-promoting factors and covariates on the torture-mental health relationship*

Apart from psychological flexibility, there were external resilience-promoting factors and covariates that were noteworthy as important predictors for mental health symptoms. For the PTSD model, employment status (β = –.25, $p$ = .002) was a significant negative predictor of symptoms, and English fluency (β = –.17, $p$ = .05) approached significance as a main effect predictor of lower PTSD symptoms. Additionally, English fluency was a significant predictor of lower anxiety symptoms (β = –.29, $p$ = .007). Self-reported community involvement was not found to be a significant predictor of any of the mental health symptoms.

Among covariates, there were also some variables to highlight that acted as the main effect predictors for mental health. Importantly, *age* was a significant predictor of both PTSD ($\beta$ = .22, $p$ =.005) and anxiety ($\beta$ = .27, $p$ = .02), such that older refugee participants reported significantly greater PTSD and anxiety symptoms. *Immigration status* was also a significant predictor of PTSD ($\beta$ = .23, $p$ = .002) such that participants with less stable immigrations status (i.e., undocumented individuals, asylum-seekers, and others) reported greater severity of PTSD symptoms than green-card holders and citizens.

Taken together, these results demonstrated psychological resilience as a significant mediator of torture-mental health relationships and revealed external resilience-promoting factors and covariates that may predict variability in mental health symptoms.

## Discussion

In the current study, we examined the impact of resilience-promoting factors on the torture-mental health relationship. As predicted by our first hypothesis, there were significant positive correlations between torture experience and mental health symptoms. Participants with a history of higher torture severity reported greater PTSD, anxiety, and depression symptoms. Inconsistent with our second hypothesis, resilience-promoting factors did not significantly moderate the torture-mental health relationship. However, as predicted by our third hypothesis, the resilience-promoting factor of psychological flexibility significantly mediated the relationship between torture severity and all mental health symptoms including PTSD, depression, and anxiety.

The refugee research literature shows a high prevalence of torture survivors as well as significant association between torture severity and mental health symptoms (Steel et al., 2009). We reaffirmed this existing body of knowledge in this study. The average number of physical, psychological, and sexual torture events reported by our participants was *five*

(Table 1), and the greater the number of torture experiences, the greater severity of depression, anxiety, and PTSD symptoms reported by the participants (Table 2). This finding highlights the importance of sensitively screening for torture experiences among refugee clients to inform trauma-informed assessment and treatment when working with such a high-risk client population.

Our finding on psychological flexibility as a potentially causal mechanism between the torture-mental health relationship offers important clinical insights. It is consistent with the emerging evidence by prior refugee studies which showed psychological inflexibility as a cognitive mediator of torture-mental health association among torture survivors (Gray et al., 2020). Recently, the World Health Organisation has developed an intervention app for refugee mental health named Self-Help Plus (SH+) which targets increasing psychological flexibility through mindfulness exercises (Tol et al., 2020). The SH+ app has been tested in a large randomized trial with almost 700 South Sudanese refugee women. After three months of the intervention, participants reported a significant reduction in psychological distress as well as improvements in functioning and well-being (Tol et al., 2020). Our study's finding contributes to this evolving literature on psychological flexibility as a malleable construct of change that can be clinically targeted to improve refugee mental health.

Our study also revealed external resilience-promoting factors for refugees such as English fluency and employment. Specifically, participants who endorsed English as one of their top 3 languages significantly reported fewer PTSD, depression, and anxiety symptoms, and the participants with employment reported significantly fewer PTSD symptoms. Among refugee torture survivors, acquisition of the new language and finding employment may represent better adjustment during their resettlement which may then lead to reducing risks of psychological symptoms. Therefore, we highlight the importance of providing multi-layered and integrated interventions in which clinical psychologists should work closely with a collaborative interdisciplinary team in treating refugee torture survivors. For example, clinicians may help improve psychological flexibility through evidence-based treatments like Acceptance and Commitment Therapy while referring refugee clients to appropriate resources to gain employment or learn English.

Interestingly, the level of self-reported community engagement was not a significant predictor of mental health symptoms in this study. However, we were only able to use a single dichotomous item to assess community engagement. In the future, we aim to advance this research by developing more informative questions that assess the level of community engagement and the quality of such experiences. For example, future studies may consider including questionnaire items on whether refugees experience a sense of belonging in their new communities after resettlement and which types of community engagement activities or resources provide such sense of belonging for refugees.

To the best of our knowledge, this study is one of the first to address factors of refugee resilience through an ecological framework such as Chronic Traumatic Stress (Fondacaro & Mazzulla, 2018), especially in a clinical sample. As suggested by the CTS model, understanding salient factors that impact refugee well-being from pre-migration (e.g., torture history) as well as post-migration (e.g., employment status, language abilities, community engagement) will allow clinicians to provide culturally informed and individualised treatments. Future studies should

similarly examine other important risk and resilience factors through a multisystemic framework to better design systemic, integrative treatments for refugees.

There were noteworthy demographic data associated with mental health symptoms in our study. The findings showed that older participants reported significantly higher symptoms of both PTSD and anxiety, and participants without stable immigration status reported higher PTSD symptoms. Older refugees may have higher risks for mental health issues due to various reasons such as accumulating a higher number of traumatic experiences, facing more cognitive challenges in adapting to new languages and customs, and struggling with isolation from the rest of one's family during transition (Pumariega et al., 2005; Steel et al., 2009). Regarding immigration status, previous studies also showed that fear of detention and deportation and other immigration-related stressors exacerbate mental health symptoms, particularly PTSD (Steel et al., 2006). Additionally, individuals with an unstable immigrant status are more likely to be exposed to human rights violations, excluded from government assistance, or presented with significant barriers to receive basic medical or social services, all of which add significant burdens to their mental health and well-being (Larchanché, 2012).

### Limitations

While this study offers many future clinical and research insights, there are a few limitations that should be considered in interpreting the findings. First, this study only used self-reported data collected during the clinical intake interview and some sensitive information (e.g., certain torture experiences, and mental health symptoms) may have been underreported. Secondly, the data available for the study only utilised single-item questions to assess the external protective factors. Therefore, we were unable to capture how different levels of external protective factors can contribute to refugee resilience. A third shortcoming of the study is its cross-sectional design, which precludes making strong causal inferences; alternative direction-of-effects and third-variable explanations of associations need to be ruled out. In the future, longitudinal study should be utilised to examine the hypothesized causal relationships between torture, psychological flexibility, and mental health symptoms to better understand the strength and direction of their relationships pre-treatment and post-treatment.

### Conclusions

This study contributes to the limited literature on mental health and resilience of refugee survivors of torture through multisystemic lens. The experience of torture is quite prevalent among refugees, and torture survivors tend to present with higher risks for mental health symptoms. It is imperative that clinicians strive for delivering trauma-informed and culturally sensitive care in working with refugee torture survivors that consider resilience-promoting factors. One promising construct to further study is psychological flexibility, which can be clinically targeted through evidence-based treatments like Acceptance and Commitment Therapy. Our findings also underscore the potential importance of enhancing public policies that protect refugee well-being by offering government assistance programs for opportunities like employment, English classes, and free legal services. Even the most effective clinical treatments will not be sufficient if the refugee client's basic safety or well-being is at risk. Especially for vulnerable groups like older refugees and refugees with unstable immigration status, clinicians should

be strategic in delivering holistic treatments that attend to their unique stressors to effectively promote refugee mental health and resilience.

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**Appendix 1**. Demographic questionnaire completed by the participants (**Numbers in bold were required for reporting to the Office of Refugee and Resettlement. **)

Name: _____ Today's Date_____

**1.** Sex: ____Male ____Female ____Other

**2.** Age: _____ **2.a.** DOB: Month_____Day_____Year_____

3. Marital Status: _____Single _____Engaged _____Married _____Divorced
_____Widowed _____Separated

**4.** What is your country of origin? _____

**5.** What ethnic group (**not nationality**) do you identify with? _____

**6.** What languages do you speak (top 3 in proficiency)
[primary:]_____
_____
_____

7. What is your religion?
___ Islam ___ Christianity ___Hinduism ___Buddhism
___Agnostic/Nonbeliever ___ Other (please list): _____

**8.** When did you arrive in the United States? Month_____Day_____Year_____

**9.** What is your current immigration status? (*if refugee at arrival, circle "former refugee" in addition to other current status*)
___ Asylum Seeker ___ Refugee/Former Refugee ___ U.S. Citizen
___ Asylee/Former Asylee ___ Permanent U.S. Resident (Greencard)
___ Other

**10.** What is your current employment status? (check all that apply)
___ Not authorized by US government to work
___ Unable to work (physical reasons)
___ Unemployed, NOT SEEKING employment
___ Unable to work (psychological reasons)
___ Unemployed, SEEKING employment
___ Student
___ Employed, full-time
___ Primary caregiver
___ Employed, part-time
___ Other

11.a. If employed, how satisfied are you with your current employment?
___ Not at all ___ A little ___ Somewhat ___ Very

**12.** What was your education level prior to arrival in the U.S.?
___ less than a year
___ 1-4 years
___ 5-8 years
___ 9-12 years
___ 13-16 years
___ 16+ years

12.a. What is the highest level of education you have completed?
___ Never attended school
___ Primary school (K-8)
___ Secondary school (9-12)
___ Some university, no degree
___ Finished university (Associate's degree)
___ Finished university (Bachelor's degree)
___ Some graduate school, no degree
___ Finished grad school (Masters or Doctorate)
___ Other (i.e. ESL classes)

13. How many children do you have? (total = alive + deceased + adopted) _____

14. Did you live in a refugee camp before coming to the U.S.? ____ No ____ Yes

14.a. If YES, for how long? _____

14.b. If YES, where? _____

**15.** What is your current housing status?
____ Stable (6+ months in one residence)
____ Unstable (more than one residence within 6 month period)
____ Homeless
____ U.S. Immigration and Customs
____ Other

15.a. How many people live in the house (including self)? _____

16. What is your INDIVIDUAL yearly income?
____ No income
____ Less than $5,000
____ $5,000 to $14,999
____ $15,000 to $24,999
____ $25,000 to $34,999
____ $35,000 to $49,999
____ $50,000 to $74,999
____ $75,000 or more

16.a. Which government subsidies do **you** receive? (check all that apply)
____ Medicare (entitled to seniors 65+)
____ Medicaid/SSI (public assistance for disability)
____ WIC (public assistance for women and children)

____ Section 8 (low-income housing)
____ 3 Squares (food stamps)
____ Reach Up (short-term assistance; kid required)
____ SSTA (transportation assistance)
____ Other

17. How satisfied are you with the community support you have from the refugee community?
___ Not at all ___ A little ___ Somewhat ___ Very

18. How satisfied are you with the community support you have from the non-refugee community?
___ Not at all ___ A little ___ Somewhat ___ Very

19. How satisfied are you with the support you receive from your family?
___ Not at all ___ A little ___ Somewhat ___ Very

20. Are you involved with any community organisations? ___ No ___ Yes

**21.** What is your primary presenting problem?
___ Psychological
21.a. If psychological, is it court mandated? ___ No ___ Yes
___ Legal
21.b. If Legal, check ONE
___ Asylum Evaluation
___ Citizenship
___ Social Work
21.c. If social work, check TOP THREE
___ support system
___ education and/or language
___ occupational
___ housing
___ economic
___ access to health care
___ childcare
___ other

22. What medical problems (acute or chronic) do you experience? (check ALL that apply)
___ Diabetes (Type I; genetic)
___ Diabetes (Type II; adult-onset)
___ Obesity
___ Cardiovascular Disease (any disease related to the heart)
___ Cancer
___ Hypertension (high blood pressure)
___ High cholesterol
___ Chronic pain

23. Please list any medications that you are currently taking or are prescribed:

_____

_____

**24.** Torture survivor: _____ Yes _____ No

**24.a.** If YES, what age where you first subjected to torture?

___ Less than 5
___ 5 – 13
___ 14 – 17
___ 18 – 24
___ 25 – 44
___ 45 – 64
___ 65 and older

**24.b.** Which types of torture have you experienced? (check ALL that apply)

__ Beating (*slapping, kicking, punching, or blows with another object*)
__ Burning (*through water, cigarettes, chemicals, burning sticks, live fire, etc.*)
__ Asphyxiation (*through immersion into liquids or any time of strangulation*)
__ Deprivation (*of food, water, medical attention, personal space, forced isolation, forced feeding*)
__ Threats/Psychological (*against victim or family, friends, colleagues, acquaintances*)
__ Pharmacological (*physiological or psychological drug effects*)
__ Electrical (*use of electric shock to inflict pain or suffering*)
__ Kidnapping/Disappearance
__ Wounding/Maiming (*with knives/sharp objects or removal of body parts such as nails or amputation*)
__ Rape/Sexual torture (*forced sexual acts, molestation, touching as harassment*)
__ Forced postures, stretching, hanging (*such as standing or kneeling for extended period of time*)
__ Sensory stress (*extreme exposure to heat/cold, immobilisation, stress to hearing/vision, etc*)
__ Witnessing torture of others
__ Dental (*pain or damage to mouth, misuse of dental equipment, no anesthesia*)
__ Severe humiliation
__ Secondary survivor *(family member or partner of primary survivor)*

**25.** Reason for Torture:

___ Ethnicity ___ Nationality ___ Political Reasons ___ Religion
___ Social Activism ___ Social Group ___ Other: _____

**26.** Country where torture occurred: _____

# Asylum seeker trauma in a student-run clinic: reducing barriers to forensic medical evaluations

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**Key points of interest**

- Asylum seekers receiving forensic evaluations at a university-affiliated human rights clinic experience a lifetime of cumulative trauma and related, untreated mental health conditions
- Intentional clinic design can support asylum applicants, students, trainees, and clinicians in the work of forensic medical evaluations
- Deploying trauma-centred practices should improve sustained commitment in asylum forensic practitioners and clinics

**Abstract**

*Introduction:* The number of forcibly displaced immigrants seeking asylum in the United States continues to rapidly increase. Movement from Latin America to the United States was the third-largest migration worldwide in 2017 (Leyva-Flores et al., 2019). As migration patterns change, understanding the background and trauma profile of newly displaced populations is essential to meet their health needs and aid successful resettlement. University-affiliated student-run asylum clinics conduct a growing number of forensic medical evaluations of asylum seekers and provide a vital lens to study changes in this population's profile over time.

