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TORTURE

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Detection and assessment of victims of ill-treatment and torture in Primary Health Care. Quick guide including developments in the 2022 updated version of the Istanbul Protocol.

Pau Pérez-Sales* and Paula de la Fuente**

Torture can be briefly defined as situations in which severe pain or suffering is intentionally inflicted on a person by State agents for a specific purpose. In particular, but not limited to, the extraction of information, obtaining a confession, retaliation, punishment or discrimination (UN General Assembly, 1984). Where intent cannot be established or the purpose is uncertain, or where the pain or suffering is considered to be of lesser severity, it is deemed, from a legal point of view, as cruel, inhuman or degrading treatment (CIDT) (Amnesty International, 2016).

The distinction between torture and CIDT is of little relevance from a clinical point of view. Both are covered by the Convention Against Torture and are forms of legal classification that imply a duty to detect and document from the health professionals¹. There are alternative definitions to that of the International Convention that are based on criteria

closer to the field of health. Torture is referred to, from a clinical point of view, as the use of strategies to weaken and break an individuals' free will. This may be done through techniques that cause physical (pain, debilitation, manipulation of the environment) or psychological (fear, humiliation, shame, anguish, guilt) suffering and harm (Pérez-Sales, 2017).

Torture continues to exist in most parts of the world, in both the global North and South, although it can take different forms and be used in contexts very different from the classic imaginary of interrogational torture to obtain information. Much contemporary torture is about "everyday" ill-treatment involving routine or seemingly banal actions that involve severe rights violations.

The Istanbul Protocol is the international guide to the legal and forensic documentation of alleged cases of ill-treatment or torture. Initially formulated in 1999, it was revised in 2004 and has recently been expanded and updated (UNHR, 2022)². This recent revision is included as part of the core of this editorial.

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1 Clinician is defined in the IP22 as a health professional who provides health-care services and/or conducts clinical evaluations of alleged torture and ill-treatment, thus including not only doctors. Mental Health Clinicians are defined as health professionals with specific

mental health training and/or certification, such as psychologists, psychiatrists, social workers, psychiatric nurses and mental health counsellors.

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

Table 1. Examples of relevant day-to-day clinical practice where ill-treatment or torture might appear

Hospital or health centre emergency room	<ul style="list-style-type: none"> • Examination of detainees brought by law-enforcement agents • Mistreatment of demonstrators • Conditions in prisons or/and other detention centres • Conditions and allegations of mistreatment of migrants in removal or deportation proceedings
Primary care consultation - community health centre	<ul style="list-style-type: none"> • Complaints of police abuse by a patient • Assistance to persons transferred to consult from places of deprivation of liberty • First care for migrant patients, especially in airport or border contexts
Paediatric Consultations	<ul style="list-style-type: none"> • Children exposed to risk of institutional harm • Signs of abuse or ill-treatment within the family (duty to protect)
Aged care homes	
Mental health centres; Psychiatric hospitals	<ul style="list-style-type: none"> • Involuntary internment • Restraints
Custodial centres - Centres for the protection of minors	<ul style="list-style-type: none"> • Drug abuse; Coercive treatments • Discriminatory behaviours when assigning medical treatment • Degrading treatment / Neglect
Care centres for people with disabilities	
Prisons	<ul style="list-style-type: none"> • Overcrowding. Physical conditions of detention
Short-stay detention centres (police stations or other)	<ul style="list-style-type: none"> • Food and Nutrition • Mental illness. Treatment of drug addictions • Physical Restraints • Complaints of ill or degrading treatment
Intentional patterns of discrimination or punishment by state or parastatal actors - administrative or institutional violence	<ul style="list-style-type: none"> • Migrants • Gender identity and sexual orientation • Social cleansing - conditions of marginalisation or poverty • Human rights activists or defenders • People in the community who cannot act for themselves and are dependent on others (dementia, physical or intellectual disability)
Cultural practices constituting forms of ill-treatment or torture	<ul style="list-style-type: none"> • Virginity examinations at the request of the family or authorities • Female genital mutilation • Anal examinations to detect heteronormative sexual behaviour

Table 1 shows contexts in which acts of ill-treatment or torture may occur and where a primary care clinician can play an important role in detecting, preventing, documenting and remedying these situations³. We do not specifically address here the role of medical personnel attached to places of deprivation of liberty, for which there are excellent guides and specific documents and rules (Méndez, 2019).

There are, in short, many contexts in which a primary health care worker may detect or intervene in cases of ill-treatment or torture (Weinstein et al., 1996). It cannot be overemphasised that, beyond personal will and ethical commitment, there is a professional obligation on health professionals stated by different World Medical Association (WMA, 1975, 2013) and World Psychiatric Association (WPA, 2017) documents and the Istanbul Protocol⁴.

In both the global North and South, the migrant population will be a particularly at-risk group for cases of ill-treatment or torture⁵. The few studies that exist in primary health care show that (1) prevalence of torture survivors may be much higher than most health professionals expect⁶, (2) patients who have ex-

perienced political violence or torture in their country of origin do not refer this experience to their primary care physician, either because they think it is not relevant, due to cultural reasons, or because they believe that their physician will not have time to listen to them or will not be interested in the issue (Eisenman et al., 2000; Shannon et al., 2012) and (3) in the vast majority of cases, the doctor also did not ask, despite suspecting that the person may have suffered violence, and did not record the suspicion in the medical record. (Ostergaard et al., 2020).

Additionally, the primary health care professional can play a decisive role in the legal protection of the patients. The available evidence suggests that many of them are candidates for asylum or other forms of international protection, but lack this information and may miss the legal deadlines. Moreover, documenting the consequences of persecution or torture and making a medical affidavit in accordance with the Istanbul Protocol significantly increases the possibility of being able to obtain asylum or other forms of international protection. (Asgary et al., 2006; Atkinson et al., 2021).

In addition to this, are the primary health care centers located in countries where torture is prevalent or has been prevalent in the recent past⁷. In

3 For further elaboration on forms of ill-treatment or torture linked to the field of health, the reader is directed to specific reviews (Mendez, 2013, 2014; Wadiwel, 2017).

4 The ethical codes involving primary care workers can be expanded in Chapters II and VII of the Istanbul Protocol.

5 It is worth recalling that the world's top refugee-receiving countries are Turkey, Colombia, Uganda and Pakistan. Countries with the highest per capita income receive only 11% of asylum seekers and refugees globally (www.acnur.org).

6 In a study among a non-Western population in primary care practices in Copenhagen, 28% of people reported having been exposed to torture in the country of origin or in transit. In 75% of cases the general practitioner had not asked and it was not recorded in the medical record. (Ostergaard et al., 2020). In a similar study of migrants treated

in the Emergency Department of a public hospital in New York, 11.5% of migrants reported having been tortured. 77.8% had never been asked about torture by a doctor and only 14.8% had applied for asylum. (Hexom et al., 2012). In the Internal Medicine Department, 8% of migrants questioned had suffered torture. Again, reviewing the medical records, none of the cases had been detected by the primary care physician nor had the patient reported it spontaneously. (Eisenman et al., 2000; Eisenman, 2007).

7 For example, in one study in a PHC practice in an urban area of Baghdad in 2006 found that the prevalence of torture directly suffered or suffered on a family member was found to be more than 50% (Al-Saffar, 2007).

Table 2. Screening instruments for torture and health settings

Context	Instrument	Questions
Screening of asylum seekers in Denmark (Munk-Andersen et al., 2021).	Torture Screening Checklist. 4 items - Checklist meeting the legal definitions of torture	<ol style="list-style-type: none"> 1. Have you ever been arrested, detained, or imprisoned? 2. Have you ever been subjected to severe violence, threats or degrading treatment? 3. Have you witnessed others being subjected to severe violence or degrading (abusive) treatment?
Screening of asylum seekers in the US and other countries (Cook et al., 2015; Shannon, 2014; Shannon et al., 2015).	Center for Victims of Torture -Torture and War Trauma Screening Questionnaire	<ol style="list-style-type: none"> 1. In your life, have you ever been harmed or threatened by the following: government, police, military or rebel soldiers, or other(s)? If yes, what was it? 2. Has any of your family ever been harmed or threatened by the following: government, police, military or rebel soldiers, or other(s)? If yes, what was it? 3. Some people in your situation have experienced torture. Has that ever happened to you? If yes, what was it? 4. Has anyone in your family been tortured? If yes, what was it?
Public health epidemiological studies in Sweden (Sigvardsson et al., 2017).	Single General Trauma Item + Refugee trauma history checklist (RTHC) (see annex 1).	<p>Sometimes things happen to people that would upset or frighten almost everyone. Examples of such difficult and frightening experiences are: being assaulted, or witnessing other people being hurt or killed.</p> <ol style="list-style-type: none"> 1. Have you experienced any of these or some other terrifying event(s)?
Screening of foreign nationals in the outpatient Internal Medicine Department of a public hospital in New York City. (Eisenman et al., 2000) (Eisenman, 2007)	Detection of Torture Survivors Survey (DTTS)	<p>In this clinic, we see many patients who have been forced to leave their countries because of violence or threats to the health and safety of patients and their families. I am going to ask you some questions about this:</p> <ol style="list-style-type: none"> 1. In (your former country), did you ever have problems because of religion, political beliefs, culture, or any other reason(s)? 2. Did you have any problems with persons working for the government, military, police, or any other group? 3. Were you ever a victim of violence in (your former country)? 4. Were you ever a victim of torture in (your former country)?
Emergency department of a public university hospital in New York. (Hexom et al., 2012).	Short version of the DTSS + Second interview with 8 additional questions more in detail (see annex 1)	<ol style="list-style-type: none"> 1. Were you ever threatened or harmed by groups such as the government, police, military, or rebel soldiers? 2. Some people in your situation have experienced torture. Has that ever happened to you or your family?

this case, clinical documentation will enable the patient to recognize himself or herself as a victim, to establish the facts and eventually, when political conditions allow, to seek justice and reparation.

Screening Criteria and Guiding Symptoms

We see, from the above, that if you are a health worker in an area where there is a high prevalence of migrant population, of people coming from high-risk countries or if you work in a place or a facility where you know that ill-treatment is not uncommon, it may make sense for you to have a screening and detection tool for victims of violence in general or specifically for detection of victims of torture.

You can also suspect it when you find a person with socio-demographic conditions of risk and with any of these four guiding symptoms:

1. Persistent anxiety, irritability or panic attacks in response to stimuli related to situations of violence.
2. Very severe insomnia that does not improve with healthy habits or first-choice hypnotics.
3. Difficulties in concentration, problems in orienting oneself or retaining new learnings or information. The person or family report that he/she sometimes seems to be absent.
4. Musculoskeletal lesions, skin scarring, and/or generalized pain patterns with no previously diagnosed cause.

Different tools have been proposed for the detection of torture in PHC. Table 2 (ex-

tended in annexes) reviews some instruments that have been suggested as useful in literature, either in the general or for migrant population⁸. As can be seen, the content of the questions is very similar among the different scales and can be adapted to the specific work context of each health professional depending on whether the professional wants to talk specifically about torture or in more general terms (threats, violence).

Myths, doubts and realities in interviewing potential victims of ill-treatment or torture in primary care

One of the dilemmas in PHC is the competence and limits of interventions. In the field of victims of violence, this is particularly complex due to a general lack of time for consultation in many centres, combined with the duty to *first and foremost do no harm*. But these elements have to be balanced against other realities; in many places, the clinician is the only one who can do this work and the benefits for the patient are multiple, especially when the clinician has a psychosocial and holistic approach to care. Besides, there is a legal obligation of the professional to detect and intervene, in accordance with international legislation and the relevant codes of ethics.

Table 3 attempts to reflect on some of the most common doubts and myths that PHC professionals often face when dealing with victims of abuse.

8 We do not include here screening measures for mental health problems among refugees, asylum seekers or potential victims of torture, such as the Harvard Trauma Questionnaire (Bertelsen et al., 2018; Berthold et al., 2019) or the Protect Questionnaire (Mewes et al., 2018). Several dozen instruments and excellent comparative reviews exist. (Magwood et al., 2022).

Table 3. Dilemmas in detecting and intervening with victims of torture in primary health care

Myths and doubts	Reality
“Torture” is not a clinical condition but a crime	It is not a question of making a diagnosis of “torture” but of taking an adequate medical history to detect and, if possible, document the medical-psychological impacts of having suffered extreme violence.
The interviews are best conducted by a psychologist or psychiatrist in a mental health consultation or in a specialized centre for refugees or victims.	Studies indicate that the main element of a good interview with a potential victim is empathy and the creation of a bond of trust from a genuine interest in the patient’s reality. Do not assume that a mental health consultation or a refugee centre will be more empathetic than you are.
I don’t have time. There is a lot of pressure here.	In primary care it is neither necessary nor useful to go into all the details of the traumatic experience. It is important to ask the basics in order to make an adequate approach and to provide orientation to the patient.
I can harm or re-traumatise the person.	A tactful interview that gives the person the freedom to express without pressure to obtain information will not be re-traumatizing. Asking about experiences of ill-treatment or torture, if not in contexts of high risk or great mistrust, is a source of understanding and relief.
Fear of how what the patient might tell, will affect me.	This is shared with other types of seriously-ill patients. For example, those suffering from disabling and/or irreversible diseases, and most health professionals would be prepared to work with them.
I am afraid of not knowing what to do. I have no specific training.	The greatest source of insecurity is the lack of information and the absence of a plan. Have basic information in your consultation on four aspects: (1) the right to asylum and where to apply for it, (2) victim care centres in your area, (3) how to do a medical and psychological examination of a victim and whether to look for specific elements, and (4) how to draw up a clinical report according to the Istanbul Protocol. In this article, we will help you with the last two.
I am afraid of being cheated or manipulated.	In the life of a refugee, sometimes “constructing truths” is a mechanism of resilience in the face of survival difficulties and a hostile environment. It is a defense reaction, just like the one that occurs when we explore a part of the body that has long been adapting to an illness. It requires understanding and patience

There may be risks for me.

I can attract attention from employer or boss for entering into sensitive political issues.

And afterwards?

I don't know exactly what my role is

There is a delicate balance between the duty to support victims, as patients, and the risks that this may entail (see below). Each person must know how far he or she can go and what reasonable risks he or she can or should take.

The same as with any other psychosocial or community problem in primary care (bereavement, crisis, adjustment to chronic illness): provide emotional support, comprehensive understanding of the symptoms, treat them from their causes, prescribe or advise. And in some cases, document for administrative processes or report to relevant health or legal authorities.

How to interview and examine a potential victim: ethical conditions required by the Istanbul Protocol

The Istanbul Protocol (IP), as a guide for practitioners, provides indications in two aspects: what are the *ethical* requirements for conducting an interview and what are the *technical* requirements for screening and reporting.

As you will see, this is no different from any clinical interview with another patient treated in primary care. In fact, the outline of the report proposed in Annex IV of the IP mimics the structure of a classic clinical history (reason for consultation, history - in this case biopsychosocial -, current episode - account of events -, systematic physical examination and clinical judgement). The particularity lies in creating an environment in which there are no coercive elements (use of shackles, custodial staff...), the need for an informed consent (as, in fact, is required in many invasive medical or surgical procedures) and the addition when possible of a judgement of consistency between the allegations and the medical evidence.

Let us address the first ones.

These are a set of specific rules that the healthcare professional must take into account when interviewing patients, especially in the context of custody and detention (see figure 1).