*Methods:* A retrospective review was conducted of the first 102 asylum seekers receiving forensic medical evaluations between 2019 and 2021 at a university-affiliated student-run clinic, reporting demographics; trauma, medical, and mental health histories; referral patterns; and legal outcomes. Bivariate statistics were used to investigate the relationship between past trauma and mental health outcomes.

*Results:* Clients reported an average of 4.4 different types of physical, psychological, and sexual ill-treatment per person. The current mental health burden was extensive with 86.9 percent of clients reporting symptoms of PTSD and/or depression. Clinician-student teams evaluated clients within a clinic structure deploying a continuous improvement model to reduce common barriers to foren-

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https://doi.org/10.7146/torture.v32i3.130227

sic evaluations and promote longitudinal follow-up and referrals.

*Discussion:* This study demonstrates the complexity of trauma exposure reported by asylum seekers, contributes to the evidence on how trauma results in mental health outcomes, and describes trauma-centred clinic adaptations that reduce barriers to forensic evaluations known to improve the rates of legal protection.

*Keywords:* Asylum seekers - Forensic medical evaluation - Health and human rights - Student-run asylum clinics - Complex trauma

## Introduction

In 2020, persecution and violence around the globe caused more than 80 million people to flee their homes (UNHCR, 2021). Displaced individuals often flee because of complex physical, psychological, and sexual torture that occurs repeatedly over an extended period of time (Aguirre et al., 2020; Asgary et al., 2006; Clément et al., 2017; Doherty et al., 2016; NCTTP, 2015; Pfortmueller et al., 2016). These traumatic experiences and fear for one's safety leave indelible marks on mental health, with as many as 3 of 4 displaced people suffering from posttraumatic stress disorder (PTSD) and depression (Başoğlu et al., 2005; NCTTP, 2015; Miller et al., 2021; Song et al., 2018). The stress of migration journeys and instability of uncertain legal residency status compounds this trauma (Grace et al., 2018; Miller et al., 2021). The duration of ambiguous legal status correlates with worse mental health outcomes, highlighting a humanitarian mandate to rapidly provide secure legal status (Hvidtfeldt et al., 2020).

International laws and treaties allow displaced people fleeing persecution to seek asylum in safe countries (Nicholson & Kumin, 2017). In 2020, 4.1 million individuals sought asylum worldwide, with approximately 300,000 new claims filed in the United States (TRAC, 2021; UNHCR, 2021). At the end of 2021, more than 1.5 million immigration cases still awaited judicial decisions, delaying legal status and impacting the mental health of asylum applicants.

In the U.S., asylum applicants face an adversarial process as they must substantiate claims of persecution, demonstrate credibility, and procure an immigration attorney (Meffert et al., 2010). Faced with language and literacy barriers, economic hardship, and high rates of trauma, asylum seekers face extraordinary challenges in navigating the asylum process. An instrumental tool to mitigate these barriers, improve asylum outcomes, and reduce prolonged ambiguous legal status is the forensic medical evaluation (FME) (Atkinson et al., 2021; Lustig et al., 2008). Conducted by clinicians and supporting legal proceedings, FMEs assess the degree to which an asylum seeker's claims of prior trauma and torture correlate with their physical and psychological exam findings.

University-affiliated student-run asylum clinics (SRACs) in the U.S. hold an increasingly prominent role in conducting FMEs (Sharp et al., 2019). Between 2010 and 2019, SRACs performed more than 1,600 FMEs, with the annual count rising each year (Gu et al., 2021). As 11 million immigrants reside in California, almost a quarter of the foreign-born U.S. population ("*An Equity Profile,*" 2017; Johnson et al., 2021), UCSF students and faculty formed the Human Rights Collaborative (HRC) in mid-2019 to support the increasing regional demand for FMEs.

SRACs and other asylum clinics have reported on the demographic and trauma histories of asylum-seeking clients and patients. These studies depict changes in the demographics of U.S. asylum seekers over time

(Asgary et al., 2006; Cuneo et al., 2021; Lustig et al., 2008; Miller et al., 2021; Moreno et al., 2006; NCTTP, 2015; Zero et al., 2019). In the 2000's, most asylum seekers identified as male, originated from African countries, and fled political persecution. In more recent studies, asylum seekers increasingly identify as female, come from Central America, and seek protection from gender and gang violence.

This paper describes the demographics, trauma experiences, mental health burden, and asylum application grant rates of the first 102 asylum seekers evaluated at UCSF HRC between 2019 and 2021. Our results provide further evidence of the demographic shift in asylum seekers and present a complex trauma profile. We compare characteristics of asylum seekers with and without histories of sexual violence, investigate the relationship between the number of past traumas and mental health outcomes, and demonstrate an unmet need for mental health treatment. We also build on studies aimed at improving SRAC sustainability by reporting strategic trauma-centric practices that reduce client barriers to FMEs and the impact of trauma exposure on clinicians and students (Gu et al., 2021; Ruchman et al., 2020).

## Methods

*Inclusion criteria and consent*

This study provides a retrospective review of UCSF HRC asylum FMEs conducted between April 2019 and June 2021. Eligible clients had entered the U.S. and applied for asylum with legal representation. Research consent and enrolment took place following FME informed consent and were conducted using certified interpreters. HRC enrolled a total of 102 clients with no clients excluded. Three clients did not consent to full data inclusion due to personal safety concerns. HRC used the same procedures for minors with parental consent. FME access was not contingent upon study enrolment. The UCSF Institutional Review Board (IRB) approved all elements of this longitudinal, retrospective observational study on December 20, 2020.

*Data collection and security*

Lead clinicians completed FMEs and medicolegal affidavits using model forensic asylum templates. Trained medical students used a Qualtrics survey to extract data elements from affidavits. Experienced HRC medical directors regularly performed quality checks through direct data extraction and comparison with student extraction. Collected data included client demographics, history of ill-treatment, medical and mental health history, and physical and psychological exam findings. Researchers anonymised all data, with no identifying information used for reporting. Researchers stored data in a HIPAA-certified, secure system managed by UCSF Information Technology services with access granted only to the IRB-approved HRC research team members. The study also utilised data from client referral forms and follow-up phone calls.

*Statistical analyses*

The authors performed all analyses using Stata 15.0 and R Studio and conducted bivariate analysis using the Kruskal-Wallis non-parametric test. Because of a significant result of skewness in the outcome variables, researchers analysed the results using a negative binomial model when the outcome did not contain a count of 0, and a Poisson model when there was a 0 count.

*Training and qualifications of HRC clinicians*

Clinicians performing FMEs were trained, licensed health care professionals, mostly physicians. Clinicians performing psychological

FMEs included physicians, psychologists, and social workers. All HRC clinicians completed a standard 6-hour asylum training at UCSF or an equivalent Physicians for Human Rights training. Most also attended advanced training in asylum forensic documentation. All new clinicians began as observers and then performed independent evaluations observed by medical directors or experienced peers. Medical directors or experienced asylum clinicians peer-reviewed all FME affidavits.

*Diagnosing PTSD and depression*

Clinicians diagnosed major depression and PTSD according to DSM-V criteria and guided by screening tools (PHQ9 and PCL5; Kroenke et al., 2001; Weathers et al., 2013) as well as a comprehensive clinical interview. Due to the high prevalence of depression and PTSD among asylum seekers, and in congruence with the reporting practices of a prior large-scale study on this population, rates of the highly prevalent diagnoses of depression and PTSD are reported (NCTTP, 2015).

## Results

*Characteristics of FME evaluations and evaluators*

Between April 2019 and June 2021, HRC conducted 102 FMEs, with 79.4 percent performed onsite in monthly clinics and the remainder, mostly psychological FMEs, on a virtual video platform or in an asynchronous clinical visit (Table 1). Based on attorney request, 57.8 percent of HRC clients received combined physical and psychological evaluations, 36.3 percent received solely a psychological evaluation, and 5.9 percent received solely a physical evaluation. During the COVID-19 pandemic, clinician-student teams temporarily performed the interview portion of combined physical and psychological visits virtually but maintained an in-person physical exam. Combined physical and psychological FMEs returned to a fully in-person setting in January 2021.

A diverse team of 34 clinicians, including physicians (55.9 percent), PhD/PsyD psychologists (26.5 percent), social workers (8.8 percent), and nurse practitioners (8.8 percent) conducted FMEs. The primary clinical specialties included Family Medicine, Internal Medicine, and Psychiatry/Psychology, with Neurology, Surgery, Emergency Medicine,

**Table 1**. HRC Evaluations and Evaluators

| | n (%) |
|---|---|
| Setting (N=102) | |
| Monthly onsite clinic | 81 (79.4) |
| Out-of-clinic | 21 (20.6) |
| Type (N=102) | |
| Combined med/psych | 59 (57.8) |
| Psych | 37 (36.3) |
| Medical | 6 (5.9) |
| Evaluator training (N=34) | |
| Physician | 19 (55.9) |
| Psychologist | 9 (26.5) |
| Nurse Practitioner | 3 (8.8) |
| Social Worker | 3 (8.8) |
| Evaluator specialty (N=34) | |
| Psychology | 12 (35.3) |
| Family Medicine | 7 (20.6) |
| Internal Medicine | 7 (20.6) |
| Pediatrics | 3 (8.8) |
| Emergency Medicine | 2 (5.9) |
| Psychiatry | 1 (2.9) |
| Rheumatology | 1 (2.9) |
| Surgery | 1 (2.9) |

Pediatrics, and Rheumatology clinicians also contributing. Clinicians conducted an average of 3 evaluations (range 1-19) over the 27-month period, typically joined by medical students and faculty clinicians in training. Four clinicians each performed 5 or more evaluations during the study period.

*Characteristics of HRC asylum seekers*

Similar to the asylum seeker community globally (Clément et al., 2017; NCTTP, 2015), HRC's client population was young, with almost half between the ages 18 to 29 (47.1 percent) and 22.5 percent ages 30 to 39 (Table 2). Females accounted for the majority of clients (62.7 percent). Most clients self-reported sexual orientation as heterosexual (83.3 percent) and the remainder identified as lesbian, gay, or bisexual (16.7 percent). More than 85 percent reported twelve or fewer years of formal education, with 43.8 percent describing 8 or less years. The remaining 14.6 percent pursued education beyond high school, with half of those earning an undergraduate or graduate degree.

The majority of clients (75.5 percent) originated in Central American from Guatemala (31.4 percent), El Salvador (25.5 percent), and Honduras (18.6 percent). Mexico (5.9 percent) and Eritrea (4.9 percent) were the next most common countries, with 10 additional countries represented by the cohort. The primary language for 79.2 percent of HRC asylum seekers was Spanish followed by the indigenous Mayan language, Mam (5.0 percent). Nine other primary languages were represented. Nearly one in six clients identified as indigenous (16.2 percent).

At the time of referral, attorneys reported legal bases for asylum as one or more of the following: affiliation with a particular social group (52.5 percent), gang violence (51.5 percent), domestic violence (45.5 percent), political persecution (34.3 percent), sexual violence (28.3 percent), gender-based violence (18.2 percent), and religious persecution (13.1 percent).

**Table 2.** Client Demographics

| | n (%) |
|---|---|
| Age (N=102) | |
| < 18 | 9 (8.8) |
| 18 - 29 | 48 (47.1) |
| 30 - 39 | 23 (22.5) |
| 40 - 49 | 16 (15.7) |
| 50 - 59 | 6 (5.9) |
| Gender (N=102) | |
| Female | 64 (62.7) |
| Male | 36 (35.3) |
| Transgender | 2 (2.0) |
| Sexual orientation (N=78) | |
| Heterosexual | 65 (83.3) |
| Lesbian | 6 (7.7) |
| Gay | 5 (6.4) |
| Bisexual | 2 (2.6) |
| Education (N=89) | |
| 0 - 8 | 39 (43.8) |
| 8 - 12 | 37 (41.6) |
| > 12 | 13 (14.6) |
| Language (N=101) | |
| Spanish | 80 (79.2) |
| Mam | 5 (5.0) |
| Tigrinya | 5 (5.0) |
| English | 5 (5.0) |
| Punjabi | 2 (2.0) |
| Other (4 languages) | 4 (4.0) |

Continued on the next page

| Country of origin (N=102) | |
|---|---|
| Guatemala | 32 (31.4) |
| El Salvador | 26 (25.5) |
| Honduras | 19 (18.6) |
| Mexico | 6 (5.9) |
| Eritrea | 5 (4.9) |
| Other (10 countries) | 14 (13.7) |
| Bases for asylum (N=99) | |
| Affiliation with a social group | 52 (52.5) |
| Gang violence | 51 (51.5) |
| Domestic violence | 45 (45.5) |
| Political persecution | 34 (34.3) |
| Sexual violence | 28 (28.3) |
| Gender-based violence | 18 (18.2) |
| Religious persecution | 13 (13.1) |
| Indigenous identity (N=99) | |
| Yes | 16 (16.2) |
| No | 83 (83.8) |

*Trauma history reported by asylum seekers*

During the FME, clinicians documented comprehensive histories of physical, psychological, and sexual trauma and torture (torture definition as it appears in the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment). Every HRC client reported past trauma or torture in their country of origin (Table 3).

Trauma types broadly fell into physical, psychological, and sexual categories, with corresponding prevalence rates of 80.8 percent, 100.0 percent, and 61.6 percent, respectively. Moreover, 78.6 percent of HRC clients experienced trauma as children. Nearly all suffered from multiple types of trauma (93.9 percent). On average, HRC clients experienced 4.4 different types of past trauma per person, with more than a quarter (26.3 percent) suffering six or more different types. The five most prevalent forms of physical ill-treatment included blunt trauma (74.7 percent), penetrating trauma (23.2 percent), asphyxiation (15.2 percent), burns (13.1 percent), and positional torture (11.1 percent). Top reported forms of psychological ill-treatment included threats (61.6 percent), witnessing the death or torture of others (34.3 percent), sexual or religious insults (16.2 percent), and forced nudity (12.1 percent).

**Table 3.** Client Trauma History Profile

| | n (%) |
|---|---|
| Broad categories of trauma (N=99) | |
| Physical | 80 (80.8) |
| Psychological | 99 (100.0) |
| Sexual | 61 (61.6) |
| Childhood abuse | 66 (78.6) |
| Number of trauma types (N=99) | |
| 0 | 0 (0.0) |
| 1 | 6 (6.1) |
| 2 | 17 (17.2) |
| 3 - 5 | 50 (50.5) |
| 6 - 10 | 23 (23.2) |
| > 11 | 3 (3.0) |
| Most prevalent forms of physical violence (N=99) | |
| Blunt trauma | 74 (74.7) |
| Penetrating trauma | 23 (23.2) |
| Asphyxiation | 15 (15.2) |
| Burns | 13 (13.1) |
| Positional torture | 11 (11.1) |

Continued on the next page

| Most prevalent forms of psychological trauma[a] (N=99) | |
|---|---|
| Threats | 61 (61.6) |
| Witnessing death or torture | 34 (34.3) |
| Insulted for sexuality/race/religion/gender | 16 (16.2) |
| Forced nudity | 12 (12.1) |
| Privacy deprivation | 9 (9.1) |
| **Most prevalent forms of sexual violence[b] (N=99)** | |
| Sexual assault[c] | 56 (56.6) |
| Insulted for sexuality or religion | 16 (16.2) |
| Forced nudity | 12 (12.1) |

a Psychological trauma refers to ill treatment that does not depend primarily on physical pain or physical stress.
b Sexual violence is defined broadly as unwanted sexual actions or words that harm another person.
c Sexual assault refers to nonconsensual physical sexual activity. It includes rape as well as acts that do not include penetration.

*Reports of sexual violence among asylum seekers*

The majority of clients reported a history of sexual violence (SV) (61.6 percent). Over half (56.6 percent) experienced sexual assault, including rape, forced masturbation, oral sex, and other unwanted sexual touching (Table 3). Asylum seekers who experienced SV were young (47.5 percent ages 18 to 29), more likely to identify as female (78.7 percent with SV vs 39.5 percent with no SV, $p<0.01$), and more likely to have fewer years of formal education (grade 0-8 peak educational attainment for 50.0 percent with SV vs 15.6 percent with no SV, $p<0.01$). As with the overall cohort, asylum seekers reporting SV experienced multiple forms of trauma, including blunt trauma (85.2 percent) and witnessing the death or torture of others (29.5 percent).

*Physical and psychological exam findings during FME*

For clients who received a physical examination during the FME, clinicians documented physical signs of trauma or torture in 90.8 percent (Table 4). Psychological evaluations

**Table 4.** Examination Findings, Evaluation Conclusions, and Case Outcomes

| | n (%) |
|---|---|
| Trauma documented on physical exam (N=65) | |
| Yes | 59 (90.8) |
| No | 6 (9.2) |
| Psychiatric diagnosis documented in FME (N=99) | |
| PTSD | 80 (80.8) |
| Depression | 37 (37.4) |
| Any | 86 (86.9) |
| Prior/current psychiatric diagnosis or treatment (N=99) | |
| Prior diagnosis | 10 (10.1) |
| Currently receiving treatment | 5 (5.1) |
| Istanbul Protocol evaluation conclusions (N=90) | |
| Not consistent with | 0 (0.0) |
| Consistent with | 24 (26.7) |
| Highly consistent with | 56 (62.2) |
| Typical of | 8 (8.9) |
| Diagnostic of | 2 (2.2) |
| Case legal outcomes (N=102) | |
| Denied | 0 (0.0) |
| On appeal | 7 (6.9) |
| Asylum granted | 23 (22.5) |
| Case rescheduled due to COVID-19 | 37 (36.2) |
| Awaiting immigration decision and/or attorney follow-up | 35 (34.3) |

documented a psychiatric diagnosis in 86.9 percent of clients, including 80.8 percent with PTSD and 37.4 percent with depression. Despite the high prevalence of mental health conditions, few reported any prior diagnostic evaluations or treatment: 10.1 percent of clients reported past psychological diagnosis or treatment and only 5.1 percent were currently receiving psychiatric medications or counselling.

*Evaluation conclusions and legal outcomes*

The Istanbul Protocol recommends standard language to describe the degree of correlation between FME findings and a client's reported persecution (*Istanbul Protocol*, 2022). Using Istanbul Protocol language, HRC clinicians concluded that FME findings were "diagnostic of" (2.2 percent), "typical of" (8.9 percent), "highly consistent with" (62.2 percent), and "consistent with" (26.7 percent) clients' reported past and fear of future persecution (Table 4).

During the study period, immigration courts adjudicated only 23 (22.5 percent) client cases. The remaining clients await immigration court decisions or attorney action. Of the 23 HRC clients with a legal status determination, 100.0 percent were granted asylum or other forms of legal protection (as compared with the 63.9 percent grant rate in San Francisco immigration court as of November 2021) (TRAC, 2021).

*Bivariate analysis for predictors of mental health outcomes*

Prior studies have attempted to understand the relationship between a traumatic event and its impact on future mental health. Findings diverge as to whether characteristics intrinsic to a trauma event, such as its severity or frequency, affect mental health outcomes (Başoğlu et al., 2005; Nosè et al., 2020; Song et al., 2018; Steel et al., 2009). We tested whether the number of types of trauma events experienced was associated with a higher prevalence of PTSD or depression at the time of FME. The analysis did not find a significant correlation between the number of types of trauma events and either PTSD or depression (Table 5).

*Referrals and outcomes from longitudinal follow up*

In response to the high prevalence of untreated psychological conditions and unmet social needs, HRC established a longitudinal follow-up program in October 2020 to increase access to social services, primary care, mental health, food assistance, and other urgent client needs. Medical students contacted clients at 2 weeks, 3 months, 6 months, and 12 months after FME. During the program's first nine months, students called 47 clients, reaching 83.0 percent and referring 74.5 percent to services. HRC placed 144 referrals for an average of 4.1 referrals per client.

**Table 5.** Number of Trauma Types Experienced and PTSD/Depression Correlation

| Number of trauma types | All clients | Received PTSD diagnosis | | Received depression diagnosis | |
|---|---|---|---|---|---|
| | n | n (%) | p-value | n (%) | p-value |
| 1 | 6 | 4 (66.6) | ns | 0 (0) | ns |
| 2-3 | 41 | 34 (82.9) | | 14 (34.1) | |
| 4+ | 52 | 42 (80.8) | | 23 (44.2) | |

The most common referrals included mental health services (28.5 percent), housing (19.4 percent), primary care (15.3 percent), food assistance (13.2 percent), and health insurance coverage (7.6 percent). Other referral types included dental care, clothing, support groups, employment services, and language services.

*Clinic interventions and adaptations to client trauma*

HRC clients carried a tremendous burden of complex trauma and mental illness. In response, clinic leaders enacted numerous adaptations to the clinic structure and function to lower barriers to FME access, reduce the impact of trauma suffered by clients, and

**Table 6.** HRC Adaptations to Trauma Burden

| |
|---|
| Improvements to the client's experience |
| 1. Diverse, language-concordant medical students called clients en route to HRC, met clients in person at the clinic, and explained FME procedures to enhance comfort and safety. |
| 2. Attendance barriers were reduced by providing childcare onsite, offering a healthy fresh meal, and paying for safe transportation to and from clinic. |
| 3. To eliminate the deployment of family, friends, or attorneys as interpreters, HRC used UCSF certified medical interpreters to improve the quality and consistency of interpretation and enhance client confidentiality. |
| 4. To meet client needs and foster social integration, medical students provided each client local referrals based on immediate needs and reached out by phone over 12 months. |
| Improvements to the evaluator's experience |
| 5. To assure a pipeline of trained clinicians, all clinical evaluators engaged in formal FME training, observed at least one evaluation, and engaged in peer review. |
| 6. Monthly onsite clinics allowed evaluators to perform FMEs with medical student volunteers and medical director support for complex evaluations. |
| 7. To optimise documentation quality, HRC used a model FME template based on the Istanbul Protocol and expert consensus. The template improved consistency and quality of the evaluations and data capture. HRC now uses a digital version of the standard template. |
| 8. Briefing meetings occurred at the beginning and end of onsite evaluations. A separate formal debrief led by a social worker focused on skill development, peer support, and secondary trauma reduction. |
| Improvements to the medical student leadership experience |
| 9. Medical student volunteers completed a 10-week elective on immigration and asylum medicine. |
| 10. Employing a continuous improvement model, student leaders reviewed referrals, affidavits, and client follow-up data to improve client-centred processes. |
| 11. To reinforce the medicolegal partnership, clinicians and students met with attorneys to review FME goals and key findings. |
| 12. By engaging in multiple roles such as program leaders, data managers, clinic operations coordinators, legal network development, and trainers, students enhanced leadership skills and dedication to social justice efforts. |

minimize vicarious trauma in HRC students and clinicians (Table 6).

## Discussion

We presented a demographic and trauma profile of asylum seekers in the San Francisco Bay Area between 2019 and 2021, conducted analyses to better understand their health needs, and reported practices aimed at minimizing FME barriers and reducing clinician and student trauma impact.

HRC site-specific data reinforce reports of the demographic shift among asylum seekers in the U.S. over the past two decades (Asgary et al., 2006; Cuneo et al., 2021; Lustig et al., 2008; Miller et al., 2021; Moreno et al., 2006; NCTTP, 2015; Zero et al., 2019). Whereas U.S. asylum seekers were previously mostly men fleeing political persecution from Africa, today the majority of asylum seekers are female victims of domestic and gang violence from Guatemala, Honduras, and El Salvador. A core competency of clinicians performing FMEs is to understand current and emerging trends in torture and ill-treatment across the world. Thus reports describing asylum seeker characteristics are essential to informed medicolegal affidavits.

HRC FMEs revealed a high burden of cumulative traumatic experiences in this population of asylum seekers. Clinicians recorded histories of ill-treatment, torture, and assault that typically involved multiple perpetrators and settings and occurred over decades. These patterns are reflected in studies of asylum populations around the world (Asgary et al., 2006, Baranowski et al., 2019, Clément et al., 2017). Together, they demonstrate a common narrative of asylum seekers as individuals who flee systemic violence after enduring multiple forms of prolonged and recurring trauma.

More than 60 percent of HRC clients, including 79 percent of women, experienced sexual violence. Comparing SV rates in HRC clients to international data is challenging due to a lack of consistent SV definitions, populations, and research methodology. A 2018 critical interpretive synthesis described that, "clear and robust SV rates among migrants, asylum seekers and refugees are lacking… there is a pressing need for high-quality representative prevalence studies on SV…" (De Schrijver et al., 2018). The range of SV rates in asylum seekers and refugees has been reported from 10-90 percent in a variety of settings and using a variety of definitions, but rarely have rates exceeded 50 percent in non-conflict settings. HRC's reported rate of sexual violence is consistent with other reports among Central American women (Aguirre et al., 2020; Baranowski et al., 2019; Cuneo et al., 2021).

The high prevalence of female asylum seekers and high rates of SV reflect the gender-based violence (GBV) from which HRC clients flee in Guatemala, Honduras, and El Salvador. Clinical interviews revealed a common narrative of women who were abused as children, entered early marriages or domestic partnerships, and remained in relationships in which they endured frequent physical, psychological, and sexual assault. Several relevant reports on migrants from Central America also document systemic gender-based violence. UNHCR's Women on the Run (2015) describes similar rates of beatings, intimidation, threats, and insecurity among detained Central American women, most of whom neither filed police reports nor felt protected by authorities. Reporting on asylum seeking women presenting for FME, Baranowski (2019) documented early exit from school, forced child labour, and intimate partner violence including blunt and sexual trauma. The current study augments existing literature by further characterizing systemic GBV in Guate-

mala, Honduras, and El Salvador and demonstrating that it persists. Importantly, a recent report suggests GBV may be worsening in these countries ("*No way out*," 2020).