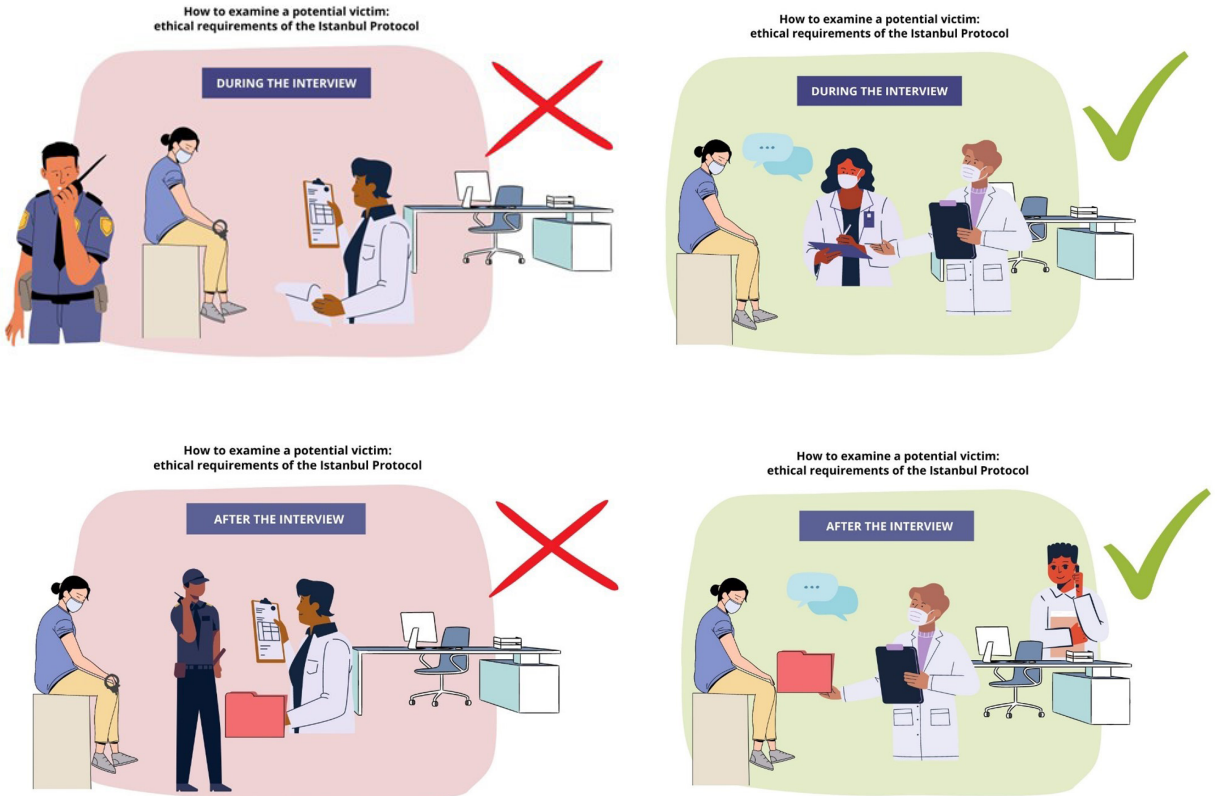
Interview conditions

1. Security conditions.

This is not usually a part of the concerns of a health worker, but in certain contexts it can be relevant and the health professional should have them in mind.

- Before assessing the person, the practitioner must assess whether there is a *risk of reprisals* for the person for speaking to the practitioner or being examined. This may occur in a detention setting (police station, prison...) or when the person is brought to consultation under police custody.
- As a rule, it is important to remember that the Protocol indicates that it should NOT be the same officers who made the arrest or who could be the potential aggressor, who bring the detainee into custody to the consultation. When this is the case, it is necessary to assess whether there are any risks to the patient. A good measure is to *ask the patient themselves* in private and get his/her opinion.
- Custodial officers will sometimes warn the practitioner of the alleged dangerousness of the detainee in order to demand to be inside the consultation room. We know that this is often information that is intended

Figure 1.



to intimidate the health worker and gain access. Except for some people in a state of mental or emotional disturbance, the professional will not be in danger if he or she is left alone with the patient. If this is the case, the general measures adopted for all agitated patients can be taken with the support of the other members of the staff.

2. Privacy and Confidentiality

Both are essential elements to build a space of trust and confidence and are basic ethical requirements.

- *Privacy* has to do with the absence in the room of any person other than health personnel or persons trusted by the potential victim who they request to be present (for instance close relative or a lawyer). Certainly not, under any circumstances, persons who could coerce the free account of the person to be examined, including custodial officers. If it is not possible to get the officers to leave the examination room, or on the grounds that they have to guard the detainee, they should remain in a place and out of sight, or at least where they cannot hear the dialogue

between doctor and patient. For example, in a waiting room, with the door closed.

- *Confidentiality* is related to the fact that the clinical report belongs only to the patient, and therefore, unless it is in response to a court order or unless the detainee expressly so indicates, the clinical report should not be given to custodial officers. If there is a duty to give the report to third parties, the patient should be informed of this obligation before beginning the interview and be allowed to decide, or consent to, on what information they wish to share with the health professional, knowing that the clinician will have to answer all the questions asked by the legal authority.

Informed consent

- If it is not the person themselves who has requested to be seen or assessed by a health professional, it is necessary to *inform the patient in a way that is understandable* and adapted to their capacity and cultural context what the assessment consists of and what the purpose of the assessment is. It is important to obtain the necessary consent before carrying out the medical and psychological examination. If the detainee refuses the medical assessment, the doctor shall not act against their will.

During the evaluation

It is important that the consultation to a health professional is produced in a normal, trusting, environment. Therefore:

- If the person is subjected to any *mechanical restraint (shackles, restraints or something similar)*, there needs to be a removal which should be requested prior to the physical and psycho-

logical examination, allowing for a comprehensive and full examination.

- It is important to minimize the risk of re-traumatization, following the principle of first, to do no harm. To this end, measures such as using an *empathetic, culturally sensitive and gender-sensitive approach* to clinical interviewing are important. Also, when there is a language barrier, consider the possibility of including an interpreter, whether informal or formal, depending on the patient's preferences. (Kumar, 2022).

It is advisable to perform the physical examination in the presence of at least one person of the same gender as the person being interviewed, especially if a genital examination is to be performed or if the patient is a minor.

After the evaluation: What do I do with the report?

The procedure is similar to any other health report issued for a patient:

- In primary health care, all reports belong to the patient and therefore, unless otherwise ordered by a court, *it will be given only to the patient or his/her legal representative*. A copy must remain in the health record of the patient. Exceptions are when the patient declines keeping the report and prefers it to remain only in the medical files for the future or authorises the report to be given to the custody agents. Alternatively, if necessary, the custody officers shall be provided with a sheet of advice and treatment recommendations for the next hours.
- Many countries also provide regulations that Discharge Reports from the outpatient consultation or the emergency room describing situations of violence with legal implications should always be forwarded to the relevant

authorities (duty law court, prosecutor's office).

- Finally, depending on the case, refer patients to other medical services for further assessment with forensic clinicians or specialized training, especially when sexual or gender-based torture is suspected, or in minors.

What structure should the clinical report have?

In a PHC setting, the aim is not to produce a full Istanbul Protocol, as would be done in a forensic setting, but to produce a clinical report that meets at least the technical requirements of the Protocol. This can be summarised in five basic points:

- Identification of the alleged victim and conditions of the evaluation
- A detailed account of allegations including torture or ill-treatment methods and physical and psychological symptoms
- A record of physical and psychological findings
- Interpretation of all findings, making a judgement of consistency and an opinion on the possibility of torture and/or ill-treatment, and clinical recommendations
- Identification and the signature of the medical expert(s)

In an emergency room or where scarce time is available:

- Produce a short narrative account of the facts in the words of the patients.
- Document the physical and psychological consequences through a full physical and psychological examination.
- Make a judgement of consistency between the account of events and the physical and/or psychological findings observed.

In addition, if the clinician has basic training on the definition of torture, the Istanbul Protocol demands to formulate an opinion on the possibility of ill-treatment or torture.

Table 4 suggests a more detailed report structure. The schema proposed here is not an official IP suggestion but a summary based in the Annex IV of the Istanbul Protocol, where you can find an even more complete report template, intended for the forensic setting. You can make your own adaptation depending on your work conditions and possibilities provided the Istanbul Principles are followed⁹. As can be seen, the structure is the same as any clinical report with a few elements added¹⁰.

There are two possible scenarios:

1. Assessment of a patient that has been recently subjected to violence (assessment in the following hours or days): We will

⁹ As stated in paragraph 607, *the Istanbul Protocol allow for some flexibility with regard to the level of detail provided in a medico-legal report. (...) The content can vary as long as the evaluations follow the Istanbul Principles.*

¹⁰ In Chapter 7 of the IP22 there is a shorter outline than the schema suggested in Table 4: *Obtain informed consent, Exclude any third parties from the evaluation room, Inquire about the cause of any injuries or psychological distress, Document physical and/or psychological symptoms or disabilities related to the alleged abuse, Conduct a directed physical examination including a brief mental status examination and a risk assessment for harm to self and to and from others, Document all injuries with body diagrams (see Annex III), and photographs if possible. If ill-treatment is alleged or suspected, make appropriate referrals and notify appropriate authorities and inform the individual of his or her right to clinical evaluations by independent, non-governmental clinical experts. Clinical interpretation of findings & conclusions on the possibility of torture may be considered by clinicians who have knowledge and experience applying the Istanbul Protocol and its Principles, but is not required.*

Table 4. Structure of a brief report of an alleged torture victim based on the suggestions of Annex IV of the IP-2022¹⁰.

1. Health centre, date, time
2. Identification data of the person assisted
3. Conditions of the interview:
 - Consent: Who requests the report (patient, authority...) and whether the patient agrees
 - Privacy: Who is present in the consultation, especially persons who may restrict the interaction between the health personnel and the patient
 - Restrictions to which the patient may be subjected (shackling or others)
 - Confidentiality: To whom the report is given and whether medical recommendations are given to custodial persons, if necessary.
4. Reason for the report (injuries...) and person/s causing the injury/s according to the patient
5. Brief account of events *using the patient's own words verbatim*, including all relevant aspects. Include date, time and place where the ill-treatment allegedly took place.
6. Personal history of interest (in relation to the injuries). Only if there is relevant information.
7. Physical examination. Make a detailed examination of all organ systems. If there are injuries, prepare a description of the injuries which includes the shape, size or dimensions, location, descriptive aspects of the colour and the origin that the person refers to for each of the documented injuries. Consider taking photographs, if possible, and if consent is given.
8. Psychological examination: emotional reactions and relevant clinical psychological impacts associated with the episode(s).
9. Complementary examinations, if performed: analytical tests (including determination of muscle enzymes), imaging tests, and if necessary, specialised gynaecological, traumatological, dermatological or neurological examinations.
10. Medical diagnostics.
11. Prognosis of physical and/or psychological injuries or impacts.
12. Consistency or compatibility judgement. Assessment of the consistency between the medical and psychological examination data and the patient's allegations of ill-treatment/torture.
13. If the person has received training, provide a medical opinion as to whether the facts could constitute ill-treatment or torture.
14. Therapeutic recommendations
15. Name, address and signature of the person making the report

explore acute symptoms and signs and look for recent injuries. Remember that although pain has classically been considered a *symptom* (because it has been considered as allegedly subjective), the tendency in modern medicine is to treat it as a *sign* and to try to give it objectivity by using validated scales of measurement. Although not explicitly recommended in the IP22, but it is a good medical practice to make a detailed exploration of pain symptoms in the physical examination as a “sign” and described in the same way as other physical signs (wounds, haematomas, etc.). (See below).

2. Assessment of a patient subjected to violence sometime after the event. In most cases, you will probably not find any acute physical injuries. In this case, it is advisable to ask about the acute symptoms and signs that the person remembers having at the time of the events and how they evolved through time. On the other hand, perform an active search for sequelae that have lasted over time (including persistent pain, sensory deficits, insomnia, etc.). In any case psychological symptoms may be much more marked and evident and might need careful assessment and appropriate referral if necessary.

What to assess, are there specific elements?

The following constitute a synthesis of key aspects in the medical assessment of suspected survivors of ill-treatment or torture. The updated version of the Istanbul Protocol provides a much more comprehensive and complete guide (chapter 5 on physical examination and chapter 6 on psychological examination). This section is intended as a quick reference guide.

Main considerations of the medical assessment

Take special care during the physical examination. The physical and psychological sequelae of torture, if they occur, occur in the context of complex trauma, superimposed on the impact of the different social determinants of health¹¹ and other chronic medical conditions, which make this diagnosis a challenge for the medical professional. (Kalt et al., 2013). Therefore, it is important to avoid the risk of re-traumatization in the medical examination by explaining empathetically, for instance, the need to remove clothing or to perform certain invasive examinations.

Take a brief medical history with a detailed examination of all organ systems, as you would do with any other patient in your daily practice. This will include:

- *Anamnesis* of the symptoms the person suffers from and what the person attributes them to. Classify symptoms into acute and chronic.
- *Physical examination.* This is not simply the observation of possible injuries, but a systematic and detailed assessment by apparatus. If specific training is available, some elements suggestive of torture may be detected, but an examination as one would do with any other patient in which the general condition is assessed is already extremely useful. There may be symptoms or signs that disappear within a few days, and others that are sequelae of past injuries.

11 In the case of migrants, the social determinants of health cut across the lives of torture survivors, both in their country of origin (violence, discrimination, flight...) during the migration journey (grief, trauma, crisis) and in the host country (loss of status, racism, housing, work, access to health...).

- *Clinical judgement*
- *Degree of consistency* between the observations and the allegations of torture¹². If trained, interpretation of the findings or conclusions.
- *Therapeutic recommendations*.
- In addition, it may include *prognostic* assessments, a statement on the *degree of disability and its socio-occupational impact*, as well as recommendations for possible *referrals to medical specialists*, if needed.

It is important not to forget that the absence of physical or psychological evidence on examination does not rule out torture. In the contemporary world, torture often aims to inflict the greatest trauma with the least residual evidence, and there is scarce presence of physical findings. (Amris & Williams, 2015).

Symptoms related to torture episodes and especially forms of pain are often misdiagnosed and sometimes treated as a manifestation of psychological trauma, psychogenic pain or somatisation. There is an under-diagnosis of pain due to its atypical presentation. (Kaur et al., 2020).

Pain as a major symptom. It is estimated that 87% of torture survivors experience chronic pain. Most commonly are headaches (93%), musculoskeletal pain (87%) and pain in the extremities (72%). (Williams & Amris, 2007). This localised pain often correlates with the mechanism of injury. However, there is a generalised pattern of pain that the patient may not understand, may not associ-

ate with the torture events, and is sometimes medically unexplainable (MUS). (Edwards et al., 2010). Knowing this, it is important in the examination to use specific pain measures, such as the VAS scale or others. (Hawker et al., 2011).

Pain in torture victims has some peculiar characteristics that make it different from other types of pain. It is persistent, generalised, non-specific, and mostly disabling. It does not usually improve with rehabilitation or analgesia, and so it must be treated with a holistic approach that includes psychological components. (Edwards et al., 2010).

Psychological and emotional assessment

All reports should always include, in addition to the physical examination, a psychological examination. Even if the psychological evaluation was carried out by another professional, it is advisable that both assessments are included in the same report signed by all the professionals involved.

The primary care clinicians are not expected to conduct an in-depth psychiatric interview, but rather a brief mental status examination. Nevertheless, pay special attention to the person's emotional state when describing the events, and explore the most frequent psychological symptoms such as panic attacks, irritability, symptoms of generalised anxiety or depression, insomnia, nightmares or signs of emotional overflow. Try to explore their connection with the alleged facts.

These psychological symptoms may be directly or indirectly related to the physical symptoms, either as somatisation or as elements that aggravate the underlying symptomatology both in its acute process and in its chronicity. Therefore, psychological symptoms may have a major impact on the person's overall state of health and are an essential consideration for general practitioners.

12 For clinicians who have knowledge and experience applying the IP, may consider providing an interpretation on the level of consistency according to the five levels recommended in legal settings: Not consistent - consistent - highly consistent - diagnostic - unrelated (see paragraph 360 of the IP).

Table 5. Recommendations for taking photographs of injuries.

General terms and conditions	<ul style="list-style-type: none"> • As soon as possible - the lesions disappear quickly. • Ask for the person's consent and/or permission • Any (mobile) camera will do.
How to take the photographs?	<ul style="list-style-type: none"> • Display the current date (if not available on the camera itself, include a calendar or newspaper in the photo). • Show the identity of the alleged victim (face) in any of the photographs or include full body photographs and then photographs of details. • It is desirable to display a scale (ruler or common object) to see the size of injuries • Use natural light instead of flash • Do not manipulate the picture, use filters or change its format.

Supplementary material for the medical assessment: Photographs and anatomical drawings

To complement the medical assessment, the Istanbul Protocol includes an annexe of anatomical drawings (annex III, pg 179) . In the drawings it is important not only to reflect external injuries, but also reflect painful areas and sites of functional disability.

Nowadays, high quality photographs can be taken with any mobile phone. Table 5 lists some basic recommendations.

Other complementary tests may also be carried out to help corroborate allegations of torture. However, when considering such tests, the risk-benefit to the individual should be considered, and the indication of such tests is generally not justified unless they would make a significant difference in a medico-legal case.

And then?

In a qualitative focus group study, torture survivors were asked what they would expect from their primary care physicians. Victims highlighted five aspects. Refugees recommended that physicians should take the time to make refugees feel comfortable, initiate direct conversations about mental health, inquire about the historical context of symptoms and provide psychoeducation about mental health and healing (Shannon, 2014).

Conflicting ethical obligations.

The new version of the Istanbul Protocol devotes much attention to Conflicting ethical obligations within the medical profession. This is referred to as a situation in which a physician or mental health professional is faced with two competing interests: the primary one, which is the duty to look after the best interests of the patient, and the secondary one, which derives from obligations to the institution for which he or she works. For interested readers, refer to Chapter II and VII of the IP-22.

Conclusions

Specialised centres for the care of torture victims exist in many countries. However, most torture victims will not be aware of their existence or be able to access them. (Piwowarczyk & Grodin, 2016). Torture is an important and critical public health problem, especially among at-risk groups. Early detection and documentation depend on good treatment of patients and the possibility of access to protection and rehabilitation measures. Training on documentation of torture in medical schools is minimal or non-existent, as the Istanbul Protocol itself points out¹³ .