Among HRC clients, mental health conditions were ubiquitous and often diagnosed for the first time during the FME. Four of every five clients received a diagnosis of PTSD, which is in the higher range of prevalence rates reported by other studies of refugees and asylum seekers (Blackmore et al., 2020; Hameed et al., 2018; van der Boor et al., 2020). The ICD-11 Complex-PTSD (CPTSD) diagnosis includes symptoms which occur more often after exposure to events from which "escape is difficult or impossible such as childhood sexual abuse, torture, and detention" (Fortuna et al., 2019; Hyland et al., 2018; Maercker, 2021). Nearly every HRC client experienced some level of psychological trauma, and almost 80 percent reported significant and prolonged childhood abuse or ill-treatment. While evaluating the high rate of PTSD in HRC clients, we considered several hypotheses. HRC has an intense focus and training on trauma-informed care environments and interview techniques. Additionally, HRC rates likely reflect an asylum population from different countries with different torture and ill-treatment patterns than in other published reports.

Asylum seekers receiving an HRC FME rarely experienced single, discrete traumatic events such as an arrest, kidnapping, or persecution of limited severity and relatively short duration. More commonly, HRC clients suffered a lifetime of traumatic experiences. Among refugees and asylum seekers, there have been various attempts to understand which components of a trauma history portend a worse mental health prognosis. Some report that mental health outcomes depend on qualities intrinsic to past traumatic events, such as number, type, or severity of trauma (Knipscheer et al., 2015; Miller et al., 2010; NCTTP, 2015; Nosè et al., 2020; Steel et al., 2009). In contrast, others theorise that mental health outcomes result from variables independent of the trauma itself ("*Australian guidelines,*" 2019, Başoğlu et al., 2005; Song et al., 2018), especially co-occurring stressors such as poverty and deprivation, perception of safety, and a lack of control over life. Our findings suggest that the prevalence of mental illness in asylum seekers is independent from the number of past types of trauma experienced. As research in this area progresses, findings will likely demonstrate that the number or severity of trauma events alone is inadequate to predict mental health conditions which are inherently multifactorial.

Contrasting the high rates of mental illness with the low rates of psychological care in HRC clients highlights their level of disenfranchisement. Literature supports that after migrant torture survivors enter the U.S., delays in treatment correlate with a higher prevalence of mental illness (Song et al., 2018). There is an urgent need for understanding the impact of FMEs and early referrals to trauma-informed healthcare on mental health trajectory. The HRC experience presents early insight into the integration of follow-up services into the FME process. Other SRACs have previously described follow-up programs (Ruchman et al., 2020). By documenting the most requested referral services, we demonstrate the health and social needs of asylum seekers. Like the reported national experience, HRC clients who received an FME and had their case adjudicated were granted asylum at a very high rate (Nicholson et al., 2017; TRAC, 2021), a critical finding given that delays in asylum decisions worsen distress and increase the risk of psychiatric disorders (Hvidtfeldt et al., 2020).

*Translating findings into HRC policies and practices*

HRC leaders enacted real-time interventions and adaptations to its clinic structure and functions in response to the complexity of client trauma and the trauma impact on clients, students, and clinicians (Table 6). HRC learned from the experiences of other SRACs in the U.S as well as from case series in similar settings across the world (Gu et al., 2021; Ruchman et al., 2020; Sharp et al., 2019). Prior studies on SRAC structure and format have focused on the challenges of optimizing logistics, retaining clinicians, building sustainable leadership, improving handoffs between student leaders, and increasing caseloads. We describe the practical steps we deployed to reduce the barriers and trauma faced by clients and clinicians.

FME access barriers included transportation to clinic, after hours options, childcare, language concordant medical students and clinicians, and free high-quality interpretation services. HRC provides FMEs, safe transportation, meals, childcare, and certified, trauma-trained interpreters at no cost to clients. HRC clinicians working in this environment of intense trauma face the challenges of client, student, and their own trauma. Clinicians and students listen to graphic stories of trauma after their regular workdays. To mitigate the impact of this exposure, HRC holds briefing meetings before and after evaluations and a monthly debrief led by experts from a partner trauma treatment centre. Finally, peer review and mentoring foster community and social connection.

*Study challenges and limitations*

The HRC population is small to date and representative of asylum seekers in the Bay Area. FMEs gather data on trauma and torture experiences through self-report, and there is typically no opportunity for independent confirmation, as is true for all asylum evaluations.

Prior studies of asylum seekers and refugees report a significant relationship between the number of prior trauma events and mental health, although with small effect sizes (Knipscheer et al., 2015; NCTTP, 2015; Song et al., 2018; Steel et al., 2009). HRC analyzed the association between the number of past types of trauma and current PTSD or depression symptoms. Sample size and uniformity as a result of high rates of PTSD limited this analysis. Evaluation of legal outcomes of FMEs in clients is limited by the large backlog of immigration cases in the U.S. during the study period.

The Istanbul Protocol outlines international legal standards and guidelines for legal and medical investigations of torture and ill-treatment. UCSF HRC employed these practices as a benchmark for conducting FMEs. While standard domains appear in most FME templates, there is no consistent national or international format that includes standard data elements across all types of evaluations. Terminology, level of detail, format, and inclusion of data elements such as psychological and functional impact, body diagrams, resilience factors and suicide risk are highly variable (Scruggs et al., 2016). Report format is influenced by evaluator preferences, type of evaluation, and other factors (Ferdowsian et al., 2019). In this study, trained medical students extracted data from narrative FMEs and, as a result, the study may underestimate the prevalence of findings due to inconsistent documentation as well as variable capture of some metrics. HRC is mitigating these limitations by ongoing training, peer review of all cases, and use of a standard evaluation template collected through a survey tool (Redcap, https://redcap.vanderbilt.edu) which allows affidavit consistency as well as direct, rapid, and

accurate data capture and analysis. The cases described in this study reflect only those performed over HRC's first 24 months, a period when the HRC did not yet use the new standard template.

*Future directions*

Studies are needed to develop standard metrics for FME documentation, post-asylum mental health and functional status measures, and strategies to improve consistency of asylum grant rates. Additionally, research is needed to investigate the impact of documentation of early or prolonged trauma on legal and clinical outcomes as well as the impact of forensic evaluations on clients and family relationships. A revised model FME template should collect data on medical comorbidities and client grief, hope, and resilience. Asylum seekers will benefit from studies clarifying the relationship between trauma events, survivors' perception of events, and incident mental health outcomes.

A serious challenge for the UCSF HRC is its location in an academic medical centre, similar to other SRACs. Models for sustainable funding for pro-bono evaluations in this typically uninsured population, academic recognition for unpaid student and faculty time, support for treatment of secondary trauma in clinicians, and systems that support ongoing clinician contributions to social and health justice are urgently needed.

## Conclusion

This report provides a descriptive analysis of the demographic patterns and characteristics of trauma and mental health sequelae among a sample of U.S. asylum seekers predominately from Central America. The constellation of lifelong traumatic events in these clients demands a trauma-centred setting for forensic evaluations. As long as human rights violations persist around the world, survivors with critical needs for safety, forensic medical documentation, and treatment will seek care and support. Systems must strengthen resources for the prevention, treatment, and resilience in trauma and torture survivors. To have a significant impact, clinicians and researchers should further describe the profile of trauma and torture survivors, as well as the impact of FMEs on their legal, psychological, social, and functional status.

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# Participation of psychologists in Istanbul Protocol based physical examinations: an applied perspective

**Daniel J. N. Weishut**[1]

**Objective**

When invited to evaluate a middle-aged male asylum seeker regarding alleged torture, the following question kept coming to my mind: Would it be appropriate, perhaps even vital, for mental health professionals to participate in Istanbul Protocol (IP) based *physical* examinations? The intent is not to *do* the physical examination but to be present, observe, ask relevant questions, and witness with the client's consent. The article elaborates on this question while sharing my perspective as a clinical psychologist and referring to relevant literature.

*Keywords*: torture and ill-treatment, clinical evaluation, interdisciplinary collaboration, Istanbul Protocol, mental health professionals, Israel.

**Introduction**

In the last decades, the IP has been the primary medico-legal tool in evaluating victims of alleged torture and ill-treatment and their consequences. The complete IP evaluation requires a multidisciplinary team, which focuses on documentation and witnessing, and is used internationally in courts (UN Office of the High Commissioner for Human Rights, 2022). The IP evaluation is considered an expertise. The first training course on the IP in Israel took place in Israel in 2014 (Abu Akar et al., 2014). It was facilitated by the International Rehabilitation Council for Torture Victims, partnering with the Public Committee Against Torture in Israel. I joined this course and subsequently completed the training of trainers.

The IP evaluation includes a psychological and a physical examination, often a full body examination, and requires the expertise of both a physician and a mental health professional because torture's consequences are often complex with psychological and physical symptoms. The IP notes that it "may be advisable for the experts in physical evidence and psychological evidence to conduct one evaluation together" (UN Office of the High Commissioner for Human Rights, 2022, p. 76). It adds that in "assessing the health consequences of torture and ill-treatment, it is important to consider and to probe into the interrelationship between the physical, psychological and social consequences of ill-treatment" (UN Office of the High Commissioner for Human Rights, 2022, p. 88)

According to the IP training, a psychologist or other mental health professional and a physician participate in the *psychological* examination, whereas only the physician partic-

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https://doi.org/10.7146/torture.v32i3.128792

ipates in the *physical* examination. (Sometimes, an interpreter participates as well.) The option of psychologists' participating in the physical part of the IP evaluation - albeit in a secondary role - has until now not been deemed an issue worthy of discussion, whereas the fact that physicians participate in the psychological part is considered obvious. The non-participation of the mental health professional in the IP-based physical examination is a professional asymmetry. This asymmetry may have to do with schooling. Physicians learn about mental health, though much less than clinical psychologists, whereas psychologists (in most branches) learn about physical health issues but do not have medical training. (Psychiatrists are an exception, as they are knowledgeable and trained in both fields.) The asymmetry seems to be also related to the interprofessional hierarchy, in which the physician - appropriately or not - is seen as a higher-status professional (cf. Gergerich et al., 2018; Hoffman & Koocher, 2018).

To demonstrate why it could be advisable for a psychologist or other mental health professional to participate in the physical examination, I will relate to three different facets of the IP-based evaluation, which are a) the holistic approach to the evaluation as a whole, b) the collaboration between psychologist and physician, and c) the concern for privacy and consent and the role of the chaperone.

### The holistic approach of the evaluation

Psychological and behavioural processes are closely related to physical health and illness (Richards & Cohen, 2020), and we may view mental health as the health of the whole body (Alessi et al., 2020). When we evaluate the consequences of torture (and not only), we take this holistic approach and relate to the combined and interacting impact of physical and mental aspects of the trauma, which is multi-faceted and often massive. It is all about integrating the physical and the emotional, while the specific interaction between body and psyche is heavily based on the subjective experience of the particular client.

Physical health may significantly impact one's psychological well-being and is therefore regularly taken into account by mental health professionals. In my practice, clients who are disabled often talk about and show me – on their initiative – their limitations so that I get a better understanding of their difficulties. Thus, one of my elderly clients feels highly distraught by the fact that due to a fall, she cannot raise her arm as she used to, though both her physician and physiotherapist declare she is okay. She displays what she can and cannot do, which gives me a better understanding. Likewise, a torture victim's little scar can be of psychological significance, as it may remind of the experienced trauma, be perceived as disfiguring the body, and impact self-esteem. The observation of the scar could be relevant for the mental health professional to obtain a better understanding of the situation.

I became acutely aware of the professional asymmetry when a physician and I interviewed an African refugee a couple of years ago. This man, who was in his twenties, had found his way to Israel after dreadful experiences in Sinai. He told us an abhorrent story and, at some point, complained that his scars had a negative effect on his self-esteem. As he was fully dressed, I could not see any scars. I also sensed a discrepancy between his words and his sporty appearance. I believed that the impression of the extent of his scars was necessary to understand the psychological dynamics, as would be his reaction to exposing the scars. However, at the time, it did not occur to me to ask to observe the physical examination.

The physician did the physical examination alone and informed me that there was ex-

tensive scar tissue. He initially did not want to show me the pictures for privacy reasons, but I insisted since I considered them highly relevant from a psychological perspective. Only after receiving the images was I able to grasp how our client must have felt, as the scars were large and numerous, with significant changes in skin color. In hindsight, I believe I should have been present during the physical examination. My presence in the physical examination would have given me a fuller picture of the damage to the man's body and the resulting impact on his self-esteem, like the presence of the physician during the psychological examination gave him a fuller picture of our client's state.

For a clinical psychologist and other mental health professionals, there is a difference between receiving pictures from a third person and obtaining a first-hand description. I could compare this with situations concerning my clients, who sometimes ask me to read their writings about traumatic events they experienced. As a psychologist, I want to get as close as possible to their experience. Therefore, I ask them to read the text aloud, as the essence is in how the client relates to the traumatic material, something I would miss if I had only received the written text. Similarly, if I obtain pictures from the torture victims' physical examination, I miss part of the experience.

**Collaboration of psychologist and physician**

The concept of clinicians meeting clients together is not new. In fact, three decades ago, I participated in a project in which psychologists joined physicians in their regular flow of primary care consultations (Aronzon, Weishut, Unger & Fraenkel, 1995). Primary care models of collaboration between psychologists and physicians described clinicians working jointly with clients and maintained that clients with PTSD respond well to this arrangement (Holloway & David, 2005). In healthcare services, there nowadays is an emphasis on interdisciplinary teams (Richards & Cohen, 2020). Moreover, a recent publication with best practices and recommendations for psychologists refers to two overarching themes for the future of global mental health: the consideration of cultural/contextual variables and collaboration (Hook & Vera, 2020).

For many tortured clients, there are more psychological than physical signs of trauma. In some places, standard practice is that mental health professionals and physicians independently perform evaluations of alleged torture. Separate evaluations make things easier for psychologists, as they have a line of professional thought in the interview, which will not be interrupted by a sometimes helpful but occasionally side-tracking physician. It also would save the physician time and emotional effort. In contrast, this is not common practice in Israel and other places, where clinicians perform IP evaluations jointly in only one session. Physicians are present during history taking and the examination of psychological symptoms. Thus, they can ask questions regarding possible medical consequences of the victim's experiences. They also may notice things that went unnoticed by the other professional. Moreover, talking to both clinicians together, the client does not need to repeat the story.

Likewise, the mental health professional would be an expert in observing psychological aspects during a physical examination and could have insights to offer. In addition, the IP requires various measures to assure objective and exact reporting of physical findings, which are complex to administer alone. The mental health professional could be instrumental in, for example, the measurement, mapping, or photographing of scars. They also could assist in taking notes of the explanations provided

by the client, comments by the physician, and the situation as a whole. To make it clear, this is not in any way to suggest that the mental health professional will do a physical examination, as this is not part of the psychological expertise.

The presence of a mental health professional during a physical examination might influence the evaluation. For example, it could impact the client's transference toward the clinicians and the relationship between the clinicians. This is comparable to the physician's influence during the psychological examination and the interpreter's presence in both the psychological and the physical examination. Moreover, not all mental health professionals will feel comfortable joining the medical doctor in the physical examination and being exposed to physical symptoms. Similarly, for physicians and interpreters, it may take some effort to become accustomed to the exposure by clients of traumatic material verbatim.

If there are any difficulties in the collaboration, they need to be discussed. After all, communication in the collaboration is essential in the success of the three-way relationship between client, physician, and psychologist, as all parts bring invaluable perspectives on the situation to the benefit of the client (Holloway & David, 2005; Hook & Vera, 2020). A study on the collaboration of physicians and mental health professionals assessing torture victims in Israel elaborates on this issue (Weishut, Gurny, Rokach & Steiner Birmanns, 2022).

### Privacy, consent and the chaperone

Privacy, informed consent, and confidentiality are concerns central in ethical codes of conduct for psychologists and physicians, such as the American Psychological Association and the American Medical Association, and the IP refers to these issues. Privacy is as relevant in the psychological as in the physical examination since the disclosure of details regarding trauma is often experienced as disclosure of an intimate nature, different but still comparable to the display of one's body. Therefore, clients need to consent to any part of the evaluation, including the presence of all individuals, and can opt out at any moment. In addition, all information obtained from the evaluation must be kept private unless the client waives confidentiality.

The privacy issue remains debatable because, during the IP evaluation, there is regularly more than one clinician in the room, often an interpreter and sometimes an observer. We leave for discussion elsewhere the question of whether clients actually feel they can refuse to have someone participate in the examination. For personal and cultural reasons or because of a perceived power differential, they may feel that they should accept the situation as is.

For safety reasons, one may consider that it is better to have the encounter between clinician and client not in private. There is an increasing tendency to make room for medical chaperones to protect both clients and physicians from alleged or actual misconduct during sensitive examinations (Pimienta & Giblon, 2018). The American Medical Association recommends having an authorised health care team member serve as a chaperone during physical examinations and suggests that this may help prevent misunderstandings (American Medical Association, n.d.). Furthermore, there was a recent call for health care institutions to provide trained chaperones to act as "practice monitors" during breast, full-body, skin, genital, and rectal exams (AbuDagga et al., 2019). Also, the University of Michigan Health (2020) provides a clear policy regarding chaperones, stating, among others:

> *1) A chaperone is a person who acts as a witness for a patient and a health professional during a medical examination or procedure. A chaperone should stand in a location where he or she is able to assist as needed and observe the examination, therapy or procedure.*
> *2) A chaperone may be a health care professional or a trained unlicensed staff member. This may include medical assistants, nurses, technicians, therapists, residents and fellows.*
> *[…]* (Chapter: Definitions)

Medical organisations in other parts of the world too recommend using medical chaperones in sensitive examinations (Alameer et al., 2021; Anikwe et al., 2021). Moreover, the lack of availability of a chaperone or the client's decline of their use poses an ethical dilemma, questioning whether the physician could proceed with an intimate examination (Thuraisingham et al., 2017).

There is no doubt that IP evaluations include sensitive physical examinations. They are sensitive not only because of their nature but also on grounds of intersectionality: issues of gender, race, class, legal status, and more. The procedure is all the more delicate in cross-gender examinations, as clients may prefer not to be alone with a physician of the opposite gender for reasons such as those related to their trauma or religion. (In Israel, most torture evaluations are of Muslim men, whereas most physicians are Jewish women.) Consequently, the involvement of a medical chaperone seems appropriate if the client consents. The chaperone could be the mental health professional with whom a relationship was established earlier in the evaluation.

In the case of the middle-aged male asylum seeker, whom I mentioned before, the female physician and I had discussed the issue of participating together in all parts of the examination. We took the anamnesis jointly, and she stayed with us during my questioning regarding his psychological state. Yet, when asked, the client had not felt the need for a chaperone during the physical examination, and the room was so small that it would be uncomfortable for another person to attend. The client had not spoken about any scars but had mentioned torture-related genital problems. With that said, we considered it less appropriate for me to observe a genital check, which is anyhow delicate. Therefore, I remained outside but close enough to hear their conversation. We agreed that if the physician felt this could help, she would call me.

## Conclusion

The article centres on the participation of psychologists (or other mental health professionals) in physical examinations that are part of the Istanbul Protocol evaluation and refers to three different facets: the holistic approach of the evaluation, the collaboration between physician and psychologist, and privacy, consent, and the role of the chaperone. It is not self-evident for the psychologist to have a physician participate in the psychological examination of a client. Likewise, physicians may struggle with having a mental health professional participate in the physical examination. Still, this form of collaboration might be the recommended arrangement for the client's sake. Therefore, let me conclude by reiterating the question: Would it be appropriate, and perhaps even vital, for mental health professionals to participate in Istanbul Protocol-based *physical* examinations? I believe the answer is positive, at least in some cases, with the client's consent.

## Acknowledgements

Thanks to Bettina Steiner-Birmanns, David Senesh and Rachel Rokach for their valuable input and support.

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# The manipulation of minds: reckoning with the legacy of the American post 9/11 torture program

**Maria Hartwig[1] and Mark Fallon[2]**

**Abstract**

In this article, we argue that the government's post 9-11 torture program was a big lie, in that the designers, executors and enablers knew all along that torture does not elicit reliable information. We review the government's own research on the matter, and we discuss the ways in which methods known to be unreliable were implemented, most saliently at the detention facility at Guantánamo Bay. We review the secrecy and propaganda surrounding the scope and horror of the torture program at Guantánamo and black sites around the world, and the painful truth of how the government knowingly adopted the terror policies of the torture program, against their own knowledge, against international human rights, and against the law.

On January 20, 2021, Joseph R. Biden, Jr. became the 46th President of the United States, following what might very well have been the most chaotic election in the recent history of the United States. The turmoil reached a peak on Jan 6, 2021, when Trump supporters stormed the Capitol in Washington, DC. At the center of this extended and ongoing political upheaval is what has been labeled "The Big Lie" – the completely disproven notion that Biden's win was based on fraudulent grounds, and that the election was stolen from Trump because of a corrupted voting process.

President Biden has consistently rejected reality warping and presents himself on the national stage as a man of reason, and a strong supporter of science. He has proclaimed "Science is discovery. It's not fiction", as he announced that his team of scientific advisors would summon "science and truth" to combat climate change, the COVID-19 pandemic and other challenges facing his new administration, adding "The same laws apply, the same evidence holds true regardless of whether you accept them."

President Biden can show his self-proclaimed commitment to truth by following through on his words with action. In particular, he can fulfil the task which his two predecessors, Trump and Obama, both failed to do: *Closing the detention facility at Guantánamo Bay*. The same United States law and international law apply; the same evidence, or lack thereof holds true for those remaining 38 prisoners being held within the confines of a US-run concentration camp in the Caribbean. The laws of science apply, the rules of evidence apply, and the rule of law applies. Science and truth cannot be situationally applied to suit political agendas, especially not

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https://doi.org/10.7146/torture.v32i3.131962

within the confines of a facility once called a "Battle Lab" (Leopold, 2015), where the military touts phrases like "honor bound" and "defend freedom" at the entrance, yet the truths of what goes on inside are withheld from the public record, via the government's complex layers of secrecy, including classification, redactions, and obfuscations.

There can be no justice without truth. The system has derailed every effort to bring the suspected 9/11 terrorists to justice before tribunals that have failed and have been derailed by torture. While President Biden can't remove the stain of the national torture policies, he can show that the Constitution endures; that the rule of law prevails, by illuminating the shadowland of the torture regime. Joe Biden needs to demonstrate that truth matters - even painful truths.

In this article, we will describe that through a painstaking and laborious process of discovery, we now know that behind the gates of Guantánamo Bay and its related archipelago of black sites there were prisoners, often held on dubious grounds or no reasonable grounds at all. We know that these prisoners were submitted to treatments aimed squarely at generating complete psychological disintegration. As we will lay out in the article, prisoners captured during Operation Enduring Freedom and Operation Iraqi Freedom were subjected to physical violence, sexual violence, and an astonishing array of psychologically abusive tactics under the misnomer 'interrogation'. We also know that the torture program metastasized into a monster, as if lifted from the pages of the most absurd of postmodern fictions, and that the United States has never held anyone accountable, nor faced any reckoning for this disaster of human rights (Senate Select Committee Study of the Central Intelligence Agency Detention and Interrogation Program, 2014). And we know that the disaster that was the torture program was all based on lies, one big lie in particular – that *torture worked to break through to truth*. The chief argument, which we will defend below, is that the schemers behind the system of torture *knew all along that this was bogus*; that torture does nothing to produce truth, that what it breaks is a person's autonomy and very selfhood, rendering them compliant in the extreme. Indeed, the CIA and United States military, who both committed war crimes, *knew all along that they propagated falsehoods* – our main argument is that the historical record shows that the CIA itself has a long history of studying precisely the effect of techniques like those employed post 9/11. As we shall see, the so called architects had no interrogation experience, but were well-versed in communist-based methodologies known to produce false information.

### Reckoning with an American Gulag

The issue surrounding Guantánamo Bay is broader than the mere closing of the physical prison and doing justice to the thirty some men still imprisoned there, if such a thing is even remotely possible at this time. It also involves a vast reckoning with America's involvement in and administration of one of the most egregious human rights violations in recent history: The state-sponsored torture program consisting of *a family of interrogational abuses* deployed in the name of the so-called War on Terror (Luban & Newell, 2019). It also involves exposing the systematic efforts on behalf of the perpetrators of the program, to hide from the American public what happened, to redact to the point of absurdity, to knowingly and pervasively transmit false propaganda about the program's nature, effects, and effectiveness. All of this entails exposing the full truth about the torture program, even if the facts that constitute the full truth are ugly, painful, or embarrassing -

without the truth, a genuine reckoning with our conduct and our professed values cannot occur. Without a reckoning of atrocities, like the trials at Nuremberg, how can we know that the United States will not commit them again? We cannot.

The transfer of power allows presidents to shape American history and control the nation's destiny. Presidents hold the power to wage war or keep the peace, to pardon and prosecute, and to convene tribunals for the violations of the laws of war. As the Guantánamo torch has been passed, Joe Biden is the fourth president to hold it. Meanwhile, lingering in a legal labyrinth and maligned procedural problems, 36 tortured prisoners remain in limbo, in classified confines on a military outpost far from their homes.

The prison at Guantánamo Bay is a symbol of a military tribunal system that is approaching its third decade, ironically established under an operation called Enduring Freedom (Bravin, 2013). Operation Enduring Freedom triggered the Guantánamo Bay war courts, whereby President George W. Bush issued a military order asserting his authority to try suspected al-Qaeda terrorists before military tribunals. Bush targeted al-Qaeda, an organization that pledged allegiance – bayat - to Osama bin Laden, whose terrorist attack, killing almost 3,000 on September 11, 2001, brought America into a state of existential shock.

Since the first prisoners arrived at Guantánamo on January 11, 2002, approximately 780 prisoners have been held captive there, with nine dying there, and all but 36 others released or transferred (see the Guantánamo Docket, 2022). Yet, there have been no trials for the 9/11 and USS Cole (DDG-67) suspects. There have been Transfer Review Boards convened by the DoD Criminal Investigation Task Force (CITF), JTF-GTMO Detainee Assessments, Combatant Status Review Tribunals, a Guantánamo Review Task Force, and ongoing Periodic Review Boards, lacking transparency, trying to imagine if they could prevent some future crime that might be committed, and keeping the crimes we committed on the prisoners shrouded in secrecy. While President Obama admitted "we tortured some folks", the who and how we tortured apparently, and who committed the torture, edges too close to potential accountability for the perpetrators, both individuals and agencies.