¹³ Chapter 8 on implementation of the Istanbul Protocol by authorities

It is important that primary care and emergency department professionals in both the global North and South develop skills in the detection and management of torture survivors because of the severity of suffering and the biopsychosocial implications involved.

References

- Al-Saffar, S. (2007). Integrating rehabilitation of torture victims into the public health of Iraq. *Torture Journal*, 17(2), 156–168. http://www.irct.org/Admin/Public/Download.aspx?file=/Files/Filer/TortureJournal/17_2_2007/art_10.pdf&origin=publication_detail
- Amnesty International. (2016). *Combating torture and other ill-treatment. A manual for action*.
- Amris, K., & Williams, A. C. d. C. (2015). Managing chronic pain in survivors of torture. *Pain Management*, 5(1), 5–12. <https://doi.org/10.2217/pmt.14.50>
- Asgary, R. G., Metalios, E. E., Smith, C. L., & Paccione, G. A. (2006). Evaluating asylum seekers/torture survivors in urban primary care: a collaborative approach at the Bronx Human Rights Clinic. *Health and Human Rights*, 9, 164–179.
- Atkinson, H. G., Wyka, K., Hampton, K., Seno, C. L., Yim, E. T., Ottenheimer, D., & Arastu, N. S. (2021). Impact of forensic medical evaluations on immigration relief grant rates and correlates of outcomes in the United States. *Journal of Forensic and Legal Medicine*, 84, 102272. <https://doi.org/10.1016/j.jflm.2021.102272>
- Bertelsen, N. S., Selden, E., Krass, P., Keatley, E. S., & Keller, A. (2018). Primary Care Screening Methods and Outcomes for Asylum Seekers in New York City. *Journal of Immigrant and Minority Health*, 20(1), 171–177. <https://doi.org/10.1007/s10903-016-0507-y>
- Berthold, S. M., Mollica, R. F., Silove, D., Tay, A. K., Lavelle, J., & Lindert, J. (2019). The HTQ-5: Revision of the Harvard Trauma Questionnaire for measuring torture, trauma and DSM-5 PTSD symptoms in refugee populations. *European Journal of Public Health*, 29(3), 468–474. <https://doi.org/10.1093/eurpub/cky256>
- Cook, T. L., Shannon, P. J., Vinson, G. A., Letts, J. P., & Dwee, E. (2015). War trauma and torture experiences reported during public health screening of newly resettled Karen refugees: a qualitative study. *BMC International Health and Human Rights*, 15(1), 8. <https://doi.org/10.1186/s12914-015-0046-y>
- Edwards, T. M., Stern, A., Clarke, D. D., Ivbijaro, G., & Kasney, L. M. (2010). The treatment of patients with medically unexplained symptoms in primary care: a review of the literature. *Mental Health in Family Medicine*, 7(4), 209–221. <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3083260&tool=pmcentrez&rendertype=abstract>
- Eisenman, D., Keller, A., & Kim, G. (2000). Survivors of torture in a general medical setting: how often have patients been tortured, and how often is it missed? *Western Journal of Medicine*, 172, 310–304.
- Eisenman, D. P. (2007). Screening for Mental Health Problems and History of Torture. In *Immigrant Medicine* (pp. 633–638). Elsevier. <https://doi.org/10.1016/B978-0-323-03454-8.50053-X>
- Hawker, G. A., Mian, S., Kendzerska, T., & French, M. (2011). Measures of adult pain: Visual Analog Scale for Pain (VAS Pain), Numeric Rating Scale for Pain (NRS Pain), McGill Pain Questionnaire (MPQ), Short-Form McGill Pain Questionnaire (SF-MPQ), Chronic Pain Grade Scale (CPGS), Short Form-36 Bodily Pain Scale (SF. *Arthritis Care and Research*, 63(SUPPL. 1), 240–252. <https://doi.org/10.1002/acr.20543>
- Hexom, B., Fernando, D., Manini, A. F., & Beattie, L. K. (2012). Survivors of Torture: Prevalence in an Urban Emergency Department. *Academic Emergency Medicine*, 19(10), 1158–1165. <https://doi.org/10.1111/j.1553-2712.2012.01449.x>
- Kalt, A., Hossain, M., Kiss, L., & Zimmerman, C. (2013). Asylum seekers, violence and health: a systematic review of research in high-income host countries. *American Journal of Public Health*, 103, e30–42. <https://doi.org/10.2105/AJPH.2012.301136>
- Kaur, G., Weinberg, R., Milewski, A. R., Huynh, S., Mauer, E., Hemmings, H. C., & Pryor, K. O. (2020). Chronic pain diagnosis in refugee torture survivors: A prospective, blinded diagnostic accuracy study. *PLoS Medicine*, 17(6), 1–14. <https://doi.org/10.1371/journal.pmed.1003108>
- Kumar, B. (2022). *Migrant health. A primary care perspective*. WONCA / CRC Press.
- Magwood, O., Kassam, A., Mavedatnia, D., Mendonca, O., Saad, A., Hasan, H., Madana, M., Ranger, D., Tan, Y., & Pottie, K. (2022). Mental Health Screening Approaches for Resettling Refugees and Asylum Seekers: A Scoping Review. *International Journal of Environmental Research and Public Health*, 19(6), 1–41. <https://doi.org/10.3390/ijerph19063549>
- Mendez, J. (2013). *Applying the torture and ill-treatment protection framework in health-care settings*

- (A/HRC/22/53) (Issue February).
- Mendez, J. (2014). *Informe del Relator Especial sobre la tortura y otros tratos o penas crueles, inhumanos o degradantes - Misión a México. A/HRC/28/68/Add.3*. <https://doi.org/10.18268/bsgm1908v4n1x1>
- Méndez, J. (2019). Right to a Healthy Prison Environment: Health Care in Custody Under the Prism of Torture. *Notre Dame Journal of International & Comparative Law*, 9(1), 40.
- Mewes, R., Friele, B., & Bloemen, E. (2018). Validation of the Protect Questionnaire: A Tool to Detect Mental Health Problems in Asylum Seekers by Non-Health Professionals. *Torture Journal*, 28(2).
- Munk-Andersen, E., Toftgaard, B., & Modvig, J. (2021). Screening asylum seekers in Denmark for torture using a structured questionnaire. *Torture Journal*, 31(2), 99–109. <https://doi.org/10.7146/torture.v31i2.122245>
- Ostergaard, L. S., Wallach-Kildemoes, H., Thøgersen, M. H., Dragsted, U. B., Oxholm, A., Hartling, O., & Norredam, M. (2020). Prevalence of torture and trauma history among immigrants in primary care in Denmark: Do general practitioners ask? *European Journal of Public Health*, 30(6), 1163–1168. <https://doi.org/10.1093/eurpub/ckaa138>
- Pérez-Sales, P. (2017). *Psychological Torture: definition, evaluation and measurement*. Routledge.
- Petersen, H., Morentin, B., & Pérez-Sales, P. (2022). Physical Torture. In J. A. Siegel, P. J. Saukko, & M. M. Houck (Eds.), *Encyclopedia of Forensic Sciences: Second Edition*. Academic Press. <https://doi.org/10.1016/B978-0-12-823677-2.00009-X>
- Piwowarczyk, L., & Grodin, M. (2016). Torture and Public Health. In *International Encyclopedia of Public Health* (Second Edi, Vol. 6). Elsevier. <https://doi.org/10.1016/B978-0-12-803678-5.00467-7>
- Shannon, P. J. (2014). Refugees' advice to physicians: How to ask about mental health. *Family Practice*, 31(4), 1–5. <https://doi.org/10.1093/fampra/cmu017>
- Shannon, P. J., Vinson, G. A., Wieling, E., Cook, T., & Letts, J. (2015). Torture, War Trauma, and Mental Health Symptoms of Newly Arrived Karen Refugees. *Journal of Loss and Trauma*, 20(6), 577–590. <https://doi.org/10.1080/15325024.2014.965971>
- Shannon, P., O'Dougherty, M., & Mehta, E. (2012). Refugees' perspectives on barriers to communication about trauma histories in primary care. *Mental Health in Family Medicine*, 9, 47–55.
- Sigvardsson, E., Nilsson, H., Malm, A., Tinghög, P., Gottvall, M., Vaez, M., & Saboonchi, F. (2017). Development and preliminary validation of refugee trauma history checklist (RTHC)-a brief checklist for survey studies. *International Journal of Environmental Research and Public Health*, 14(10), 1–10. <https://doi.org/10.3390/ijerph14101175>
- UN General Assembly. (1984). *The Convention Against Torture and other forms of cruel, inhuman and degrading treatment or punishment. 10 December 1984*. United Nations, Treaty Series, vol. 1465, p. 85. <https://www.ohchr.org/en/professionalinterest/pages/cat.aspx>
- UNHR. (2022). *Istanbul Protocol. Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment*. Office of the High Commissioner of Human Rights. <https://doi.org/10.2307/j.ctt207g8gw>
- Wadiwel, D. (2017). Disability and torture: exception, epistemology and 'black sites.' *Continuum*, 31(3), 388–399. <https://doi.org/10.1080/10304312.2016.1275134>
- Weinstein, H. M., Dansky, L., & Iacopino, V. (1996). Torture and war trauma survivors in primary care practice. *The Western Journal of Medicine*, 165, 112–118.
- Williams, A., & Amris, K. (2007). Pain from torture. *Pain*, 133, 5–8. <https://doi.org/10.1016/j.pain.2007.10.001>
- WMA. (1975). *World Medical Association Declaration of Tokyo - Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment* (pp. 2–4).
- WMA. (2013). *Doctors Urged to Document Cases of Torture* (pp. 1–2). <http://www.wma.net/en/20activities/20humanrights/40torture/>
- WPA. (2017). World Psychiatric Association Declaration on Participation of Psychiatrists in Interrogation of Detainees. In *Torture Journal* (Vol. 27, Issue 3, pp. 94–98). World Psychiatric Association. <https://doi.org/10.7146/torture.v27i3.103980>

Annex 1

DIGNITY and Danish Red Cross Screening Instrument for Torture

Part 1. Questions for the interviewee

Have you ever been arrested, detained, or imprisoned?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been subjected to severe violence, threats or degrading treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you witnessed others being subjected to severe violence or degrading (abusive) treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If the answer is no to all the first three questions, the screening closes with the conclusion that the interviewee has not been subjected to torture. If the answer is yes to just one of the three questions, the interviewee is encouraged to provide a narrative account:

Would you mind telling me what happened?

Help questions for the narrative presentation:

- a. What did they do to you?
- b. Who exposed you to it?
- c. Do you know why they did it?

The help questions are intended as inspiration to guide the interviewee's narrative and do not necessarily need to be read out. The answer also serves as a guide to the interviewer as to whether there has been inhuman treatment or punishment. If the interviewee has been subjected to several incidents, he/she is asked to choose the incident that affected him/her the most. After the interview, the interviewer completes Part 2 of the form encoding the torture criteria

Part 2 Coding of Torture Criteria

To be filled in by the interviewer based on the interviewee's narrative statement

Was the person exposed to severe pain or suffering, physically or mentally?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was it done intentionally?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was there a purpose to the action?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was it a public official who committed or instigated the action?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Conclusion

Coding result	Screening result
YYYY	The interviewee has probably been subjected to torture
Y N NY	The interviewee has probably been subjected to ill-treatment
Any other combination	The interviewee has probably been subjected to other forms of trauma

The Refugee Trauma History Checklist (Sigvardsdotter et al., 2017)

The questions in this section concern difficult and frightening experiences, and can awaken distressing memories. It is important for us that many people answer these questions. However, if you find it is too distressing, please take a break or skip this section.

Before you left your home, have you experienced any of the following situations or events?

War at close quarters	<input type="checkbox"/> Yes <input type="checkbox"/> No
Forced separation from family or close friends	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss or disappearance of family member(s) or loved one(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical violence or assault	<input type="checkbox"/> Yes <input type="checkbox"/> No
Witnessing physical violence or assault	<input type="checkbox"/> Yes <input type="checkbox"/> No
Torture	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sexual violence	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other frightening situation(s) where you felt your life was in danger.	<input type="checkbox"/> Yes <input type="checkbox"/> No

The Single General Trauma Item (SGTI)

Sometimes things happen to people that would upset or frighten almost everyone. Examples of such difficult and frightening experiences are: being assaulted, or witnessing other people being hurt or killed. Have you experienced any of these or some other terrifying event(s)?

Torture and Trauma Screening Interview (Hexom et al., 2012)

1. Were you ever threatened or harmed by groups such as the government, police, military, or rebel soldiers?
2. Some people in your situation have experienced torture. Has that ever happened to you or your family?

Those who answered positively to one of the two questions were given an additional short interview.

1. Who were you tortured by?
2. What best describes what happened to you?
3. Why you were tortured?
4. Did you leave your home or country as a result of being tortured?
5. Do you have any physical disabilities as a result of being tortured?
6. Do you have any recurrent intrusive or distressing memories as a result of being tortured?
7. Has a doctor ever asked you if you have been tortured?
8. Have you ever applied for political asylum?

**The Spanish and French versions of this paper can be found on
<https://tidsskrift.dk/torture-journal>**

Oral and maxillo-facial injuries in victims of political repression during the Chilean dictatorship

Jesús Silva¹

Key points of interest

- The orofacial area should not be left out in the documentation and rehabilitation process.
- Oral consequences of torture are both physical and psychological, and often long lasting.
- Dental professionals need to be aware of torture victims' challenges with receiving dental treatment.

Abstract:

Introduction: Chile was under a civil-military dictatorship from 1973 to 1990. During that time, systematic violations to human rights were perpetrated. Oral and maxillo-facial trauma was not an exception, and such trauma was carried out through different methods of torture or ill treatment by agents of the State. Currently, Chile has laws and programs in the public healthcare system to carry out the rehabilitation and reparation process in victims, and the registration of the suffered injuries is considered an important part of these medico-legal procedures. The aim of this study is

to describe and classify the type of torture or ill-treatment in the orofacial area of victims of political repression during the Chilean military dictatorship and relate them to the injuries registered in written reports.

Methods: 14 reports of oral and maxillo-facial injuries of tortured victims from 2016 to 2020 were analyzed, considering the alleged history of the patient, the visible effects on the oral examination, and the type of torture that was inflicted. Historical clinical records and X ray exams were analyzed when available.

Results: 6 variations of torture and ill-treatment that involve the maxillo-facial area were caused by agents of the State during the dictatorship period.

Discussion: According to the patient's account and the clinical examination, all of the torture techniques applied caused, directly or indirectly, the loss of teeth. This resulted in not only physical problems, but psychological problems for the victims.

Keywords: Dental Torture, Oral Cavity, Forensic Odontology, Chilean Dictatorship.

Introduction

On September 11, 1973, Chile suffered a break in its history when a coup d'état occurred against the government of Salvador Allende by the armed forces. This regime lasted for 17 continuous years until the return

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to democracy in 1990. During this period, acts which were in violation of human rights were widely documented by investigative commissions that registered the deceased victims, the living tortured victims, and the disappeared.

Under this historical context, inhuman treatment in Chile developed systematically, with dedicated facilities and detention centers. State agents were sent abroad to learn 'counterintelligence techniques' within the framework of training at the »School of the Americas« (Biblioteca Nacional de Chile, 2020. Cohn, 2011). It is estimated that about 1,560 Chilean soldiers were sent abroad to receive military training, with 58% of them sent between 1973 and 1975, the first 2 years of the Chilean military dictatorship (Gill, 2004). Some of the techniques taught to the military were based on one of the first official CIA Torture administration documents called the »KUBARK Manual« (Santos, 2020), which dates from 1963 and was declassified by the Pentagon in 1997. It details techniques that combine psychological knowledge with the use of physical restrictions or torture in order to 'break' the victim in every sense, both internally, causing a personal struggle, and while maintaining an external force that tries to defeat the individual.

Physical torture, as defined by the 1984 United Nations Convention against Torture, can include different parts of the body, and the oral-maxillofacial area is no exception, and often, physical sequels, such as the loss of teeth, affects the victims for the rest of their lives.

Current Chilean legislation about torture and reparation:

Chile Ratified the "Convention against torture and other cruel, inhuman or degrading treatment or punishment, adopted by the General Assembly of The United Nations" (Ministerio de Relaciones Exteriores, 1988), a fact that

still occurs being in dictatorship. However, the concept of "torture" was not recognised as such in Chilean legislation until 2016 by Law 20,968 (Ministerio de Justicia, 2016), which is a crime attributable only to workers of the state/public officials.

Prior to that, Chilean Law 19,123 created the "National Corporation of Reparation and Reconciliation" (Ministerio del Interior, 1992), which recognises the victims of human rights violations during the military dictatorship, as well as granting reparatory processes and other benefits. This includes: 1) a money allowance for the direct victim of political repression, or their parents/descendant if the victim is dead, 2) free healthcare services in the public system for the same group, and 3) scholarships for children of victims.

In this context, the recognition of damage and health repair became fundamental aspects to be developed in this specific group of patients, consolidated through Law 19,980 (Art. 7) which created the "Integral Health Care Repair Program", also called "PRAIS" (Ministerio del Interior, 2004). This was ratified again in Law 19,992 (Art. 10), which guaranteed the right of victims to receive support from the state in their physical and psychological rehabilitation (Ministerio del Interior, 2004).

PRAIS, created in 1991 and managed by the Ministry of Health, responds to the reparation commitment assumed by the Chilean State with the victims of Human Rights violations that occurred between September 1973 and March 1990. The 'PRAIS units' are located in facilities that depend on local public healthcare services and are composed for a multidisciplinary team of healthcare professionals, with each unit working independently. However, not all the PRAIS units provide the same services to the target population, for example: from a total of 29 'PRAIS units' in the country, only 6 bring dental healthcare.

Table 1. Testimonies of victims of torture related to oral and maxillo-facial area found on “Valech commission” report.

Sex, year and location of the victim.	Testimony
Man, arrested in 1973, VIII region.	<i>“They brought me a dentist, according to them, but for me it was another torturer (...) he asked me the corresponding questions and I indicate my pain, but the criminal (in reference to “the dentist”) began to pull my teeth without any anesthesia. I lost three teeth there; he had helpers holding you down by pulling your hair and the others from hands and feet. The pain was unbearable, and I had no right to ask for a pain reliever”.</i>
Man, arrested in 1973, Osorno, X region.	<i>“I lose consciousness and when I wake up, I realise that I am bleeding a lot from my head, nose and mouth... then I realise that I am missing eight teeth... he (in reference to a policeman “carabini-nero”) had proceeded to remove them with pliers...or hits, I don’t know”.</i>
Woman, arrested in 1975, Metropolitan Region.	<i>“...They applied electricity to various parts of my body. My front teeth were blown off with gun butts. I suffered sexual abuse and repeated rapes that resulted in a pregnancy”.</i>

Antecedents related to oral injuries in victims of political repression in Chile:

The documentation of torture by qualified professionals is an important step for the purposes of administering justice (Herath, 2017). The torture and ill-treatment during Pinochet’s regime were well documented by the “Valech Commission” (Comisión Nacional sobre Prisión Política y Tortura, 2005). In this document, a few testimonies are related to oral and maxillo-facial injuries caused by torturers, summarised in Table 1.

The aim of this study is to 1) describe and classify the type of torture and ill-treatments related to the orofacial area reported by victims of political repression during the Chilean military dictatorship, and 2) correlate them with the injuries recorded in written reports made by a professional dentist between years 2016 and 2020 in a context of a future rehabilitation or for medico-legal purposes.

Materials and methods

This is a descriptive retrospective study. Reports of “Oral and Maxillo-facial injuries” written by a professional dentist working in a PRAIS unit between the years 2016 and 2020 were analyzed and the following data of the patients were considered: anamnesis, the records of their oral condition by an odontogram, and a written record of the repressive situation experienced and how it affected their oral and maxillo-facial condition through a semi-structured interview, including the year in which the alleged events occurred. By keeping the personal data of the patients confidential, only sex and age were considered relevant. Additionally, orthopantomography or other X ray exams available to support the diagnosis were analyzed. When possible, historical dental records were reviewed to rule out other possible pathological causes for the reported effects. All the reports

were made by the same professional, who is the author of this study.

It was determined that, as inclusion criteria, each record must: contain complete information, the patient of each report was within the registry of official commissions as a direct victim of repression, be a current patient of the PRAIS program in public health care services, and their repressive situation has been caused by State agents in the Chilean territory during the military dictatorship. From a total of 23 reports, 14 met the established criteria.

The reports were made following the guidelines of the Istanbul Protocol (United Nations, 2004). This instrument is aimed at medical professionals and professionals in charge of the administration of justice within an international dissemination framework. In this manual, dental examination is recognised as a crucial part of the complete physical examination of the victim, using the term “dental torture” for those cases that involve injuries to oral and maxillofacial structures. In this context, the analyzed dental reports are part of a complete examination made by a multidisciplinary team of professionals in the PRAIS unit (medical doctors, dentists, psychiatrists, psychologists, and social workers).

This study has been analyzed and approved by the Ethical Committee of the Valparaíso-San Antonio Public Health Service (Act #29/2021).

Results

Of a total number of patients (N = 14), 9 correspond to men and 5 to women. In most of the reviewed cases, there was physical torture that involved the maxillofacial area as a trauma recipient (n = 11) or denial of care during periods of incarceration (n = 3). All the patients report having lost at least one or more teeth as a result of the reported events. When comparing the accounts of the victims with the

oral examinations, the conditions were rated as compatible with the facts reported in 12 cases and rated as possibly compatible in 2 cases.

Although the reports record pathologies present at the time of the examination, such as caries and periodontal diseases, the possible sequelae of torture or ill-treatment were analyzed with greater emphasis based on the account of the patient.

Table 2 summarises the age of the patient at the moment of the record, the year in which the alleged events occurred, the classification of the type of torture registered based on the account of the patient, and the effects recorded by the professional dentist according to the clinical oral and maxillo-facial exam:

Discussion

By virtue of the compilation of previous information, it was evidenced that human rights violations were perpetrated over nearly the entire period that the dictatorship in Chile lasted, with cases registered from 1973 to 1988. However, this study recorded that the highest number of cases occurred during the first year of dictatorship with 5 out of 14 cases in 1973.

Despite being a small sample, the declarations as victims of torture tend to be more frequent in men than in women. Jorquera et al. (2020), determined from a gender perspective that these differences are because, for women, it is a highly sensitive experience as a traumatic event, often accompanied by sexual violence, which causes the victim a social stigma that leads them not to declare themselves as such and to avoid giving testimony in commissions or instances of recognition as victims of political repression.

As a breakdown, the following types of harassment were determined:

Direct injuries caused by a third-party: (5 of 14 patients) The Istanbul Protocol recognises trauma to the face and skull as

Table 2. Description of each case recorded in written reports of oral and maxillo-facial injuries.

Record No.	Age	Sex	Year of the facts	Type of torture classified	Effects recorded by professional
1	79	male	1973	Injury by firearm	Loss of right mandibular and maxillary molars and premolars, mandibular asymmetry, face scar.
2	55	female	1984	Direct injuries by third party	Loss of premolar and molars both sides.
3	66	male	1973	Electric shocks	Loss of maxillary molars.
4	46	male	1988	Direct injuries by third party	Loss of one mandibular molar.
5	48	male	1986	Direct injuries by third party	Loss of 2 maxillary central incisors.
6	79	female	1973	Deprivation of access to hygiene or health-care.	Toothless Patient.
7	53	male	1986	Electric shocks	Toothless patient.
8	58	male	1973	Intentional fall	Loss of 2 maxillary central incisors.
9	62	female	1973	Electric shocks	Loss of maxillary and mandibular molars.
10	50	female	1988	Direct injuries by third party	Loss of mandibular premolars and molars (both sides).
11	58	female	1985	Direct injuries by third party	Loss of right maxillary premolar and molars, and mandibular premolars and molars (both sides).
12	52	male	1984	Deprivation of access to hygiene or health-care.	Loss of maxillary and mandibular premolars, old and extensive restorations.
13	62	male	1976	Dental torture and intentional fall.	Loss of 25 teeth, “home-made” repair restorations.
14	64	male	1984	Deprivation of access to hygiene or health-care.	Loss of maxillary and mandibular premolars molars.

one of the most common forms of torture. In the registered cases, these were given with fists, kicks, or gun butts in the maxillary and mandibular lateral areas, which is consistent with the finding of missing teeth in posterior areas (molars and premolars) in the 5 patients who had suffered this type of injuries.

By analyzing the available orthopantomograms, it can be determined that the dental losses were not recent.

Trauma caused by intentional falls: (2 of 14 patients) Intentional falls are also on the list of possible ways of torture. One of the patients reveals in his testimony that he was thrown from a bridge as a minor, which caused the loss of his two upper central incisors, while another recounted the loss of a central incisor as a result of a fall caused in a simulation of execution. This type of trauma has already been previously reported in the literature with similar consequences (Arge et al, 2014).

Application of electric shocks in the oral cavity: (3 of 14 patients) In some cases, torture techniques were supported by other tools to achieve coercion of the individual, including the application of electric current, usually in areas of high sensitivity, such as the palms of the hands, soles of the feet, armpits, genitals, and oral cavity.

The direct application of electric current on human tissue will cause a burn due to thermal damage, the destruction of which will vary according to the resistance given by the tissue (expressed in Ohms). In the case of mucous membranes, like the oral soft tissues, this resistance does not exceed 100 Ohms / cm², well below dry or even wet skin (Valencia & Garcia, 2009).

Those patients who were subjected to this type of torture report having suffered from subsequent infections, tooth pain involved in the area of application and in some cases, sub-

sequent tooth loss. This may be explained by the lack of access to medical care that most of these patients experienced, usually related to periods of deprivation of liberty.

Maxillofacial injuries caused by firearms: (1 of 14 patients) There is a documented case of injuries caused by firearms in the maxillofacial territory, without the result of death.

The X ray requested from the victim revealed a wide mutilation of the oral cavity, with loss of a large number of teeth and adjacent bone on the right side, as well as asymmetry in the condyle and right mandibular condylar neck based on what was observed in orthopantomography.

Deprivation of access to hygiene and medical care: (3 of 14 patients) This kind of ill-treatment could occur independently or arise in association with the situations already described. The victims indicate that they were incarcerated for varying periods of time, ranging from days to years, during which they did not have access to any kind of health service or medical care. The Istanbul Protocol (2004) and Singh et al (2008) establishes that periods of deprivation of liberty generate a worsening of oral health conditions, either due to previous worsening symptoms or new pathological symptoms presented during the imprisonment. Usually, this denial is deliberately provoked. Dello (2009), in a letter sent in response to an article of Speers et al. (2008), uses the term “passive torture” in reference to this kind of treatment.

In two cases, patients report not having received dental care until after they were released and in one case, until the return of democracy, because the victim did not attend hospital centers for fear of being “registered” and “located” again by the military regime.

Dental Torture: (1 of 14 patients) In this case, the patient indicated that he had under-

gone unnecessary dental interventions without anesthesia in a dental chair installed inside a military barracks, indicating that his torturers “were probably dentists due to the way in which they used the instruments.”

The participation of dentists in the application of torture is not a common report in the literature, except for certain cases known during the World War II. However, because dental pain can be one of the strongest that human beings can feel, the participation of dentists can be “beneficial” for torturers seeking information or a confession (Speers et al., 2008).

In the particular case of this patient, it was possible to observe a high level of oral damage, loss of multiple teeth, and restorations in poor condition which were repaired in a “homemade” way, in addition to the presence of caries and periodontal disease. This traumatic experience caused the patient to avoid visits to dentists in later stages of his life, a common situation in torture victims (Høyvik, Lie & Willumsen, 2019, Singh et al., 2008; Speers et al., 2008).

The challenge of bringing dental care to victims of torture.

The PRAIS program not only gives legal assistance to the victims expressed by the analyzed reports, but the main objective is also bringing a reparation and rehabilitation process based on the available service of the Chilean public healthcare system, supported by the laws mentioned previously. Dental healthcare is a high-demand service and is available in some PRAIS units along the country, however, it is not available in all regions. Treating patients who have been victims of torture requires dental practitioners to be aware of the condition of their patients. Høyvik et al. (2021), in a study with African and Middle Eastern refugees in Europe, state that patients with a

torture background tend to postpone or avoid dental appointments due to 3 main factors: the pain, the traumatic memories, and the dentist. From the experience of this author, all these factors have a crucial role at the moment of the dental examination to elaborate the analyzed reports and to bring dental care. Dentists and their work teams cannot forget that the environment and working conditions that seem normal to us can be a major stress factor for this type of patient. Willix et al (2021) established that proper education for healthcare professionals about how to treat patients with a torture background, how to identify signs of torture in the oral cavity, and multidisciplinary work with other healthcare professionals will prevent or minimise the risk of re-traumatisation.

Limitations

This study involves a small sample of cases, which represent particular cases in a specific region of the country. However, it may serve as an initial input on this unexplored topic in this historic and political context. Another limitation is the ‘time of registration’ since the injury occurred. In this case, events that occurred 30 or 40 years ago were analyzed, which is a limitation also registered in other studies related to victims of torture (Arge et al., 2014); even with closer periods of time. The same occurs in the presence of other oral pathologies, which can hinder the search for compatibility of injuries. Given the above, access to health care and documentation of injuries should be carried out as soon as possible in situations of human rights violations, ideally following the guidelines provided by the Istanbul Protocol for addressing these cases. This will allow a much more expeditious and complete administration of justice and the subsequent reparation.

Conclusions

Based on the information previously exposed and analyzed, it was determined that the oral and maxillo-facial area was a recurring area of reception of trauma caused by State agents during the period of the Chilean civic-military dictatorship, hence, dental records and maxillo-facial examinations requires to be included as part of the documentation and rehabilitation processes in those patients accredited as victims and should not be left out.

All types of torture or human rights violations observed directly or indirectly led to teeth loss. Considering that teeth are an important part of a person's identity and aesthetics, the damage caused can be considered within both the physical and psychological spheres. A study of both variables may be recommended in the future, also considering the psychological factor of facing dental procedures, which in certain registered cases prevented patients from accepting the need for treatment, further worsening their conditions, and showing that the damage continued even after the end of the repressive period.

Due to all the above, dental professionals who are caring for patients who were victims of torture or human rights violations and who are involved in the entire public and private health network in Chile, should be aware and understand the situations they experienced and the treatment they need to achieve correct dental care.

References:

- Arge, S., Hansen, S., & Lynnerup, N. (2014). Forensic odontological examinations of alleged torture victims at the University of Copenhagen 1997-2011. *Torture Journal*, 24(1), 17-24. <https://doi.org/10.7146/torture.v24i1.109710>
- Biblioteca nacional de Chile (2020). El impacto de la guerra fría en Chile. (*The impact of the cold war in Chile*). Available at: <http://www.memoriachilena.gob.cl/602/w3-article-94598.html>
- Cohn, M. (2011). *The United States and Torture. Interrogation, Incarceration, and Abuse*. New York, NY: New York University Press.
- Comisión Nacional sobre Prisión Política y Tortura (2005). Informe de la Comisión Nacional sobre Prisión Política y Tortura (Valech D). (*Report of the National Commission on Political Imprisonment and Torture*). Available at: <http://bibliotecadigital.indh.cl/handle/123456789/455>
- Dello, N. (2009). Letters: The terrors of torture. *Journal of American Dental Association*, 140(4), 399-400. <https://doi.org/10.14219/jada.archive.2009.0175>
- Gill, L. (2004). *Escuela de las Américas: entrenamiento militar, violencia política e impunidad en las Américas. (Schools of the Americas: Military training, and political violence in the Americas)*. Santiago de Chile: LOM Eds. Cuatro Vientos. Available at: <http://www.memoriachilena.gob.cl/602/w3-article-73339.html>
- Herath, J., & Pollanen, M. (2017). Clinical examination and reporting of a victim of torture. *Academic Forensic Pathology*, 7(3), 330-339. <https://doi.org/10.23907/2017.030>
- Høyvik, A. C., Lie, B., & Willumsen, T. (2019). Dental anxiety in relation to torture experiences and symptoms of post-traumatic stress disorder. *European Journal of Oral Science*, 127(1), 65-71. <https://doi.org/10.1111/eos.12592>
- Høyvik, A. C., Willumsen, T., Lie, B., & Hilden, P. K. (2021). The torture victim and the dentist: The social and material dynamics of trauma re-experiencing triggered by dental visits. *Torture Journal*, 31(3), 70-83. <https://doi.org/10.7146/torture.v32i3.125290>
- Jorquera, M., Madariaga, C., Burrone, M., Tapia, E., Colantini, L., Alvarado, R. (2020). Estudio descriptivo de mortalidad en sobrevivientes de tortura y prisión política en el periodo de la dictadura militar en Chile, 1973-1990. (*Mortality in survivors of torture and prison during the Chilean dictatorship between 1973 and 1990*). *Revista médica de Chile*, 148(12), 1773-1780. <http://dx.doi.org/10.4067/S0034-98872020001201773>
- Ministerio del interior de la República de Chile (1992). Ley 19.123. Crea corporación nacional de reparación y reconciliación, Establece pensión de reparación y otorga otros beneficios en favor de personas que señala. (*Law 19.123. Creates a national reparation and reconciliation corporation, establishes a reparation pension and grants other benefits in favor of the persons indicated*). Available at: <https://www.leychile.cl/Navegar?idNorma=30490&r=1>
- Ministerio del interior de la República de Chile (2004). Ley 19.980. Modifica la ley n° 19.123,