The people currently imprisoned at Guantánamo Bay are suspected war criminals, captured in the war on Afghanistan, by now the longest-lasting war in US history. This war has outlasted the Civil War, Spanish-American War, both World Wars, and the Korean War combined. The Constitutionality of the military commissions processes have been repudiated by the Supreme Court, required Congressional revision, and have resulted in international condemnation. President Obama failed to close the Guantánamo prison through two terms, and President Trump, who campaigned he would "load it up with some bad dudes," signed an executive order to keep the prison at Guantánamo Bay open. The time to close it is overdue. On July 2, 2021, the last official military officials were exfiltrated from Afghanistan, ending two decades of occupation. Bagram Air Base, which had housed the Bagram Collection Point, where so many Guantánamo prisoners transited through, was overrun by looters. On July 26, 2021, President Biden and Iraqi prime minister Mustafa al-Kadhimi sealed a deal, formally ending the US combat mission in Iraq by the end of 2021, evoking images of the famous "Mission Accomplished" banner that hung behind President George W. Bush on the aircraft carrier USS Abraham Lincoln (CVN-72), declar-

ing major combat operations in Iraq had ended in May 2003. With Operations Enduring Freedom and Iraqi Freedom over, the only way for President Biden to deal with the human remains of those operations, the Guantánamo 36, is to come to terms with the American torture program.

### The torture regime: a big lie

In the beginning of this article, we referred to the contemporary 'Big Lie' of 2021 as the one claiming that Biden's presidential authority is invalid because of a fraudulent election. From a historical perspective, this is surely not the only political lie of noteworthy scope– we could point to many examples (e.g., the Watergate scandal, the secrets that were exposed in the Pentagon papers, see Ellsberg, 2003, and the revelation of the program of covert criminal activities conducted by the FBI, partly under the codename COINTELPRO, see Johnson, 2015). Here, we point to another Big Lie; one that is not relegated to history but in fact unfolds in present time and runs like a thread through Operation Enduring Freedom and Operation Iraqi Freedom into the present day.

This Big Lie is about the torture techniques employed under various euphemisms - Enhanced Interrogation Techniques (EIT), or Counter-Resistance Strategies (CRS). These were the restoration of the psychological torture legacy programs described in the KUBARK Counterintelligence Manual and later called Human Resource Exploitation (HRE), when images of CIA "interrogation" invoked too many unpleasant images. As we shall see, these tactics were known all along by the very government that administered them, to NOT be effective in generating true information – making this an intentional act to mislead the public about the actual effects of the techniques. The government engaged in a series of propaganda and public perception management efforts about interrogation in order to promote the view that harsh tactics including physical, psychological and sexual abuse were necessary to produce true information – again, a view they themselves had known to be false for a long time.

We make bold claims. How do we know that the government told a big lie when they touted the harsh interrogation techniques? There are at least three reasons. First, the Department of Defense (DoD) and the Central Intelligence Agency (CIA) possessed a plethora of documents, some produced by the entities themselves, outlining the maltreatment and torture of prisoners of war (POW's). The government widely catalogued the treatment of POW's captured and detained during World War II, the Korean war, and by Communist Soviet and China.

Second, the government, in particular the CIA, has a long history of experimentation on human subjects, far beyond the reach of modern ethical review boards necessary by federal law. In the case of the CIA's programs, their pattern is one of focus on *manipulation and control of the mind*. Before providing some detail of the CIA's efforts and investment in programs of mind control, let us pause to contemplate what the purpose of such a program was likely to be. Numerous writers and commentators have likened the purpose of these experimentation to the creation of a psychological blank slate – a erosion of the self and a suspension of volition so profound that the subject in question would commit actions even against the fundamental instinct for self-preservation.

Third, the government continuously rejected the advice of interrogation professionals responsible for investigating al-Queda – these professionals adviced against harsh mea-

sures and instead advocated the use of rapport-based methods (Fallon, 2017).

In short, the government has clearly known for many decades that people, through relentless use of tools that exploit the human mind and body, people can be made to behave like slaves (or more precisely, become slaves), driven to comply with any command, including saying anything they believe their masters want to hear. Despite this, after the terror attacks on 9/11, the CIA carried out a systematic information operation which manipulated the media, the public, and policymakers, and the entire chain of command to enforce the known lie that the process of psychologically breaking a person can and will lead to reliable intelligence (Senate Select Committee Study of the Central Intelligence Agency Detention and Interrogation Program, 2014).

### The CIA's pursuit of mind manipulation and control

A government can justify interest in matters of mind manipulation for defensive purposes. For example, understanding how a person can be systematically broken down is of relevance for United States' POW's and the threat they may pose to national security. However, mind manipulation and control can also be deployed offensively, in order to gain some form of perceived advancement, as in the case of the CIA.

As early as 1956, the CIA produced a report entitled *Brainwashing: A Psychological Viewpoint*, which drew on some 300 previously classified or unclassified documents on the topic (with an estimate that the total number of such documents available at that time likely exceeded 1,000). This remarkable report was unclassified in 1999 and begins with a quote from the French writer Jules Verdain: "We know now that men can be made to do exactly anything……. It's all a question of finding the right means. If only we take enough trouble and go sufficiently slowly, we can make him kill his aged parents and eat them in a stew".

The aim and anticipated outcomes of brainwashing are clearly reflected in the foreword to the CIA's early report, in which a brainwashed person is described as "an involuntarily re-educated person". The means to this end are described in detail, including the systematic process of isolation, sleep disruption, environmental and dietary manipulation and sustained situational, social and psychological stressors. The report described techniques which rendered the subject "completely helpless" and as viewing the interrogation as a welcomed break "after a long period of isolation, anxiety and despair."

Below, we will describe how the United States government rolled out, under the guise of 'interrogation', a program of mind control – that is, psychological and physical torture - entirely similar to the techniques studied by the CIA under the theme of 'brainwashing', as well as related methods used in current military training for those at high risk of capture (e.g., SERE training, for Survival, Evasion, Resistance, Escape). They did so despite knowing the effects. It is sometimes stated that the government 'reverse-engineered' these methods to create an "interrogation" program for high-value targets who were supposedly trained in sophisticated techniques to withstand interrogation[1]. In fact, the $81 million program

1 A document found in an al-Qaeda cell in Manchester which contained scattered information about how to prepare for battle became the foundation for the widely floated myth that al-Qaeda members were armed with counterinterrogation techniques, and therefore may need extraordinary measures. In fact, there has never been any evidence presented that the so-called Manchester manual was widely circulated beyond the British cell, nor

executed under a CIA contract awarded to James Mitchell and Bruce Jessen was a direct replica of well-known techniques of interrogational abuse (Biederman, 1956, Report of the Committee on Armed Services, 2008). In a civil suit brought by the ACLU involving three detainees, one of whom died in CIA custody, Mitchell and Jessen denied any legal responsibility, and mounted a defence based on an unflattering comparison between their role as contractors and those who sold Cyklon B to be used in Nazi gas chambers[2]. Regardless of legal responsibility, it is clear that the effects of the torture techniques were long known, and the government had *no basis to believe that their 'enhanced' interrogations would lead to gains in intelligence*. In fact, there was tremendous opposition by individuals, commands and agencies within the government (Fallon, 2017).

### The big lie unfolds: the 9/11 torture program

On August 6, 2001, President George W. Bush was briefed that bin Laden was determined to strike the US. Signals of danger in the intelligence community included uncorroborated threat reporting from another service that 'Bin Laden wanted to hijack a US aircraft to gain the release of "Blind Shaykh" 'Umar" Abd al-Rahman and other US-held extremists" (National Commission on Terrorist Attacks Upon the United States, 2004). While the system was blinking red, and bin Laden's intentions should have been clear following the attack on the USS Cole (DDG-67) and al-Qaeda's history, 19 hijackers turned commercial aircraft into missiles and were able to commit a premeditated mass murder claiming the lives of almost 3,000 people. In the days and weeks following those attacks, the Bush administration set in motion a political and legal process that culminated in the American GULAG archipelago of black sites. In this big lie to the American public, the administration proceeded to utilize techniques that they knew generated nothing of substance – and furthermore, deployed them in thick clouds of secrecy, so that the American people would never know the depravities perpetrated in their name.

On November 13, 2001, President Bush made the historically unusual move to invoke the military in the pursuit, prosecution and punishment of these crimes. He issued an order that held that the perpetrators of the 9/11 attacks should be brought to justice via a system of military tribunals. On September 17, 2001, President Bush secretly issued a Memorandum of Notification which allowed the CIA to establish the Rendition, Detention and Interrogation (RDI) program, one of several euphemisms for processes and programs that included kidnapping and torture. After urging by the CIA, on February 7, 2002, he signed a memorandum stating that the Geneva Convention – which former Deputy Counsel of the CIA John Rizzo called 'pesky little international obligations' (Ladin, 2016) - did not apply to the conflict with al-Qaeda, further paving the way for the commission of torture.

is there evidence that al-Qaeda operatives were systematically trained in counter-interrogation. In spite of this, the CIA used the myth on repeated occasions to justify the expansion of the torture program and subsequent execution of ever-more brutal treatment.

2 This defense strategy is strange, since the Nuremburg tribunals did in fact hold suppliers of Cyklon B responsible. Furthermore, the comparison is half-baked because while suppliers of lethal gas presumably did only that, Mitchell and Jessen were far more involved in the events – Mitchell himself functioned as an 'interrogator' on multiple occasions, and he has admitted in public hearings to waterboarding Khalik Sheik Mohammed (while also committing physical assault).

On March 28, 2002, Abu Zubaydah was captured in Pakistan and transferred to CIA custody. His case marks the first known instance in which the government resorted to the use of torture after 9/11. Not long after the torture of Zubaydah began in the fall of 2002, CIA detainee Gul Rahman died, chained to the wall in a detention site called COBALT (most likely the CIA black site Salt Pit north of Kabul, Afghanistan), naked from the waist down in what is called a stress position designed to maximize pain, with the apparent cause of death being hypothermia. His family has never been officially notified that he is dead, and his body has not been returned. It is worth noting that the CIA officer who ordered Gulman's shackling distorted the course of events around his death to CIA headquarters, but that rather than facing consequences for his actions, a CIA station recommended that he be awarded a $2,500 cash award for his 'consistently superior work'.

### The case of prisoner 063

The victims of the government-sponsored torture program are too many to list here, and the gruesome treatment they endured is too vast. We can however use the case of Mohammed al-Qahtani, aka prisoner 063, as an illustrative example of the methods used in the torture program (Zagorin & Duffy, 2005). He was believed to have been the so-called "20th hi-jacker", who landed in Orlando, Florida in August 2001, allegedly in order to meet with Mohammed Atta, the ringleader of the 9/11 plot. An immigration officer rejected his cover story based on its implausibility, and al-Qahtani was deported. More than a year later, he was captured, detained, and subjected to a stunning range of abuses by his captors, the United States government, and specifically the US military. His case is the only instance in which the United States has confessed to committing torture (Glaberson, 2009). al-Qahtani now remains in custody, reportedly in a psychiatric facility in Saudi Arabia.

The treatment of al-Qahtani was documented by the government itself, using a routine system for logging activities. The interrogation logs read like a diary of an extended nightmare. There are at least 83 pages of entries documenting a process that somehow manages to be systematic, haphazard, relentless and arbitrary all at once. It is a document of torture – again, the government admits it - but it also stands as a horrific exemplar the CIA's longstanding obsession with 'brainwashing', the process we characterized earlier as breaking a person apart entirely in order to reach a point of complete submission and subjugation.

The interrogation log, beginning in November 2002 reports a remarkable range of mistreatments, including relentless sleep deprivation, humiliation and manipulations aimed at producing in the detainee an experience of complete loss of control and autonomy.

For example, on November 24, 2002, al-Qahtani, after having been allowed to sleep at midnight the night before, is woken up at 4:00 am for continued interrogation. The 9th and 10th log entries of that morning read "*0457: SGT R advises detainee not to sleep*." And "*0509: SGT R advises detainee not to sleep.*" The 24th log entry of that day is at 8:40 am: "*SGT R has the detainee stand for 10 minutes to stretch and avoid sleeping.*", followed by "*0900. SGT A asks the detainee if he wants to pray and sleep. The detainee says yes. SGT A says you have to drink water. The detainee says no. SGT R gives detainee 1 more chance. The detainee says no. SGT R empties water on floor and tells the detainee "you had your chance". The Corpsman then checks the detainee's vital signs, they are OK. 0925: SGT A discusses levels of guilt and sin. 0930: SGT A talks about the embarrassment of using a weak cover*

*story and mixes in the "You can make this stop" approach. The detainee remains unresponsive*." In the late afternoon, al-Qahtani is so dehydrated that medical personnel coercively administer fluids via IV: "*1800: Medical personnel checked vital signs and determined that detainee needed to be hydrated*.", after which the interrogation resumes. The last log entries of November 24 read "*2330: Detainee began to cry. 2400: Pressure wrap was put on detainee's feet to combat the swelling. Detainee was put to bed*", with interrogation beginning at 4 am on the following day.

The onslaught of tactics and the seemingly haphazard way in which they were employed are also illustrated by the logs for November 26 (another of the many days with interrogations beginning at 4:00 am). They read "*1835: SGT M takes over the interrogation. P&E down*[3] *was employed (ie You look like hell. Do you want to see me everyday and pray on the floor where you urinated?). 1845: Manchester Document*[4]*/ Futility- The Al-Qaida training manual was written by somebody who never went through an interrogation. 1850: Why doesn't Usama bin Laden use his children, or why does he not participate in suicide missions? Al-Qaida is falling apart theme/futility. SGT M reviewed with detainee the slips that he made. 1905: Manchester Document theme/futility. 1930: P&E down. 1940: SGT B takes over interrogation.*

*2010: Detainee drinks a bottle of water and is allowed to pray. Comparison is made between idol worship and swearing Bay'a to Usama bin Laden*."