- Ley de reparación, ampliando o estableciendo beneficios en favor de las personas que indica. (*Law 19,980. Amends Law No. 19,123, Law of Reparation, expanding or establishing benefits in favor of the persons indicated*). Available at: <https://www.leychile.cl/Navegar?idNorma=232231>
- Ministerio del interior de la República de Chile, Subsecretaría del interior (2004). Ley 19.992. Establece pensión de reparación y otorga otros beneficios a favor de las personas que indica. (*Law 19,992. Establishes reparation pension and grants other benefits in favor of the persons indicated*). Available at: <https://www.leychile.cl/Navegar?idNorma=233930>
- Ministerio de relaciones exteriores de la República de Chile (1988). Decreto 808. Promulga la convención contra la tortura y otros tratos o penas crueles, inhumanos o degradantes, adoptada por la asamblea general de la Organización de las Naciones Unidas mediante resolución 39/46, de fecha 10 de diciembre de 1984. (*Decree 808. Promulgates the convention against torture and other cruel, inhuman or degrading treatment or punishment, adopted by the General Assembly of the United Nations Organization through resolution 39/46, dated December 10, 1984*). Available at: <https://www.leychile.cl/Navegar?idNorma=15722>
- Ministerio de justicia y derechos humanos de la República de Chile (2016). Ley 20.968. Tipifica delitos de tortura y de tratos crueles, inhumanos y degradantes. (*Law 20,968. Classifies crimes of torture and cruel, inhuman and degrading treatment*). Available at: <https://www.leychile.cl/Navegar?idNorma=1096847>
- Santos, J. (2020). Los silencios de la tortura en Chile. (*The Silence of the torture in Chile*). *Revista de Ciencia Política*, 40(1), 115-136. <http://dx.doi.org/10.4067/S0718-090X2020000100115>
- Singh, H., Scott, T., Henshaw, M., Cote, S., Grodin, M., & Piowarczyk, L. (2008). Oral health status of refugee torture survivors seeking care in the United States. *American Journal of Public Health*, 98(12), 2181-2182. <https://doi.org/10.2105/AJPH.2007.120063>
- Speers, R., Brands, W., Nuzzolese, E., Swiss, P., van Woensel, M., & Welie, J. (2008). Preventing dentists' involvement in torture. The developmental history of a new international declaration. *Journal of American Dental Association*, 139(12), 1667-1673. <https://doi.org/10.14219/jada.archive.2008.0109>
- United Nations (2004). Istanbul Protocol: Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment. Available at: <https://digitallibrary.un.org/record/535575>
- United Nations (1984). Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Available at: <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-against-torture-and-other-cruel-inhuman-or-degrading>
- Valencia, H. R., & García, H. J. (2009) Quemaduras eléctricas en boca. (*Electric burns in mouth*). *Perinatología y Reproducción Humana*. (*Perinatology and human reproduction*), 23(2), 116-123. <https://www.medigraphic.com/cgi-bin/new/resumen.cgi?IDARTICULO=21871>
- Willix, K., Ekman, E., Klefbom, C., & Karlsson, L. (2021). Qualitative exploration of dental and health care personnel's awareness of signs displayed in victims of torture with focus on the oral cavity. *Torture Journal*, 31(3), 84-95. <https://doi.org/10.7146/torture.v32i3.127791>

Exploratory study on the quality of forensic assessments using the Istanbul Protocol in a virtual versus face-to-face environment

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Abstract

Introduction. With the advent of the Covid-19 pandemic, most torture victim care centres had to adapt their forensic assessment methods and move to online methodologies. Therefore, it is essential to assess the advantages and disadvantages of this type of intervention, which seems to be here to stay.

Method. Structured administered surveys were conducted with professionals (n=21) and with torture survivors (SoT) (n=21) from a sample of 21 Istanbul Protocols (IP). Comparing face-to-face (n=10) and remote (n=11) interviews in relation to the evaluation process, satisfaction, difficulties encountered, and compliance with therapeutic aspects. All assessments were primarily psychological. Three remote and four face-to-face interviews included a medical assessment.

Results. No significant problems were found in relation to the ethical requirements of the IP. Satisfaction with the process was positive in both modalities. Regarding the online method, there were frequent connection problems and a lack of adequate material resources

in the remote assessments, requiring a significantly higher number of interviews in most cases. Survivors were more satisfied than evaluators. Overall, the forensic experts described problems in complex cases with an understanding of the person's emotional response, they established a bond, and they undertook psychotherapeutic interventions in the event of an emotional crisis during the assessment. In the face-to-face protocols, logistical and travel problems were frequent, which meant that forensic work times had to be adapted.

Discussion. The two methodologies are not directly comparable but have specific issues to be studied and addressed. More investment and adaptation in remote methodology is needed, especially given the poor economic situation of many SoT. Remote assessment is a valid alternative to face-to-face interviews in specific cases. However, there are very relevant human and therapeutic aspects that indicate that, whenever possible, face-to-face assessment should be preferred.

Keywords: Istanbul Protocol. Remote Assessment.

Introduction

The Covid-19 pandemic has affected models of care and forensic assessment of asylum seekers, which, after initially stalling, have shifted significantly to remote formats com-

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patible with the total or partial lockdown. Different studies have reported on these changes either in assessments conducted by telephone (Cohen et al., 2021), by video call (Mishori et al., 2021), or using a combination of both methodologies (Green et al., 2020; Pogue et al., 2021). While these studies have generally supported the use of remote assessments alone (Greenhalgh et al., 2020; Pogue et al., 2021), others have recommended a hybrid approach (Gruber et al., 2021). However, such assessments are not without problems, such as the lack of material means, resources to carry them out, problems related to rapport building (Mishori et al., 2021), and transference and psychotherapeutic aspects.

SiR[a] is a centre that provides therapeutic, legal, and psychosocial support in contexts of violence (www.psicosocial.net/sira) with teams in Madrid and Barcelona. Forensic assessments based on the Istanbul Protocol (IP) are part of the support provided in the asylum application process for survivors of torture (SoT). In this context, prior to Covid-19, SiR[a] already carried out a portion of assessments in remote format (7.4%). However, the pandemic and the period of lockdown, together with the severe mobility restrictions, meant that a substantial part of the SiR[a]'s IP interviews had to move to a remote format during 2020 and 2021, representing 46.5% of the total number of assessments.

This study aims to assess the quality of remote IP interview evaluations compared to face-to-face interviews by collecting feedback on the evaluation process from both expert evaluators and asylum seekers.

Method

Research design. In October 2020, the project “Conducting Istanbul Protocol in times of Pandemic” started with the design of a case-control protocol. The study was approved by SiR[a]'s

ethics and deontology committee. Between May and June 2021, SoT and professionals were contacted by email and an informed consent form for voluntary participation sheet was administered. Once the informed consent form was signed, they received structured self-administered questionnaires in their email and completed them remotely. The questionnaires were administered in Spanish, English, or French. All SoT had already completed their assessment process, and the organisation had submitted their report to authorities, so participation in the study would not influence the outcome of the IP assessment.

Sample. A purposive sampling was carried out, contacting all professionals and SoT who had participated in IP interviews between 2019 and 2021. These interviews were conducted according to the guidelines of the “Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment” (OHCHR, 2004). Finally, 21 IP interviews (10 face-to-face and 11 remote) conducted in SiR[a] with expert professional evaluators were analysed. 21 SoT and 21 professional evaluators were part of the sample. In the IP interviews conducted remotely, online meetings were used with Zoom (N=7) and Skype (N=4) as virtual platforms. All professionals were psychologists or psychiatrists with specific training in IP assessment and experience in conducting IP interviews. In necessary cases where a medical assessment was required, this professional was also interviewed.

Instruments. Two ad hoc questionnaires were developed, one version for SoT and the other for experts (Appendices 1 and 2). Both were composed of open-ended and closed-ended questions and included socio-demographic data and information on the type of assessment (face-to-face/distance). The questionnaire for the SoT included a section about

general satisfaction with the process, emotions during the interviews, information on the status immediately after the completion of the interviews as well as after some time has passed and the process has been closed, and aspects related to the medical examination (in those cases where it was necessary). In addition, a section on satisfaction with interpretation during the interviews was included, which was only completed in some cases (those where the use of an interpreter was necessary). The questionnaire for the professionals included aspects related to ethical elements, the interview and therapeutic process, preparation of the report, and feedback to the examinee. Again, an optional section about the satisfaction with the interpretation was included.

Data analysis. Descriptive analyses were carried out in relation to the answers obtained in the questionnaire. Qualitative responses were analysed in the pertinent cases by inspection and reading of each of the responses. Data was analysed using SPSS v24 software.

Results

Characteristics of the sample.

Most face-to-face interviews ($n=7$, 81%) took place at SiR[a]'s headquarters in Madrid. In four of those cases (19%), the person travelled from another city. Also, in four cases, the team travelled to the SoT's town of residence ($n=4$, 19%).

In the face-to-face IP, the assessment lasted an average of 2 to 3 sessions; however, in the remote evaluations, a much higher number of sessions were required (4 to 7; 63%). The average duration of the evaluations was longer in the face-to-face sessions. A medical evaluation was required in 4 face-to-face and 3 virtual IP (verbal and visual evaluation), and

in all cases, it went smoothly. Table 1 shows results in detail.

Information obtained from SoT

Characteristics. The majority were male ($N = 16$, 76.2%), from Latin American (Colombia, Mexico, Peru, and Venezuela) ($N = 6$, 28.6%), African (Guinea, Ivory Coast, Sahara, Somalia, and Uganda) ($N = 9$, 42.8%) and Eastern European or Central Asian countries (Belarus, Georgia, Russia, and Tajikistan) ($N = 6$, 28.6%) with a mean age of 31 years.

Overall satisfaction. In general, all SoT evaluated remotely were satisfied (100%) with the process, and the majority of those evaluated in person were also satisfied (80%). Some of the qualitative testimonies collected on this subject were as follows “*It was good to have this interview through video conferencing, otherwise I would feel confronted or uncomfortable*”; “*It was a very difficult time for me. The presence of people helped me to overcome my sorrows.*”

Interview process and report writing. All participants were satisfied with the process except for two people in the face-to-face format ($n=2$, 20%). In both of those cases, the interviews were conducted in a single session of around 5 hours due to the team's travel time from Madrid to their city of residence. Moreover, in one of them, the asylum application had been rejected at the time of the study. Regardless, all the people interviewed in both modalities perceived an attitude of empathy and listening on the part of the professionals and the interpreter when needed.

Closure and feedback. Overall, in the face-to-face format compared to remote, more people felt good immediately after the interview (50 vs 45.5%) and at the end of the process, when the report is already revised and closed (80 vs 55%). Some of the qualitative testimonies in relation to this were: “*Some days after the interview I was a bit more nervous. But*

Table 1. Remote versus face-to-face forensic assessments

	Remote (n=11) n (%)	Face-to-face (n=10) n (%)
Number of interviews		
2	0 (0)	7 (70)
3	4 (36.6)	3 (30)
Between 4 and 7	7 (63.6)	0 (0)
Average time of interview (min.)	173	258
Need of interpreter	9 (81)	5 (50)
Medical assessment	3 (27.2)	4 (40)
Professionals		
Ethical aspects		
Information and signature of informed consents	11 (100)	10 (100)
Security problems for the survivors	2 (18.1)	0 (0)
Interview process		
Inadequate interview location - privacy issues	5 (45.4)	0 (0)
Problems of connection/material resources	4 (36.3)	0 (0)
Timing problems	4 (36.3)	4 (40)
Difficulties with interpreter assistance	0 (0)	2 (20)
Difficulties understanding emotional response	6 (54.5)	2 (20)
Closure and feedback		
Difficulties giving feedback	0 (0)	2 (20)
Survivors of Torture (SoT)		
Positive overall satisfaction	11 (100)	8 (80)
Interview process		
Empathy and listening from interviewer	11 (100)	10 (100)
Right timing	9 (81.8)	10 (100)
Perception of good technical quality of the work	7 (63.6)	6 (60)
Emotional impact		
Feeling well immediately after interviews	5 (45.5)	4 (50)
Feeling well at the end of the process	6 (55.5)	8 (80)
Post-process resilience	7 (70)	9 (81)
No need for subsequent psychological support	5 (45.5)	4 (40)
Closure and feedback		
Feel satisfied - A good summary of the history	11 (100)	10 (100)
Empathy and listening	3 (100)	4 (100)
Well-reflected physical sequelae	3 (100)	3 (75)

a few weeks later I felt calmer". On the other hand, all respondents felt that the final report adequately reflected their personal history and the events of torture they experienced. 70% of the respondents evaluated face-to-face and 81% evaluated remotely felt that the process facilitated the construction of a more resilient narrative about their experience. However, around 60% in both formats stated that they would have needed psychological support after the interviews: *"I believe that after the interview, at least for a month and a half, there should be accompaniment by the same psychologist who participated in the interview so that the person does not have to be telling his or her story to a new professional"*.

It is worth noting that while 90% of those who were assessed face-to-face would not want to change the format, 27.3% of those assessed online would have preferred to conduct the interviews face-to-face: *"In this type of situation, physical contact and closeness are important."* *"It was a very difficult time for me. The presence of people helped me to overcome my sorrows"*.

Medical assessment. In all cases, the person reported that they felt comfortable and respected during the medical examination. Their physical complaints and discomfort were adequately reflected even if the medical assessment was conducted remotely.

Information obtained from professionals

Characteristics. All professionals were psychologists. The majority were female (N = 15; 71%) and reported that they had not received any training in online or remote forensic assessment (N = 17, 81%), with a small percentage reporting informal self-training (N = 4, 19%).

Ethical aspects. In no case were problems reported in completing the informed consent forms and in the provision of the necessary information about the evaluation process. In a small but relevant percentage of virtual IP

interviews (N = 2, 18%), the conditions of the interview did not guarantee confidentiality due to the location of the SoT, as they were either public spaces with other people present or because the platforms used were not considered secure (subjective perception of the evaluator). *"The SoT was in the room of the shelter where she lived. The space was not entirely comfortable, she was lying on her bed and sometimes sitting on it"*.

Interview process and reporting. In the remote evaluations, problems were identified in almost half of the cases related to the location of the evaluated (small, poorly lit, and poorly ventilated rooms) (N = 5, 45.5%) and internet connection problems during the evaluations (N = 4, 36.36%), which also caused alterations in the time dedicated to the interviews in 40% of the cases. At the face-to-face level, there were no problems related to material resources. However, difficulties were detected in terms of time (N = 4, 40%), as face-to-face interviews were considered either excessively long or short due to the need for travel by either party. Remote evaluations allow for both cost savings and a better adjustment of time needed due to the flexibility they offer, especially in cases of travel.

Concerning emotional and psychotherapeutic aspects, in the remote IP interviews, the forensic experts reported difficulties in understanding the emotional response of the examinee in more than half of the cases (N = 6, 60%), identifying specific empathic barriers. For example: *"On this occasion, as the person was emotionally affected and the aggression was of a sexual nature, it was important to be present in person. In addition, the fact of having to contrast their story, in the face-to-face format, allows us to take more care of the process and obtain non-verbal information...etc."* Also, problems were found in discerning speaking rhythms, choices of words, and in understanding the

emotions transmitted by the examinee when he/she could not connect the camera. Finally, in the face-to-face protocols, problems with interpreter attendance due to lockdown or COVID-related reasons were reported in two cases (20%). Conversely, no problems were reported with interpretations in remote evaluations. The possibility of conducting the interviews online made it easier to find an interpreter, since there were no geographical limitations.

Closure and feedback of the results to the SoT. No difficulties were encountered in the virtual IP interviews. In contrast, in the face-to-face ones, problems were reported in a couple of cases (20%). The feedback process could not be appropriately completed in full because the intensive interview format, used in some of the face-to-face interviews, did not allow enough time for it. In online assessments, this could be solved by extending the time of the interview.

Some qualitative information that complements the results obtained: *“The examinee was very reluctant and distrustful to be able to share his story, so I think that being able to generate a link in person was essential. At the same time, as he was outside Madrid, SIRA had to travel and because of this, the evaluation was condensed into a very short time and I think this generated a certain fatigue on the part of the appraiser.”; “In this case, I believe that the virtual format was an absolute advantage. The expert witness had a fairly elaborated story to tell and there were no traumatic elements that triggered overflowing emotional responses. From this point of view, the virtual format was a light and clear process”*

Discussion

The data show that, on the whole, forensic evaluators are not as satisfied with the remote evaluation system as they are with the face-to-face system. They consider that in a significant minority of remote cases (25-30%),

there are problems ensuring security and confidentiality, the interviewee is in an unsuitable location for a good interview, there are connection problems (poor image quality, Wi-Fi, or other), and, as assessors, they have difficulties in understanding the emotional response of the victim at specific points in the story. Overall, forensic experts consider remote assessment a somewhat worse option.

On the other hand, survivors show an overall positive evaluation for both formats. In both environments, they similarly perceive the empathy of the interviewer, find the length of the interview adequate, and perceive a good technical quality of the forensic team.

It is worth noting that while a similar number of survivors report feeling emotionally impaired immediately after the interview, at the end of the process, those who have had face-to-face interviews report being comparatively somewhat better off emotionally than those who had a remote interview. This finding is attributed to two factors: (a) Virtual interviews go into less detail about the painful aspects of the experience. Therefore, the interviews are shorter and more focused on the strict subject of sustaining asylum claims. (b) In face-to-face interviews, it is easier to detect when the interviewee is going through an emotionally difficult situation and make a therapeutic intervention. It is common that during long and intense IP interviews people experience discomfort when reliving their traumatic experiences, however, it is important to understand that the IP is a process, where the person is accompanied as much as possible, and a return and recollection is made with a closure. Thus, it is common that although the experience is hard, in the end the person can rescue positive elements and feel better than after the initial interviews. Non-verbal communication is positioned in this sense as a central element for the achievement of a greater emotional rapport

and therefore a greater emotional depth in the evaluations. Hence, the virtual format, while generating difficulties in the understanding of this non-verbal communication, also presents difficulties in this emotional deepening. These proprieties may mean that face-to-face protocols have a greater restorative effect.

However, this does not determine the final quality of the account of events, which in both cases is considered to have been correct. It should be considered that it could influence a loss of information in psychological and psychosocial impact assessment, something that could not be verified in this study due to its characteristics. Finally, it is worth highlighting the perception that a good rapport was developed during the remote medical examinations, despite the a priori difficulty they could entail for online assessments. This may be due to the fact that in this case, nonverbal communication may be less important for the evaluation.

Limitations

Among the elements that may explain the discrepancies between experts and survivors is that experts are mostly middle-aged women from European ancestry. In contrast, survivors are primarily young men from multiple non-European cultural backgrounds. These differences may imply different levels of importance being attached to emotional and transference aspects during the assessment process. It would also be necessary to carry out a study to increase the sample size, as well as to equalize the number of men and women, in order to be able to generalize the results obtained, as well as to carry out a gender-based analysis.

It must be taken into account that, although a level of emotional stability is always required to start an evaluation of this type, in the case of virtual evaluations, the team made sure that the person had greater emotional stability, which

guaranteed that they would not be a great emotional overflow, or failing that, there would be professionals close to the person to be able to carry out emotional support if this were necessary. Therefore, there may be a bias in the selection of the people who have carried out the virtual evaluations, and in general they may be people who present less emotional impact at the time of the interview.

Conclusions

The present study shows differences in the assessment made by torture survivors and forensic experts regarding face-to-face versus virtual IP interviews. In virtual IP interviews, difficulties are observed in the lack of material resources (inadequate equipment, Internet connection, and suitable places in the survivor's environment to conduct the interviews). Consistent with previous similar studies (Pogue et al., 2021), these difficulties affect the time of the process, involving more sessions than in face-to-face cases. In addition, due to the difficulties that the virtual format generates in the understanding of non-verbal communication, in a few cases problems have been detected in collecting information and establishing the transference bond with the examinee, where specific difficulties might appear in terms of warmth, empathy, and rapport in the process. These results are also consistent with previous studies, both in telephone and video call interviews (Cohen et al., 2021; Mishori et al., 2021). In contrast, in face-to-face interviews, the study shows problems related to travel logistics, including time allocated to the interview, the process's financial costs, and the organisation with interpreters, which sometimes limit the duration and number of interviews.

Overall, survivors' feedback is positive in all areas, with no major differences according to the evaluation format. However, many of those

evaluated virtually would have preferred to be interviewed in person. There are also slight differences in the level of emotional distress generated after the interviews, being slightly higher in the remote sessions with a higher perceived need for psychological support afterwards. These differences are probably related to the difficulties in establishing an adequate transfer and therapeutic connection, also referred to by the experts in this study and existing literature (Mishori et al., 2021).

The Covid-19 pandemic has meant a significant change in our forensic documentation practices, forcing the adaptation and implementation of virtual methodologies, which in many cases have been carried out without prior preparation of professionals and a lack of specific training. Nor has there been an adequate adaptation of spaces and investment in technological resources. On the other hand, the results show that remote interviews expand access to corroborating evidence for asylum applicants (Raker & Niyogi, 2022) and have positive aspects concerning organisational ease and accessibility, avoiding long journeys, and allowing more flexible interviews to be carried out in familiar environments for the person being assessed. However, the results seem to reflect that remote methodology is not comparable to face-to-face methodology in relation to the human and, above all, therapeutic aspects. These elements related to good practice are a priority when we want the forensic assessment to be therapeutic by itself. We do not focus only on the outcome but also the process.

Both methodologies allow the evaluation process to be carried out in a successful and accurate way. Based on the results obtained, we consider that the remote methodology can be used in specific cases to avoid large displacements or costs, as well as in cases where a great need for therapeutic work is not expected. In

these cases, being face-to-face would seem to guarantee a better alliance. Perhaps a future perspective might be the possibility of working with mixed methodologies, which would allow both methodologies to be combined according to the needs of each case. However, this decision must be made carefully, as the human and therapeutic aspects of the forensic process must always take precedence over the logistical and functional aspects to ensure that the person being assessed is treated appropriately and with due care.

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References

- Cohen, J., Gregory, B., Newman, K., Rowe, E. J., & Thackray, D. (2021). Remote medico-legal assessment by telephone during COVID-19: Monitoring safety and quality when documenting evidence of torture for UK asylum applicants. *Medical and Psychological Perspectives. Torture Journal* 31(1), 37.
- Green, A. S., Ruchman, S. G., Katz, C. L., & Singer, E. K. (2020). Piloting forensic tele-mental health evaluations of asylum seekers. *Psychiatry Research*, 291, 113256. <https://doi.org/https://doi.org/10.1016/j.psychres.2020.113256>
- Greenhalgh, T., Koh, G. C. H., & Car, J. (2020). Covid-19: a remote assessment in primary care. *BMJ*, 368.
- Gruber, M., Eberl, J.-M., Lind, F., & Boomgaarden, H. G. (2021). Qualitative interviews with irregular migrants in times of covid-19: recourse to remote interview techniques as a possible methodological adjustment. *Forum: Qualitative Social Research*, 22(1).
- Mishori, R., Hampton, K., Habbach, H., Raker, E., Niyogi, A., & Murphey, D. (2021). "Better than having no evaluation done": a pilot project to conduct remote asylum evaluations for clients in a migrant encampment in Mexico. *BMC Health Services Research*, 21(1), 508. <https://doi.org/10.1186/s12913-021-06539-5>
- OHCHR - UN Office of the High Commissioner for Human Rights. (2004). *Manual on the Effective Investigation and Documentation of Torture and*

Other Cruel, Inhuman or Degrading Treatment or Punishment (“Istanbul Protocol”). HR/P/PT/8/Rev.1, available at: <https://www.refworld.org/docid/4638aca62.html>

Pogue, M., Raker, E., Hampton, K., Saint Laurent, M. L., & Mishori, R. (2021). Conducting remote medical asylum evaluations in the United States during COVID-19: Clinicians’

perspectives on acceptability, challenges and opportunities. *Journal of forensic and legal medicine*, 84, 102255. <https://doi.org/10.1016/j.jflm.2021.102255>

Raker E., Niyogi A. (2022) Performing Remote Asylum Evaluations. In: McKenzie K.C. (eds) *Asylum Medicine*. Springer, Cham. https://doi.org/10.1007/978-3-030-81580-6_9

The effectiveness of psychoanalytic psychotherapy in individuals diagnosed with PTSD due to torture and severe human right violations

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Key points of interest

- Despite its evident methodological limitations, the study is a contribution supporting the application of psychoanalytic psychotherapy to individuals diagnosed with PTSD as a result of torture and severe human rights violations.
- Psychoanalytic psychotherapy applied to PTSD patients can exert positive effects and such positive effects tend to increase with the continuity of therapy.

Abstract

Introduction: Various psychotherapies have been applied to individuals who have been subjected to torture and severe human rights violations. However, studies assessing the effectiveness of such therapies are limited. Psychoanalytic psychotherapy is said to be used

frequently in practice for these patient groups. Yet, there are scarcely any studies assessing its efficacy. In this study, we aim to assess the effectiveness of psychoanalytic psychotherapy in patients with PTSD associated with torture and severe human rights violations.

Methods: 70 patients who were diagnosed with PTSD due to being tortured and severe human rights violations in accordance with DSM-IV-TR and who applied to the Human Rights Foundation of Turkey were given psychoanalytic psychotherapy. CGI-S and CGI-I scales were applied to the patients (in Months 1, 3, 6, 9, and 12); and the patients' continuity of therapy and the changes in their recovery during the one-year psychotherapy period were assessed.

Results: 38 (54.3%) of the patients were female. Their mean age was 37.7 years ($SD = 12.25$), while their mean baseline CGI-S score was 4.67. The drop-out rate was 34%. The mean length of treatment was 21.9 sessions ($SD = 20.30$). Mean scores for CGI-I scale were 3.46, 2.95, 2.23, 2.00, and 1.54 for months 1, 3, 6, 9 and 12 respectively. As the number of sessions increased, the final CGI-I scores of the patients improved significantly ($p < .001$) towards recovery. 75.4% of the patients benefited from the treatment in general according to their final CGI-I score.

Conclusions: Considering the limited literature in the field, this study has provided sig-

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nificant data on the effectiveness of the use of psychoanalytic psychotherapy in individuals diagnosed with PTSD related to torture and severe human rights violations, despite its limitations such as not involving a control group, not having been conducted blindly and randomized and being based on a single scale.

Keywords: torture, PTSD, post-traumatic stress disorder, psychotherapy, psychoanalytic therapy, effectiveness

Introduction

156 countries signed the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment and Punishment (United Nations General Assembly, 1984), yet, torture is still very common around the world. According to the Amnesty International Report 2014, torture and other forms of ill treatment have been documented in 141 countries (Amnesty International, 2014; Hamid et al., 2019). Turkey is one of the countries where torture and systemic violence are quite frequent, intense and perpetual (Human Rights Foundation of Turkey [HRFT], 1994; Human Rights Watch, 2005; Refugee Health Care Center, 1988; Yilmaz et al., 2015).

It has been reported that the lifetime prevalence of PTSD is up to 15 percent in population-based studies, and the prevalence in individuals who are at risk for trauma varies between 3 and 58 percent (DSM-IV; American Psychiatric Association [APA], 1994). Torture is a key risk factor (Steel et al., 2009), and torture survivors are more likely to report symptoms of PTSD, major depression, and elevated anxiety compared to the individuals who have been subjected to other forms of violence; and these symptoms often have severe consequences for daily functioning long after the events that precipitated them (Basoglu, 1993; Holtz, 1998; Weiss et al., 2016).

Studies on the efficacy of treatments in relation to the frequency and severity of torture are often limited. A review conducted in 2011 describes a limited range of interventions for torture survivors, tested in studies with significant limitations such as small sample sizes and unvalidated outcomes (Hamid et al., 2019; Jaranson & Quiroga 2011). In addition, Weiss et al. (2016) identified 88 studies including interventions against torture and systematic violence victims in their literature review, but there is no study from Turkey among them.

Several psychological treatment models including cognitive behavioral therapy, narrative exposure therapy, psychoeducation and supportive counselling have been proposed for improving PTSD symptoms in torture survivors. However, the effectiveness of the treatments was understudied. Additionally, the results of review studies which investigated the effect of psychological treatments (McFarlane & Kaplan, 2012; Weiss et al., 2016; Patel et al., 2016) were controversial. While McFarlane and Kaplan (2012) suggest that psychological treatments are largely effective in reducing psychological symptoms, Patel et al. (2016) found that the studies used psychological treatments had no immediate effect on PTSD symptoms.

It has been reported that studies on the treatment of torture-related PTSD have significant limitations and research is needed on the effectiveness of different intervention options that have not been studied so far (Hamid et al., 2019; Patel et al., 2016; Pérez-Sales, 2016; Weiss et al., 2016). On the other hand, very few studies assess the effectiveness of psychodynamic psychotherapies, psychoanalytic ones in particular, in either tortured individuals or, even in general, patients with PTSD even though psychodynamic therapies are among the therapies that are frequently used in the treatment practice for PTSD (Hamid et al.,

2019; Patel et al., 2016; Weiss et al., 2016; Fonagy, 2015; Leichsenring, 2014).

This study aims to assess the effectiveness of psychoanalytic psychotherapy primarily in the patients diagnosed with PTSD related to torture and severe violations of rights. Additionally, the study seeks to monitor the continuity of therapy in the first year and its relationship with general clinical change.

Method

Scope and subjects

This study reports on the research findings of the Psychoanalytic Psychotherapy Programme of HRFT Istanbul.¹ The study sample consisted of 70 people who applied to the Istanbul Centre of HRFT and were admitted to the psychoanalytic psychotherapy programme between 2013-2017. Subjects were individuals diagnosed as (primarily) suffering from posttraumatic stress disorders according to DSM-IV-TR. These PTSD patients met the full criteria required for the diagnosis of PTSD and they were not subthreshold. 27 patients who were included in the program without a diagnosis of PTSD during that period, and 15 patients whose files could not be reached in the archive for various reasons were excluded from the study.

Procedure

The process for determining torture, diagnosing and measuring

Torture was determined according to the definition in UNCAT and by experienced

medical doctors who received training according to the Istanbul Protocol -consultations and clinical team (medical doctors, psychiatrists, psychologists, social workers, forensic medicine doctors) meetings took place for evaluation when necessary.

Psychiatrists who have extensive experience in diagnosing PTSD have conducted the psychiatric assessments of the patients and diagnosed PTSD according to DSM-IV-TR criteria. They also filled out the sociodemographic and clinical data forms, and determined the rating scale scores (CGI-S prior to the therapy, and CGI-I at the 1st, 3rd, 6th, 9th, 12th months of the therapy). Diagnosis has been made with a half-structured process which is based on DSM-IV-TR. The same psychiatrist diagnosed and followed a given patient with CGI-S and CGI-I scale assessments (completely independent of the therapists). A total of three psychiatrists took part in the study. The rating scale scores and attrition up to the first year of therapy were analysed in the study.

Therapies

Therapeutic processes and therapists are completely outside the scope of the application of diagnosis, forms and application of scales (CGI-S, CGI-I). The therapies were conducted by 15 therapists who were trained in the psychoanalytic method and had experience of more than ten years. Almost all the therapists were analysts who were members of the International Psychoanalytic Association (IPA) or candidates undergoing their psychoanalytic training under the supervision of the IPA, and all the therapists either underwent or were undergoing personal analysis.

Therapies were designed exclusively according to analytical principles, hence case-specific and confidential. The psychotherapy process, on the other hand, was not designed to carry out a specific study, and individuals were pro-

¹ The Psychoanalytic Psychotherapy Programme was awarded the IPA in the Community Awards in Humanitarian Organizations (first prize) by the International Psychoanalytic Association (IPA) in 2019.

vided psychoanalytic psychotherapy in a natural course by HRFT. The patients received psychoanalytic therapy on a once per week basis, without a set time-limit, in analysts'/candidates' private office; and the course of therapy was determined based on the necessities of the analytical space. HRFT carried out the treatment of patients free of charge, with the help of a budget formed through various funding and projects -that are run independently of the state. A payment was made to the therapists for the sessions from the HRFT treatment budget -the fees were relatively low compared to the average session prices in the market.

Some basic principles of the *HRFT Psychoanalytic Psychotherapy Program* and some core components of the therapy processes are presented in Table 1. For more details, you can also refer to our previous publications (Özyıldırım et al., 2017, Özyıldırım & Aslantaş Ertekin, 2021).

Approval for the study was obtained from the Ethics Committee of Istanbul Arel University (Istanbul, Turkey).

Measures

Sociodemographic information form

Includes information regarding patients, their stories and the assessment of the torture they have suffered. In this study, an exclusively arranged version of this form was used.

Clinical information form

This form, which was created by HRFT, includes detailed clinical history and evaluation of patients, physical and mental complaints and findings, diagnosis and improvements during the treatment. In this study, an exclusively arranged version of this form was used.

Clinical Global Impression Scale (CGI)

The Clinical Global Impression Scale (CGI) is a scale created to enable a brief, stand-alone

assessment by the clinician regarding the severity of the illness prior to initiating a treatment and the clinician's view of the patient's general clinical course during the treatment process. The assessment process is performed by considering all the available information, including the patient's history, psychosocial circumstances, symptoms, the impact of behaviour and symptoms on the patient's functionality (Busner & Targum, 2007).