Some of the degrading treatments are so absurd that they border on the incomprehensible. For example, the fourth log on December 2, 2002, reads "*0630: Detainee taken to bathroom and exercised. Control started session with Arabic lesson and explained how Saudis go to Bahrain for alcohol and prostitutes. Continues we are in control approach*.", followed by "*0800: Detainee taken to bathroom and offered water. 0900: Detainee woken up and offered MRE – refused.*

*0910: Lead cleaned detainee's face and combed hair and beard. Showed 9-11 video. 1000: Lead and control explained that detainee has no control. 1030: Control began "birthday party" and placed party hat on detainee. Detainee offered birthday cake - refused. Interrogators and guards sing "God bless America". Detainee became very angry*." The next day, at 09:30 am: "*Interrogators gave class to new MPs in view of detainee stating the resistance training, clouded thinking, series of mistakes, and attempts to gain control that the detainee has exhibited. Interrogators ran puppet show satirizing the detainee's involvement with Al Qaida.",* and on December 13, the log reads "1115: *Detainee taken to bathroom and walked 10 minutes. Offered water – refused. Interrogators began telling detainee how ungrateful and grumpy he was. In order to escalate the detainee's emotions, a mask was made from an MRE box with a smiley face on it and placed on the detainee's head for a few moments. A latex glove was inflated and labelled the "sissy slap" glove. This glove was touched to the detainee's face periodically after explaining the terminology to him. The mask was placed back on the detainee's head. While wearing the mask, the team began dance instruction with the detainee. The detainee became agitated and began shouting. The mask was removed and detainee was allowed to sit. Detainee shouted and addressed lead as "the oldest Christian here" and wanted to know why lead allowed the detainee to be treated this way.*".

3 This is shorthand for Pride Down and Ego Down, two Army Field Manual-endorsed tactics which entail various attacks on the person's self and identity as well as their belief systems. In this instance, the 'interrogator' was likely referencing an earlier logged event where the detainee was denied requests to use the bathroom, forcing him to urinate in his pants.

4 See footnote 1.

Of what use could puppet shows, birthday party hats, and 'sissy slap gloves' be in gaining intelligence? The answer is as plain as it seems – none. However, these spectacles serve a different purpose, and that is the purpose of humiliation. 063 was far from the only prisoner who was subjected to *systematic humiliation*, and the telegraphic text of his interrogation logs belies the brutality with which humiliation was used (Harris & Mak, 2014; Senate Select Committee Study of the Central Intelligence Agency Detention and Interrogation Program, 2014). Some of the themes of humiliation were based on existential belief systems (e.g., desecrating symbols of the holy) - behavior that may seem innocuous but can cause profound inner turmoil, reactions that are rooted deeply in our evolutionary past (Rozin & Haidt, 2013).

Other themes of humiliation weaponized by the CIA were sexual in nature, whereby a range of harassments and assaults were inflicted on the sexual identity of the detainee, with the chief purpose, again, of humiliation and subjugation. Detainees were groped, forced to look at sexual materials and pornography (the 063 logs document at least three instances in which al-Qahtani was forced to wear a string of binders [sic] of scantily clad women around his neck), forced to masturbate, and/or they were sexually assaulted under the euphemism of "Invasion of Space by Female". One writer notes that "[t]he mounting evidence of sexualized interrogation of suspected enemy combatants makes clear Abu Ghraib was not an isolated incident. Rather, the evidence points to it being a calculated strategy of war. Indeed, evidence of this policy, including interrogation methods that exploit the interrogator's gender, comes directly from the government itself" (Rumann, 2010).

Some of the harassment and assault on detainees, including the sexual abuse, was tailor-made for a given person, based on exploitation of their personal and medical history. Relatedly, other forms of abuse were gross exploitations and/or violations of the body conducted on quasi-medical grounds (e.g., forced rectal 'rehydration' or 'feeding' administered in a punitive manner). Unbiased data shows that these abuses led to permanent psychological scarring (Iacopino & Xenakis, 2011).

Regarding psychological scars from Guantánamo Bay (Apuzzo, Fink, & Risen, 2016) and the case of al-Qahtani, it is worth noting that al-Qahtani already suffered from severe mental illness before being taken into custody by the United States government. As an 8-year old boy, he suffered a traumatic brain injury which led to permanent mental impairment, including severe dysregulation of emotion and impairments in executive functioning (i.e., the basic ability to exercise self-control, see Center for Constitutional Rights, 2020). As a teenager, he displayed signs of schizophrenia (with which he was diagnosed in 2000), and he was confined to a psychiatric facility after a public psychotic episode.

Let us zoom out from the details for a moment. What happened in the case of prisoner 063 is that the United States knowingly deployed a range of extremely violent tactics on a deeply ill man. Beyond ethics; it is a legal absurdity: Even the most primitive systems of justice display some degree of jurisprudence whereby certain categories of people are not liable criminal targets because of their basic incompetence to fulfil the criteria of *mens rea*, in simple terms, the possession of a guilty mind. We do not prosecute children nor the deranged (at least in theory), for this reason. In the United States justice system, there exists a variety of safeguards and barriers meant to screen out those not mentally competent to meet the criteria of mens rea. Considerations

of a person's mental state occur at multiple levels – for example, a person needs to meet certain criteria for competency to stand trial in the first place; they also need to be mentally competent to make various legal choices (e.g., whether to waive the right to an attorney, the right to a jury trial, and even the competency to be executed).

It was former Secretary of Defense Donald Rumsfeld who personally authorized the plan to proceed with the full scope of brutality against al-Qahtani (who, again, ought to be a moot subject for prosecution because of his insanity). Further, Rumsfeld was "personally involved" in his interrogation plan and requested "weekly briefings" on his case.

It is morbid to think of one of the most high-ranking politicians in the nation personally engineering the suffering of a sick prisoner. Yet, this is what happened. Would the Secretary of Defense give direct advice on (botching) a surgical procedure in a given military field operation? Of course not, the notion is absurd; surgery requires professionalism and skills, and in any event, such a matter would be far below the level of the Secretary of Defense. Yet, in the case of al-Qahtani, the absurd could not be more real – Rumsfeld's physical signature of approval to proceed to torture al-Qahtani is documented by the government itself.

Interestingly, in 2011, several media outlets including CNN reported that al-Qahtani had provided critical information related to the courier whose positions and movements were used to hunt and kill Osama Bin Laden (Joscelyn, 2011; Ross, 2011). These accounts were based on 'anonymous government officials', who implied, if not outrightly stated, that it was the torture of al-Qahtani that generated this supposedly key piece of intelligence. The media reported on (and thus contributed to) a re-ignited defence of the torture program based on the intelligence attributed to al-Qahtani. Even if the claim was true, it certainly does not morally nor legally justify anything. But is the claim true? In fact, it is completely implausible. Recall that the Pentagon's own records show that al-Qahtani was already at Guantánamo Bay undergoing torture in November 2002 – he was captured by Pakistani security forces on December 15, 2001 and brought by the US to Guantánamo Bay on Feb 12, 2002. How is it logically possible that al-Qahtani could have possessed intelligence about the whereabouts of Bin Laden's courier, after nearly 10 years of imprisonment, even if it is true that he met the person in question prior to his capture? It is not. The only reasonable conclusion to be drawn is that the media propagated government lies that seemed designed to smear al-Qahtani, provide further justification for torture. The CIA's intentions were forecast long before the conspiracy to torture was perpetrated and can be found on the CIA's own website (declassified for release in 2016). This chilling legal analysis executed on November 26, 2001, establishing *institutional mens rea*, states: "A policy decision must be made with regard to U.S. use of torture in light of our obligations under international law, with consideration given to international opinion on our current campaign against terrorism—states may be very unwilling to call the U.S. to task for torture when it resulted in saving thousands of lives" (Mazzetti, 2014).

The case of prisoner 063 is a travesty of justice and a tragedy, regardless of his planned involvement in the 9/11 plot. The fundamental injustice of his treatment by the United States government, along with his pre-existing mental illness, generates in its totality a picture of an unimaginable personal hell – a hell he is still suspended in as we write these words. The treatment of prisoners in US custody should shock the conscience of anyone able to see through the thin remaining veil of secrecy, and

the deceptive calculus of the torture enthusiasts and their enablers. After 20 years of indefinite detention, '20th Hijacker' was repatriated to Saudi Arabia for mental health care, in a move opposed by three Republican senators (Rosenberg, 2022).

### The age-old propaganda machine muddling the truth

Whatever ideological differences may exist in general, or however people may differ in their moral, political and religious belief systems, under international law it remains factually true that the American government committed war crimes during the so-called War on Terror. As we have described, the documentation is overwhelming. Despite this, some vocal defendants of the torture regime engaged, and continue to engage in linguistic acrobatics regarding the definition of torture, and/or rely on phony and made-up legal justifications to downplay numerous elements of what was done to prisoners of war, on the soils of the American GULAG that included Guantánamo Bay (Honigsberg, 2017). Denial of the facts that the US engaged in war crimes can of course partly be driven by purely instrumental, self-oriented motivations to escape scrutiny and possible punishment for involvement in criminal conduct. But it is also worth noting that existential shock and fear alters people's patterns of thought in ways that may not be clear to a lay observer, or even to the person themselves: Social psychological science shows that fundamental fear, of the kind that was instilled in many by the terrorist attacks on 9/11, leads people to psychologically close ranks, to rally against an enemy, real or perceived, and to seek punishment, partly as a symbolic way to display adherence and loyalty to the code of one's own tribe (Pyszczynski, T., Solomon, S., & Greenberg, 2003). In this view, much of the torture regime was not driven by rational reasoning at all, but by psychological motives for existential relief. To the extent those who continue to embrace torture operate based on a (likely non-conscious) hunger for raw retribution (Carlsmith & Sood, 2009), they are likely to be beyond rational argument.

### Restoring truth, justice and the American way

President Biden must expose the big lie about torture, restore the rule of law and adhere to international conventions on human rights. Cruelty as policy must be repudiated. The prohibition against torture is absolute and the fruits of that poisonous tree must be acknowledged. Every drop from the poisoned chalice is contaminated. For justice to prevail, torturers must be unmasked. Accountability can take many forms and one of them is a public acknowledgement and reconciliation of truth. The military commissions process at Guantánamo Bay is not justice delayed, it is justice deceived. A clean team, one not involved in any manner in the torture program, should conduct a complete review of the full Senate Torture Report, with a view towards transparency. If fair trials cannot be conducted, prisoners should be released. No one should be held indefinitely without trial. The danger posed here is not from their release, but an insider-threat - from ourselves. As the late Senator John McCain said in his impassioned speech from the floor of Congress when the Torture Report Executive Summary was released: "But in the end, torture's failure to serve its intended purpose isn't the main reason to oppose its use. I have often said, and will always maintain, that this question isn't about our enemies; it's about us. It's about who we were, who we are and who we aspire to be. It's about how we represent ourselves to the world."

## Concluding remarks

What the government set in motion resulted in incalculable suffering and loss. There has been no justice for the victims of 9/11, nor for the war crimes committed in the pursuit of the culprits. Instead, there has been bloodshed, dread, tears and terror – all unfolding under a defunct military commission which seemed foolish to begin with. Under the most common of moral and legal frameworks, the government, including but not limited to the CIA, is culpable for this mess, on the simple basis that their actions were *purposeful* – malice aforethought, because they knew the effects of the physical and psychological weapons they deployed; they knew the harm it would cause, and – despite the lies they told the public – they knew it would not work to elicit accurate and reliable intelligence.

All of this is painful to acknowledge; to think that there has been such a big lie, such an ugly lie, that this lie has been told to us repeatedly by representatives of a government that claims democracy; that not a single score has been settled with regards to those responsible; all this in its totality resists psychological processing. It is our human nature to believe that the world is a fair and just place. We *want* to believe this, because such a belief structure provides order to the terror of an uncertain world. We shudder to imagine a place where gratuitous pain is inflicted on the undeserved, perhaps because in such a morally agnostic universe, we ourselves are candidates for victimization. But our epistemic preferences are one thing, and the truth is another. If we are to live in a rational world, a principled one, truth must trump existential discomfort – it may even be that truth must be the most cherished principle of all.

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# Literacy limitations to psychological evaluation tools: The case of MU*

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## Introduction to the reader

In this case, a survivor of torture presents with symptoms clinically consistent with both major depressive disorder (MDD) and post-traumatic stress disorder (PTSD). During her evaluation, a validated psychological questionnaire for PTSD was administered verbally through a translator and accurately identified this diagnosis. However, a self-administered (read and completed by the client) questionnaire for MDD vastly underestimated the severity of her symptoms and failed to diagnose her with depression. The client had not completed grade school, so it is likely that her literacy level impacted the accuracy of this questionnaire. This highlights one of the many limitations that exist when administering psychological surveys. Through understanding these limitations, forensic evaluators can develop ways to identify, mitigate, and overcome limitations of these useful tools.