CGI consists of 3 subscales. A 7-point rating is used in the first two subscales which are severity of illness (CGI-S) and improvement (CGI-I). The third subscale, efficacy index, is created to assess the side effects of treatment. The assessment is based on the symptoms, behaviours, and functionality that have been observed and reported in the past seven days (Busner & Targum, 2007). Assessment of improvement (CGI-I) is done by considering the individual's condition prior to the treatment, by comparing it with the initial condition at the interviews after the initiation of the treatment. The initial rating for the severity of illness is the baseline for the assessment (Busner & Targum, 2007).

CGI helps to monitor the clinical progress in a short period of time and allows the clinician to determine whether the applied intervention is effective. The CGI scale is applicable for all research populations; and a useful measure that correlates with longer and more time-consuming assessment tools used for several psychiatric diagnoses (Busner & Targum, 2007). In this study, CGI-S and CGI-I scales were used. The HRFT Psychoanalytic Psychotherapy Programme is not focused on scientific research, but on the clinical picture and treatment of patients. Given this emphasis, CGI scale was preferred in this study for its quick and easy administration, and its correlation with specific rating scales on disorder severity and improvement of the symptoms.

Table 1. Basic principles of the HRFT Psychoanalytic Psychotherapy Program and some core components of the therapy processes.

A. Some of the basic principles of the HRFT Psychoanalytic Psychotherapy Program.

- The Program does not directly equate the traumatic event with the traumatic effect, nor miss the fact that the traumatic is shaped within a *subjective realm* and a *psychic reality*.
- The therapists conduct the therapeutic processes with an analytical sensitivity to the subjective intrapsychological dynamics unique to each patient, rather than using a ‘standardized’ approach.
- The Program places emphasis on establishing a *sustainable and long-term setting and frame* for in-depth psychoanalytic therapy; and avoiding, to the extent that is possible, to justify ignoring the requirements of psychoanalytic work on the grounds that extraordinary conditions are present.
- Given that the therapists are also often exposed to the general social traumatic environment that creates torture, the Program pays attention to the analysis of the countertransference and the intersubjective effects of this *shared reality*.
- The Program was carried out with the general sensitivity of adopting a position involving social *recognition* and *witnessing* in the face of torture.

B. Some core components of the psychoanalytic psychotherapy processes. The therapists;

- Attempted to represent and symbolize traumatic intrapsychic hyperarousal and affective dysregulation.
- See the traumatic symptoms as temporary maintainers of a certain internal balance, not as problems that need quick relief.
- Try to transform the effect of torture on the internal object relations within the processes of transference and countertransference.
- Aim to analyze the internal conflicts, unconscious fantasies and defensive processes associated with torture.
- Aim to process the introjective and identificative processes related to torture, aggression and losses.
- Studied the effects of traumatic experiences on the patient’s life and relationships and unconscious compulsive repetitions.

Statistical analysis

Statistical analyses were performed using IBM SPSS 22.0. First, preliminary analysis of the data was done, and Kolmogorov-Smirnov Test was applied to examine normal distribution. The test results showed that the variables were not normally distributed, and non-parametric tests were used for the main statistical analysis. For the examination of difference between groups, the Mann-Whitney U Test was used for the groups with two categories, and the

Kruskal-Wallis Test was used for those with more than two categories. Total points were obtained to perform a Spearman Rank Analysis to analyse the correlation between variables. The Chi-Square Test of Independence was used to determine the relationship between categorical variables. Friedman Test was performed for the effectiveness of treatment, and Wilcoxon Signed-Ranks Test was used to determine the difference in time measurements.

Table 2. Sociodemographic and Clinical Distribution of the Participants

	n	%	Range	<i>M</i>	<i>SD</i>
N	70	100			
Age	70	100	22-70	37,7	12,25
Education (year)	70	100	1-19	11,3	3,79
Time between torture to therapy (month)	70	100	3-447	78,7	110,36
Gender					
Women	38	54,3			
Marital status					
Married	44	62,9			
Reason for application					
Torture	58	82,9			
Bomb attack	7	10,0			
Relative of deceased victim of torture	5	7,1			
Comorbidity					
Major Depressive Disorder	27	38,5			
Dysthymic disorder	4	5,7			
Other	5	7,1			
Psychopharmacotherapy					
Received	14	20			
Torture history (sub type)					
Threats/insults	50	86,2			
Coercive behaviours	24	41,3			
Physical interventions	47	81,0			
Positional tortures	26	44,8			
Physical/chemical factors	15	25,8			
Sexual assaults	25	43,1			
Restricting requirements	21	36,2			

General classification of torture methods in the HRFT reports (taking into account the Istanbul Protocol): *Threats/insults*: insults, humiliations, various threats against oneself or his/her relatives... *Coercive behavior*: eyeballing, making a person witness torture, having a person to listen to a loud anthem, offering to be an agent, torturing in the presence of relatives, forcing obedience... *Physical interventions*: beating, bastinado, electrocution, squeezing testicles... *Positional tortures*: hangers, crucifixion, strappado... *Physical/chemical factors*: pressurized/cold water, exposure to chemicals, burning, asphyxiation... *Sexual assaults*: undressing, verbal/physical sexual abuse, anal cavity search/naked search, rape and rape threat... *Restricting requirements*: cell isolation, restriction of eating/drinking, prevention of urination/defecation, prevention of sleep...

Table 3. Participants' CGI-S and CGI-I scores

CGI	<i>n</i>	<i>M</i>	<i>Mdn</i>	<i>SD</i>	Range
CGI-S	70	4.67	4	1.18	2 - 7
CGI-I Month 1	61	3.46	3	0.62	2 - 5
CGI-I Month 3	42	2.95	3	0.69	2 - 4
CGI-I Month 6	35	2.23	2	0.77	1 - 4
CGI-I Month 9	25	2.00	2	0.70	1 - 4
CGI-I Month 12	24	1.54	1	0.72	1 - 4

CGI-S: Clinical Global Impressions-Severity, CGI-I: Clinical Global Impressions-Improvement
 CGI-I: 1, *Very much improved*; 2, *Much improved*; 3, *Minimally improved*; 4, *No change*; 5, *Minimally worse*; 6, *Much worse*; 7, *Very much worse*.

Results

Sociodemographic and clinical data

The sample comprised of 70 people who were diagnosed with post-traumatic stress disorders according to DSM-IV-R. The sample comprised of 58 people who had experienced torture (82.9%), 7 people who survived a suicide bombing attack (in Ankara) (10.0%) and 5 people who had lost a loved one as a result of torture and enforced disappearance by a paramilitary force (7.1%). About 90% of survivors had been tortured while in custody/prison for political reasons. Sociodemographic data of the patients are presented in Table 2.

Participants' CGI-S and CGI-I Scores

The CGI-S and CGI-I Scale scores of the patients are presented in Table 3. As age increases ($r = .24, p = 0.04$), CGI-S scores gets higher in married participants ($U = 292,500, p = 0.02$) and participants with comorbidity ($U = 401,500, p = 0.01$). No association was found between CGI-S and education, time between torture to psychotherapy and torture methods ($p > .05$).

It has been observed that out of 61 patients who received CGI-I assessment at least once,

75.4% (46) of the patients benefited from the treatment in general according to their final CGI-I score (final CGI-I = 3, 19.7%; final CGI-I = 2, 31.1%; final CGI-I = 1, 24.6%). As the number of sessions increases, final CGI-I scores of the patients significantly improved ($r = -.76, p = .00$; $\chi^2(3, n = 61) = 34.732, p = .00$) towards recovery.

Continuity to psychotherapy

Considering the one-year period, the mean length of therapy in the entire group was 21.9 ($SD = 20.30$) sessions and 5.66 ($SD = 5.01$) months. It was found that the total number of sessions was higher in women ($U = 436,000, p = 0.04$). On the other hand, there was no meaningful relation between the total number of sessions and variables such as age, marital status, torture method, presence of comorbidity, presence of concomitant psychopharmacotherapy, and CGI-S scores ($p > .05$). As a criterion for premature discontinuation, if we take those who dropped out of therapy with no any CGI-I assessment (9 patients) and those who dropped out of therapy with no improvement in their CGI-I score -i.e. CGI-I scores of 4-7 (15 patients), the drop-out rate is 34% (24 patients).

Table 4. Distribution of Final CGI-I Scores of Patients who Received Only Psychotherapy (No Concomitant Pharmacotherapy)

Number of sessions	<i>n</i>	<i>M</i>	<i>SD</i>	4	3	2	1
0 – 3	8	3.38	,92	5 (62.5%)	1 (12.5%)	2 (25%)	-
4 – 11	10	3.40	,52	4 (40%)	6 (60%)	-	-
12 – 23	3	2.00	,00	-	-	3 (100%)	-
24 – 35	4	1.50	,58	-	-	2 (50%)	2 (50%)
36 – 47	2	1.50	,71	-	-	1 (50%)	1 (50%)
48+	22	1.45	,51	-	-	10 (45.5%)	12 (54.5%)

CGI-I scores of patients who received only psychotherapy

Concomitant psychopharmacotherapy was applied in addition to psychotherapy in a total of 14 patients (20%). The majority of patients, who also received pharmacotherapy, are patients with comorbidities (12 out of 14 patients) ($p = 0.004$). In addition, when patients who received concomitant pharmacotherapy in addition to psychotherapy and those who received only psychotherapy are compared in terms of CGI-I scores, the former group showed significantly greater improvement ($p = 0.001$). Table 4 shows the final CGI-I scores of the patients who received only psychotherapy (56 patients), excluding the patients receiving concomitant pharmacotherapy. In the group that received only psychotherapy, it is observed that more patients' CGI-I scores tend to concentrate towards improvement as the continuity of therapy increases.

Effect size

As shown in Table 5, there is a statistically significant difference between the data obtained from the CGI-I scale at different months (CGI-I Month 1, CGI-I Month 3, CGI-I Month 6, CGI-I Month 9, CGI-I Month 12 $\chi^2(4, n = 24) = 73.62, p < .001$). When the entire group and the group re-

ceiving only psychotherapy were assessed separately, a strong (Effect size $r = .62, r = .64$, respectively) and statistically significant ($p = .000$) change was identified in CGI-I scores between the first month and the first year. Accordingly, the change becomes more evident from the point forward the third month of the therapy (see Table 5).

Discussion

Limitations of the study

Nevertheless, our study has several significant limitations including not involving a control group, not being blind and randomized, not employing an assessment scale specific to PTSD which is filled by patient, deciding the effectiveness based on a single indicator, not having manualized interventions, not measuring to what extent which symptom groups have changed throughout therapies, and not performing to end-of-treatment evaluations of the CGI-S scale and patient's condition of meeting the diagnostic criteria for PTSD. These significant and determinant limitations should certainly not be forgotten while considering the results of our study on effectiveness, which should also be evaluated considering aforementioned limitations.

Table 5. Wilcoxon Signed-Rank Test Results

	N	CGI-I measure time	Mean Rank		z	p	Effect size r
			Positive Rank	Negative rank			
All patients	42	CGI-I-1-3	25.00	12.50	-4.158	,000	.45
	35	CGI-I-1-6	,00	15.50	-4.932	,000	.59
	25	CGI-I-1-9	,00	12.00	-4.283	,000	.61
	24	CGI-I-1-12	,00	12.00	-4.323	,000	.62
PT only	35	CGI-I-1-3	,00	12.00	-4.796	,000	.57
	31	CGI-I-1-6	,00	15.00	-4.849	,000	.62
	24	CGI-I-1-9	,00	12.00	-4.283	,000	.62
	23	CGI-I-1-12	,00	12.00	-4.323	,000	.64

Note: Bonferroni correction was conducted to avoid Type 1 Error ($p < .0125$). The effect size was calculated by dividing the absolute Standardised test statistic z value by the square root of N. Cohen's classification can be used as 0.1 = *small*, 0.3 = *moderate*, and 0.5 = *large* (Pallant, 2016). PT: Psychotherapy.

Significance of the study

Studies on the effectiveness of therapies in relation to the frequency and severity of torture are limited and controversial (Hamid et al., 2019; Jaranson & Quiroga, 2011; Patel et al., 2016; Pérez-Sales, 2016; Weiss et al., 2016). Given the scant literature, greater understanding of what works in treatment and rehabilitation for torture survivors is crucial in order to obtain maximum benefits from scarce resources. In the literature, it has been reported that, as in the specific case of torture, studies on the treatment of PTSD in general have also certain limitations such as limited effectiveness, loss of effectiveness in follow-up, high drop-out, and it has been stated that there is need for studies on intervention options different from those which had been thoroughly studied (CBT interventions in different forms, narrative exposure, testimony) so far (Hamid et al., 2019; Patel et al., 2016; Weiss et al., 2016).

On the other hand, although psychodynamic therapies are among the therapies that

are frequently used in PTSD treatment practice (Schottenbauer et al., 2008), there are almost no studies evaluating the effectiveness of psychodynamic therapies, especially psychoanalytic psychotherapies, in tortured patients (Hamid et al., 2019; Patel et al., 2016; Weiss et al., 2016). For instance, no psychoanalytic psychotherapy practice has been found in those who have been subjected to torture or systematic violence in the two reviews that have been conducted in recent years and include RCT studies (Hamid et al., 2019; Patel et al., 2016). Weiss et al. (2016), on the other hand, state that a total of 102 intervention arms were tested in 88 studies related to torture and systematic violence, which they identified in their systematic review. Accordingly, most of these arms are CBT and psychosocial studies, while only three are psychodynamic. The authors commented that “the effectiveness of psychodynamic therapies was unclear; unclear was defined as a situation in which the coder was unable to determine, from the content of

the article, the results of the study regarding the symptom in question (PTSD in this particular case)” (Weiss et al., 2016). Besides, even when assuming that existing studies are “psychodynamic”, their content is not very psychoanalytic, and their therapy methods are very different from each other. Also, the arm sample numbers for psychodynamic therapy in these studies are also very limited (Holmqvist et al., 2006, $n = 14$; Nicholson & Kay, 1999, $n = 15$). In this context our study is a contribution to the literature as it was carried out in Turkey -a country where torture is quite intense and prevalent, and it was investigated the effects of less studied psychoanalytic treatment option in the fields of torture and PTSD.

Effectiveness of psychodynamic therapies

The study of Nicholson and Kay (1999) was conducted with 15 Cambodian refugee women who migrated to the United States; with this group, Yalom Group Psychotherapy had been conducted in single group for 2 years. At the end of the study, it has been reported that there was a decline in depressive, anxiety and PTSD symptoms, as well as an increase in their self-esteem and functionality. However, reports of symptoms, diagnosis, and consequences were only anecdotal.

Holmqvist et al. (2006) found a considerable remission in PTSD symptoms and more moderate changes in self-image in their study which examines the changes in self-image and the change of PTSD symptoms with short-term therapy with 14 refugees who were victims of war and torture. The therapists of the research applied short-term psychodynamic psychotherapy.

In addition to abovementioned specific limitations, our study has some features that relatively overcomes such limitations of these existing studies that research the effectiveness

of currently available psychodynamic psychotherapy on torture (e.g., higher number of patients, a relatively purer patient group, a more specific diagnosis group, clarity of the psychoanalytic content of psychotherapy and the clarity of the standards of the therapists’ psychoanalytic psychotherapy formation, etc.).

Also, there are very few studies that evaluate the effectiveness of psychoanalytic psychotherapy on PTSD patients in general beyond torture as a specific notion. Different authors (Fonagy, 2015; Leichsenring et al., 2014) who regularly monitor and review the effectiveness of psychodynamic psychotherapies refer to a single study by Brom et al. while assessing the effectiveness of psychodynamic therapies in PTSD patients. According to Fonagy (2015),

There is only one study of PDT [psychodynamic psychotherapies] as an approach to post-traumatic stress disorder (Brom et al., 1989), which shows a significant reduction of intrusion and avoidance compared to wait-list, to about the same extent as hypnotherapy and trauma desensitization. Systematic reviews found insufficient evidence in relation to PTSD to warrant comment, although strong theoretical and clinical arguments have been advanced for incorporating a psychodynamic approach into PTSD treatment programmes. ... The case is weakened, however, by the absence of evidence for PTSD and the evidence of absence of effect for obsessive-compulsive disorder. In general, the methodological weaknesses of earlier studies call meta-analytic findings into question. (p.140-141)

In this study conducted by Brom et al. (1989), a total of 29 patients were included in a short-term psychodynamic therapy, and the majority of these patients were those who lost a relative to a disease; clinically significant improvements could be observed in about 60% of these patients. Furthermore, more re-

cently, a study by Levi et al. (2015) has been reported which compares CBT with psychodynamic therapy for combat-related PTSD patients who were combat soldiers or other military personnel. A significant improvement on symptoms has been monitored as a result of both therapies; no difference has been found in terms of effectiveness measurements; at post-treatment, 45% of the psychodynamic patients remitted. In our study, it has been observed that 75.4% of the patients benefited from the treatment in general according to their final CGI-I score. For such studies, the differences among the patient groups, trauma types, the features of applied psychodynamic therapy, effectiveness measurements etc. do not make a detailed comparison feasible in terms of treatment results.