## Background

Patient MU is an approximately 35-year-old female seeking asylum in the United States after experiencing years of gender-based violence in Central America. Growing up, she attended school through the third grade before her father removed her from further education because he believed education was not for girls. As a young child, MU was sexually abused by her father's co-workers, a relative on her mother's side, and later her own father.

In early adulthood, MU endured ongoing psychological, physical, and sexual abuse from her long-time partner. This included being hit in the head to the point of losing consciousness and being forcibly confined to the house for one month. MU reported this abuse to the local police multiple times, but they never took her partner into custody and told her they could not help her. When she discovered that her partner was also sexually abusing her young son, she left Central America and travelled to Mexico with two of her children.

In Mexico, MU's partner threatened to report her to the local authorities and to have her killed if she returned to her home country. MU felt that she had insufficient evidence to bring charges against her partner if she returned home, so she travelled to the United States to seek asylum. Under the United Na-

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* Non-peer-reviewed section. The views expressed in the contributions to this section are those of the authors and guest editors

https://doi.org/10.7146/torture.v32i3.132023

tion's Convention against Torture, MU meets criteria for torture as she experienced severe physical and emotional harm as a result of her gender and with acquiescence of the local police. She was evaluated shortly thereafter by a psychologist as part of her asylum case.

### Ethical considerations

Written or verbal informed consent was obtained from the patient for de-identified information to be used for research and case reports.

### Psychological signs and symptoms

MU was interviewed in her primary language of Spanish, via a professional interpreter. On examination, she was relaxed, cooperative, and articulate, with a normal thought process. Her affect was depressed and she became tearful when discussing painful and traumatic memories. She expressed hope for the future.

MU reported multiple psychological symptoms as a result of her trauma, including difficulty falling and staying asleep, frequent nightmares, and problems with concentration and memory. She described being easily startled and experiencing flashbacks of her trauma, especially when she saw accounts of intimate partner violence on television. Traumatic memories of her past frequently intruded her thoughts, causing her to cry and feel anxious. She also felt guilt and shame over what happened to her and her children.

During her evaluation, MU completed the Patient Health Questionnaire 9 (*PHQ-9*, a 9-item validated questionnaire for depression), and the Harvard Trauma Questionnaire (*HTQ*, a 16-item validated screening tool for Post-Trauma Stress Disorder in refugee populations). She completed a self-administered written Spanish language version of the PHQ-9 assessment on the computer. She scored a 4 (out of 27 possible points), which is below the cut-off for a diagnosis of depression. On the other hand, the HTQ was read aloud to MU in English by the evaluator, and then translated into Spanish by an interpreter. On this test, MU received a 2.52, with scores higher than 2.5 consistent with a diagnosis of PTSD.

### Interpretation and conclusion

The psychological findings uncovered during MU's evaluation were highly consistent with the years of abuse MU described, and she met clinical criteria (per the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, known as the* DSM-V) for both Major Depressive Disorder and PTSD based on the symptoms she described. While she scored only a 4 on the PHQ-9, MU spoke of more severe depressive symptoms during her interview, including depressed mood, sleep difficulties, issues with concentration, and guilt. This discrepancy suggests that her low score on the PHQ-9 underestimated the severity of her depressive symptoms. Given that her father removed her from school in third grade, it was thought that her literacy level contributed to an inability of the self-administered questionnaire to measure her depressive symptoms.

In contrast, MU scored higher than 2.5 on the HTQ, exceeding the cut-off point for a diagnosis of PTSD. This diagnosis was consistent with her reported symptoms of intrusive thoughts, nightmares, flashbacks, hypervigilance, sleep disturbance, and difficulty concentrating. As the HTQ was administered verbally through a Spanish translator, it captured a more accurate assessment of her symptoms.

### Discussion

In this case, the self-administered PHQ-9 vastly underestimated MU's current depressive symptoms, while the verbally adminis-

tered HTQ more accurately reflected her current psychological symptoms. Given the frequency that clinicians (especially those who are not mental-health specialists) utilise self-administered psychological assessments in forensic evaluations, the limitations of these tools must be considered and best practices established to avoid the pitfalls of their use.

The utility of diagnostic surveys may potentially be affected by the mode of questionnaire administration, as well as issues of literacy, language, and cultural difference. For example, face-to-face oral interviews can establish rapport and create space for open-ended questions. However, social desirability bias may cause the interviewee to water down responses to be more agreeable to the interviewer (Bowling 2005). Conversely, while self-administered surveys may suffer less from social desirability bias, they place a greater language and literacy burden on the survey taker (Bowling 2005), as in the case of MU.

Employing a mixed-mode design (e.g. interview followed by a self-administered survey) or alternative method of survey administration could help mitigate these biases (Bowling 2005) and limit the burden on the client. For example, telephone-administered PHQ-9s have been shown to yield similar results to self-administered PHQ-9s, demonstrating that a verbal administration reliably measures depression (Pinto-Meza et al. 2005). Additionally, some clinically validated surveys are available at different literacy levels. Assessing literacy prior to administration could also help to choose the right tool or delivery method (Olson et al. 2011). Finally, clinicians may consider the use of other scales to measure symptoms of depression, such as the Hamilton Depression Rating or Beck Depression Inventory. However, recent studies have suggested that the PHQ-9 is more accurate and reliable in distinguishing the severity of depression when compared with the Hamilton Depression Rating (Ma et al. 2021). When the PHQ-9 was compared with the Beck Depression Inventory (BDI-II), both scales were virtually interchangeable for assessing symptoms of depression. Given that the PHQ-9 is shorter and free to use as opposed to the copyrighted BDI-II, the study concluded that the PHQ-9 was still preferable for use (Kung et al. 2013). At many institutions, the PHQ-9 is the preferred questionnaire for depression screening during forensic asylum evaluations.

As the content of the PHQ-9 correlates directly with the DSM-V criteria for depression, it allows forensic evaluators to use the DSM-V as a standardized framework to easily support a diagnosis before a judge or legal system. It also provides structure for non-psychiatrist evaluators to supplement their physical exams with a brief, validated, psychiatric evaluation tool. That said, even with an improved mixed-method approach to survey administration, the cultural and linguistic limitations of questionnaires must also be considered. Studies have shown that the PHQ-9 is effective at assessing symptoms of depression across certain ethnic groups, cultures, and migration backgrounds, specifically showing validity and reliability in Spanish speaking countries in Central America such as Honduras (Wulson et al. 2002) and also Mexico (Arrieta et al. 2017), which can be applied to the case of MU. However, it remains possible that individual patients may face barriers to having symptoms of depression fully elicited by the PHQ-9 (Galemkamp et al. 2017; Zhong et al. 2014; Reich et al. 2018). First, for questionnaires created in English and translated into another language, the essence of a question may be lost in translation or not culturally understood in the way it was originally intended (Soukenik 2020). Moreover, conceptualizations of depression and mental health can vary across

cultures, which may pose a challenge when administering a questionnaire based on concepts derived from Western cultures (Lindheimer et. al 2020). Studies investigating how depression presents cross-culturally support the idea that different cultures may express and demonstrate various conditions differently (Hwang et al. 2008). There also may be significant stigma attached to expressing certain mood or other mental health symptoms, or perhaps a normalization of certain symptoms (fatigue, sleep difficulties) that a client may not identify as pathologic on a Likert-based scale like the PHQ-9. While there are likely universal forms of depressive symptoms that our tools can accurately identify, cultural variability should also be considered when working with a diverse patient population and making an accurate case for those we evaluate (Baradaran Eftekhari et al. 2021).

Overall, while validated psychological questionnaires are useful tools in forensic psychological evaluations, it is imperative to recognise their limitations and consider their results in conjunction with clinical judgement. In MU's case, an initial assessment of literacy level could have determined that an oral rather than written administration of the questionnaire would produce more accurate results. Still, even when such surveys are administered in a mode best for an individual client, significant obstacles may remain to applying them across cultures. In the case of MU, administering a verbal survey in her primary language yielded the most reliable description of her psychological symptoms, allowing the evaluator to accurately diagnose her and support the consistency of her experience.

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# Launch of the revised version on the Istanbul Protocol

**Zeynep Koseoglu**

On the 29th of June 2022, an updated version of the Istanbul Protocol was launched in Geneva, Switzerland; twenty three years after its first official endorsement by the OHCHR (Office of the Human Rights Commisioner, UN) in 1999. The Istanbul Protocol, or the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; guides human rights activists, experts, and organizations around the world.

The launch of this revised version was enabled by the contributions from more than 180 experts of the anti-torture field. It was hosted by the Geneva Academy of International Humanitarian Law and led by the Istanbul Protocol Editorial Committee.

The Istanbul Protocol lays out the international legal norms and standards for dealing with torture and ill-treatment. It sets the relevant ethical codes, and provides guidelines for the legal investigation of torture. The Protocol also details general considerations for interviews and the guidelines for documenting physical and psychological evidence. The revision adds in two sections which respectively underlines the role of health professionals in documenting torture through various contexts and provides recommendations on the implementation of the Protocol.

Informed by six years of preparation and consultation, this revised version was spearheaded by four civil society organizations (the Human Rights Foundation of Turkey, REDRESS Trust, Physicians for Human Rights, and the International Rehabilitation Council for Torture Victims) and four UN bodies, (Committee against Torture, the Subcomittee on the Prevention of Torture, Special Rapperteur on Torture; as well as the UN Voluntary Fund for Victims of Torture).

This is the second update to the Protocol, the first being 18 years earlier in 2004. The revision of the Istanbul Protocol is not a replacement but rather an expansion. The document attempts to fill in the gaps created by almost two decades of global change.

In the foreword of the updated document, Michelle Bachalet, UN High Commissioner for Human Rights, calls for states to make the Istanbul Protocol an 'essential part of training for all relevant public officials and medical professionals engaged in the custody, interrogation and treatment of persons subjected to any form of arrest, detention or imprisonment' (OHCHR, 2022).

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https://doi.org/10.7146/torture.v32i3.133934

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

# Integrating livelihoods in rehabilitation of torture survivors

**Pau Pérez-Sales, Editor-in-Chief, and Berta Soley, Associate Editor. Torture Journal.**

### Background

There is an on-going discussion about the need for a holistic approach to torture rehabilitation, claiming that psychosocial and medical services are not effective if basic needs remain uncovered. Mental and physical health has been a primary focus of rehabilitation programmes, but many found that progress was difficult to maintain without socio-economic support as well. Survivors still have households to feed, battled unemployment and disabilities caused by the atrocities committed against them.

Recognising the complexity and inter-connectivity of social, economic, medical and psychological sequelae of torture, where one aspect can negatively or positively affect the other, **this special edition of the Torture Journal seeks to explore how the integration of rebuilding a life project and the livelihood's component can influence rehabilitation processes**. Indeed, additional academic contributions are required to better understand how healing processes can be enhanced by including socio-economic support in rehabilitation programme.

### Call for papers

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

a. Defining livelihoods and its relationship with the concept of development in the context of the work with torture survivors. Going beyond a definition centered in material outcomes and working with the idea of life projects and finding meaning as part of the work with torture survivors.
b. Survivor participation in design and implementation of livelihoods programs
c. Innovative experiences in livelihoods programs: evolving from a business perspective to livelihoods programmes for social change.
d. Transcending the individual or family perspective: from cooperatives to collective forms of organisation in livelihoods programmes.
e. Beyond vulnerability: innovative approaches to resource allocation in precarious

environments.

f. Ensuring sustainability of livelihoods programs. The role of the State and civil society.
g. Working in unstable contexts: livelihoods programs under conflict situations.
h. Barriers to livelihoods programmes: limitations to work and employment integration in asylum seekers and refugees.
i. Transnational experiences connecting refugees, relatives and comrades in country of origin.
j. Effects on the overall well-being and quality of life resulting from the integration of a socioeconomic component into the rehabilitation processes.

**Deadline for submissions**
31st December 2022

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- For general submission guidelines, please see the Torture Journal website. Papers will be selected on their relevance to the field, applicability, methodological rigor, and level of innovation.

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

# Perspectives on survivor engagement in the work with torture survivors

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

### Background

Though the term 'survivor engagement' is itself contested, it generally entails processes or activities through which people who have undergone traumatic experiences become actively involved in efforts to address the causes or consequences of those experiences at a community or societal level.

It is apparent that a considerable knowledge gap exists with relation to 'survivor engagement' in torture rehabilitation and advocacy. In particular, there is a paucity of research and documentation which examines the various approaches to and the effectiveness and ethical dilemmas of 'survivor engagement'.

In an effort to address this knowledge gap, the Torture Journal is issuing a call for papers.

The objective is to **gather and disseminate perspectives and experiences from researchers and practitioners on survivor engagement** within the anti-torture sector. These are expected to help organisations engaged in the sector to understand what works and under what conditions.

### Call for papers

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

a. What is 'survivor engagement in an anti-torture or torture rehabilitation context'? The definition and the theoretical underpinnings of advocacy or health-based models
b. Psychosocial and quality of life impact on survivors after participating in survivor engagement activities
c. Stigma and other barriers to survivor engagement
d. Re-traumatisation: risks and safeguards
e. Advocacy engagement of people seeking asylum
f. The role of healthcare workers and civil society organisation's in supporting survivors to engage – balancing empowerment and duty of care
g. Recommended practice in survivor engagement with mass media
h. Mechanisms to support survivors to access decision-making roles in organisations addressing

torture rehabilitation or legal reparation

i. The impact of survivor engagement groups in community networks
j. Gender-specific needs and gaps in participation

**Deadline for submissions**
31th December 2022

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ISSN 1018-8185