Finally, our study -despite its evident methodological limitations- represents a contribution to the literature mainly for two reasons. First, it was conducted in Turkey which is a country where torture is practiced intensely. Second, research data on the psychoanalytic treatment for PTSD due to torture is sparse in the literature and has not been studied extensively. Well-structured further studies of psychoanalytic psychotherapy in patients with PTSD associated with torture and severe violence are required.

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References

- American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.
- Amnesty International, 2014 Amnesty International. Torture in 2014: 30 years of broken promises. Amnesty International. 2014. <http://www.amnesty.org/en/library/info/ACT40/004/2014/en>. [cited 21 June 2019].
- Basoglu, M. (1993). Prevention of torture and care of survivors. An integrated approach.

- JAMA: Journal of the American Medical Association*, 279(5), 606-11. doi:10.1001/jama.1993.03510050072030
- Brom, D., Kleber, R. J., & Defares, P. B. (1989). Brief Psychotherapy for Posttraumatic Stress Disorders. *Journal of Consulting and Clinical Psychology*, 57(5), 607-612. https://doi.org/10.1037/0022-006X.57.5.607
- Busner, J., & Targum, S. (2007, July). The Clinical Global Impressions Scale: Applying a Research Tool in Clinical Practice. *Psychiatry*, 4(7), 28-37.
- Fonagy, P. (2015). The effectiveness of psychodynamic psychotherapies: an update. *World Psychiatry*, 14 (2): 137-150. https://doi.org/10.1002/wps.20235
- Hamid A, Patel N, Williams A.C.D.C (2019) Psychological, social, and welfare interventions for torture survivors: A systematic review and meta- analysis of randomised controlled trials. *PLoS Med* 16(9): e1002919. https://doi.org/10.1371/journal.pmed.1002919
- Holmqvist, R., Andersen, K., Anjum, T., & Alinder, B. (2006). Change in Self-Image and PTSD Symptoms in Short-Term Therapies with Traumatized Refugees. *Psychoanalytic Psychotherapy*, 20(4), 251-265. https://doi.org/10.1080/02668730601020341
- Holtz T.H. (1998). Refugee trauma versus torture trauma: a retrospective controlled cohort study of Tibetan refugees. *Journal of Nervous & Mental Disease*, 186(1), 24-34.
- Human Rights Foundation of Turkey (HRFT) (1994). Annual Report. File of torture: Deaths in detention places or prisons, 12 September 1980-12 September 1994. Human Rights Foundation of Turkey Publications, Ankara.
- Human Rights Watch (2005). Still critical. Prospects in 2005 for Internally Displaced Kurds in Turkey. (https://www.hrw.org/reports/2005/turkey0305/turkey0305.pdf)
- Istanbul Protocol (2004) *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. New York, United Nations.
- Jaranson J.M. & Quiroga J. (2011). Evaluating the services of torture rehabilitation programmes. *Torture*, 21(2), 98-140.
- Leichsenring, F., Klein, S., & Salzer, S. (2014). The efficacy of psychodynamic psychotherapy in specific mental disorders: a 2013 update of empirical evidence. *Contemporary Psychoanalysis*, 50(1-2), 89-130. https://doi.org/10.1080/00107530.2014.880310
- Levi, O., Bar-Haim, Y., & Fruchter, E. (2015). Cognitive-Behavioural Therapy and Psychodynamic Psychotherapy in the Treatment of Combat-Related Post-Traumatic Stress Disorder: A Comparative Effectiveness Study. *Clinical Psychology and Psychotherapy* 23, 298-307. https://doi.org/10.1002/cpp.1969
- McFarlane, C. A., & Kaplan, I. (2012). Evidence-based psychological interventions for adult survivors of torture and trauma: a 30-year review. *Transcultural psychiatry*, 49(3-4), 539-567. https://doi.org/10.1177/1363461512447608
- Nicholson B.L., Kay, D.M. (1999). Group treatment of traumatized Cambodian women: a culture-specific approach. *Social Work*, 44(5):470-9.
- Özyıldırım, İ., Orhon, A. L., Gürsel, B., Kula Güney, A. (2017). Notes on Psychoanalytic Work with Individual and Social Traumas. *Psychoanalytic Writings*, 34: 115-144 [Turkish]. [https://pep-web.org/]
- Özyıldırım, İ., Aslantaş Ertekin, B. (2021). Kitleleş travmalar sonrasında psikanalitik psikoterapiler. In. *Kitleleş Travmalar ve Afetlerde Ruhsal Hastalıkları Önleme, Müdahale ve Sağlıkum Klavuzu*, ed. Yüksel, Ş., Başterzi, A. D. TPD Publishing, İstanbul, s. 231-247.
- Pallant, J. (2016). SPSS kullanma kılavuzu: SPSS ile adım adım veri analizi (S. Balci ve B. Ahi, Çev.) [SPSS survival manual: A step by step guide to data analysis using IBM SPSS]. Ankara: Anı Yayıncılık.
- Patel N, Williams A. C. D. C., Kellezi, B. (2016) Reviewing outcomes of psychological interventions with torture survivors: Conceptual, methodological and ethical Issues. *Torture*, 26(1): 2-16.
- Pérez-Sales, P. (2016). Psychotherapy for torture survivors - Suggested pathways for research. *Torture* 27 (1):1-12. https://doi.org/10.7146/torture.v27i1.26528
- Refugee Health Care Center (1988). Annual report. Rijswijk, Netherlands: Ministry of Welfare, Health and Cultural Affairs.
- Schottenbauer, M. A., Glass, C. R., Arnkoff, D. B., Tendick, V., & Gray, S. H. (2008). Nonresponse and dropout rates in outcome studies on PTSD: Review and methodological considerations. *Psychiatry: Interpersonal and biological processes*, 71(2), 134-168.
- Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., van Ommeran, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: A systematic review and meta-analysis. *JAMA*, 302(5), 537-549. doi:10.1001/jama.2009.1132 United Nations General Assembly (1984).

Convention against torture and other cruel, inhuman or degrading treatment or punishment. Constitution. Dec; 5(7):5.

Weiss, W. M., Ugueto, A. M., Mahmooth, Z., Murray, L. K., Hall, B. J., Nadison, M., Rasmussen, A., Lee, J. S., Vazzano, A., Bass, J., Bolton, P. (2016). Mental health interventions and priorities for research for adult survivors of torture and

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Protocol on medico-legal documentation of threats

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Key points of interest

- This Protocol summarises the relevant conceptual (health and legal) factors regarding threats as a method of coercion and it outlines an interview protocol for eliciting and assessing information from persons to whom coercive threats have been made.
- This Protocol complements the Istanbul Protocol when documentation of threats is required.

Abstract

Introduction. The use of threats remains prevalent in law enforcement practices in many parts of the world. In studies with torture survivors, credible and immediate threats have been considered a distinctly harmful method of torture. Notwithstanding this prevalence, there is a considerable degree of difficulty in legally substantiating and establishing harms

produced by threatening acts. It is also generally difficult to clearly identify the harms that go beyond the fear and stress inherent (therefore not unlawful) in law enforcement practices. We present a Protocol on Medico-Legal Documentation of Threats. The aim of the Protocol is to improve documentation and assessment of harms so that stronger legal claims can be submitted to local and international complaints mechanisms.

Methods. The Protocol has been developed based on a methodology initiated by the Public Committee against Torture in Israel (PCATI), REDRESS and the DIGNITY - Danish Institute against Torture (DIGNITY) involving: compilation and review of health and legal knowledge on threats; initial drafting by the lead author; discussion among the members of the International Expert Group on Psychological Torture; pilot-testing in Ukraine by local NGO Forpost; adjustments were made according to the results of the pilot study.

Results. We present the final Protocol and a Quick Interviewing Guide. This Protocol is cognisant of the significance of the specific social, cultural, and political contexts in which threats are made and might be subjected to adaptations to specific contexts. We hope that it will improve the documentation of threats as a torture method or as part of a torturing environment, as well as inform efforts on their prevention more broadly.

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Introduction

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

Building on the Istanbul Protocol (IP) and experience among the authors, the aim of this Protocol is to improve medico-legal documentation of threats as torture or ill-treatment so that – inter alia – legal claims submitted to courts and complaints mechanisms can be better corroborated by medical evidence. This Protocol focuses mainly on threats used in law enforcement, namely by the police and other officials during policing, arrest, interrogation, and detention.

Although it can be used as a stand-alone tool, the Protocol should be better viewed as a supplement to the IP, with specific guideline on how to document threats when this is allegedly the main or a very significant torture method. Therefore, some questions related to describing the events might overlap with those of the IP.

The generic content of threats as described in this Protocol should be assessed in light of the socio-cultural, legal, and political context of that country and person. The context will determine the factual circumstances of each case.

The United Nations *Convention against Torture and Other Cruel, Inhuman or Degrading*

Treatment or Punishment (UNCAT) recognizes and prohibits threats as a method of torture and ill-treatment (articles 1 and 16). There is neither a universally accepted definition of a threat nor an authoritative list of what constitutes a threatening act which violate the prohibition of torture and ill-treatment. The IP, however, mentions various examples, including among others threats of death, harm to family, further torture, imprisonment, attack by animals, and verbal sexual threats.

Methodology

The Protocol has been developed based on an interdisciplinary methodology developed by DIGNITY - Danish Institute against Torture, Public Committee Against Torture in Israel (PCATI) and REDRESS involving the following steps: compilation and review of health and legal knowledge on threats; initial drafting by the lead author; discussion among the members of the International Expert Group on Psychological Torture¹, and pilot-testing (cf. Søndergaard et al. 2019). This follows the same methodology as the protocols on sleep deprivation (Pérez-Sales et al. 2019) and solitary confinement (this issue) produced by the same authors.

The pilot-testing of this Protocol, which was planned to take place in Ukraine from November 2021 - May 2022, was undertaken by Forpost, an organisation working with victims of torture or other forms of violence, and supported by DIGNITY. Both organisations developed an informed consent form, as well as

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

specific inclusion criteria to be used in the selection of cases. Inclusion criteria included (a) the alleged victim had been subjected to threats, as per the definition adopted by the Protocol, and that threats were an important aspect of the torture; (b) the acts occurred no later than three years ago; (c) the case occurred within a criminal law setting; (d) the case involved an alleged victim above the age of 18; and, (e) the person was able and willing to provide informed consent to participate in an interview. The cases were to be selected by Forpost among its clients and within its referral network that included two partner organisations (SICH and Alliance of Ukrainian Unity). It was planned to test the Protocol on a total of ten cases; initially on six cases and then after an evaluation of the first testing, to use the Protocol on four more cases.

Three cases were selected for interviews to be conducted in November - December 2021. The cases related to persons who had been detained and received threats during police interrogation. Subsequently, they had been released from detention. In one case the threats continued after release from detention.

The three persons selected (one woman and two men) were middle age (25 to 37 years-old). The plan to select more cases was abandoned due to the outbreak of the war in Ukraine in late February. However, Forpost continues to use the Protocol to document threats and at the time of writing, the organisation is preparing two court submissions regarding threats.

The three interviews were conducted jointly by a lawyer and a psychologist using the Protocol. They wrote an analysis of the implementation of the Protocol in each case.

The results of the pilot phase showed that: 1) using the same tool for documentation of threats created a common understanding of the matter among the lawyer and the psychol-

ogist that also facilitated better collaboration about the specific case; 2) there was a general recognition that the police practice of using threats should not be perceived as a normal procedure; 3) for the lawyer, using the Protocol created a more solid case and facilitated collecting evidence that would not have been considered otherwise; and 4) from the alleged victim's perspective, participation in the interview made the person understand that threats might violate his/her rights and should not be perceived as a "private matter" to be managed with by the person alone.

The pilot phase also gave the following results specifically regarding the contents and structure of the Protocol: (1) practitioners would prefer a practically oriented Protocol; (2) it should be emphasized that the Protocol's questions supplement the IP rather than substitute parts of it; (3) the purpose of each section of the Protocol should be made more clear; (4) the Protocol should state explicitly that the interviewer is not required to seek answers for each question, but should rather use the Protocol as a general guideline for the interview; (5) clinical experience is essential for parts of the Protocol; and (6) the psychological and psychiatric sections of the Protocol should illustrate to the extent possible the causal links between the acts and the consequences.

Two sections follow: I. Conceptual and Legal and Medical/Psychological Considerations; and II. The Protocol itself.

I. Conceptual and Legal and Medical/Psychological Considerations

This section provides a summary of the conceptual, legal, and medical aspects of threats, specifically concerning their nature and consequences. It draws substantially from two more expansive articles (Pérez-Sales, 2021 and Cakal 2021).

(1) Conceptual aspects

The following section details the definition of threats and its three key elements: 1. Nature; 2. Purpose; and 3. Credibility.

A threat, in brief, sends a message that danger is coming, and it might subsequently evoke intense aversive emotions that might force persons to act against their will. Thus, threats have a sender and a receiver and must be understood as interactive and relational. We can define threats as *“the explicit or implicit expression of intentionally harming someone, in order to coerce to change opinions, intentions, or behaviours or to punish a person, through the production of mental suffering, usually intense fear and anxiety”* (Pérez-Sales, 2021).

1. Nature: Threats might be linked to announce physical sufferings (e.g., “Nobody has survived without water”, “We will beat you and your son”) or be linked to psychological sufferings through manipulation of expectations, cognitions, and emotions (e.g., “We might detain your wife and kids”). There is a unique subjective element in how specific content affects each person depending on past and present personal, cultural, and sociological elements.

To describe the nature of a threat we might consider four elements:

- a. Directness and contextuality:** The human brain processes a direct threat (e.g., a gun pointing at your head) and a contextual threat (e.g., a blood spatter on an interrogation room left unwashed) differently. Fear related to context does not need to be rational or conscious, as the human brain processes contextual information automatically. The person might recall an environment as threatening, without being able to detail the specific elements that triggered fear or terror.
- b. Explicitness and implicitness:** Threats do not need to be overt. In other words, threats might be *explicit* (e.g., “We will kill you” “We will beat your family”) or *implicit* (e.g., “Your brother is in the university, isn’t he?”, “It is difficult to get insulin in this area”; “The authorities have never come for a visit here in years”, “We have all the time in the world”). Thus, threatening expressions must be analysed beyond what they literally indicate.
- c. Immediacy and delay:** Threats that are immediate produce mental suffering, but not exclusively. It is important to consider that threats which are *gradual* (increasing with non-compliance), *delayed* (the threat will be acted upon in the immediate future) or *remote* (permanent damage or death as an ultimate consequence in an ambiguous future) can also produce severe mental suffering. The idea that a threat to produce severe mental suffering must be immediate, as some jurisprudence suggests (Cakal, 2021) is thus only partially right. Gradual, delayed, or remote threats can also activate the anxiety and shame or guilt circuits and produce severe mental suffering and long-lasting physical and mental health damage.
- d. Predictability and unpredictability:** Predictability and perceived control have long been considered key elements in explaining the impact of torture experiences (Başoğlu et al., 2007). A threat is considered to be *predictable* when it is possible to anticipate when and how it will occur (e.g., facing day and night random interrogations versus interrogations in fixed days and times). There are different patterns of response towards predictable versus unpredictable threats, although both can produce high levels

of fear and anxiety. Predictable threats produce *phasic fear*: fear increases at the moment where pain or damage approaches. By contrast, unpredictable threats that can happen at any given time tend to produce *sustained levels of fear and anxiety*. Predictable threats are linked to (a) focused attention to the menace, (b) lack of attention to the surroundings, and (c) generalized fear. By contrast, unpredictable threats are linked to (a) general and sustained hyper-vigilance (b) attention to surroundings to detect signals of alarm, and (c) fear dependent on the detection of potential threatening cues. Furthermore, a predictable threat allows for developing coping strategies to face the threat and strategies for emotional regulation when the threat is close to happen. Both coping methods allow a sense of control that can sometimes mitigate the impact of the threat. On the opposite, unpredictable and unescapable threats will more likely produce mental defeat and depression (Pryce et al., 2011)

2. **Purpose:** Threats as communication messages pursue a purpose. There are two broad categories of purposes that should be taken into account here:
 - a. **Threats linked to compliance.** The threatening person focuses on their demands, and the person threatened focuses on the costs of compliance or non-compliance of the demands (e.g., giving information). An essential element here is the differential way that the sender of the threatening message as contrasted with their receiver perceive the threat.
 - b. **Punitive or discriminatory threats.** The main aim of threats is to produce

mental suffering through creating aversive cognitive and emotional states to produce short and/or long-term damage. Thus, the threats are unconditional to being compliant or not, and the purpose is to infringe mental pain in the person to whom the threats are made.

3. **Credibility of the threat:** As a relational construct, both if the threat is linked to compliance or if it is punitive or discriminatory, it is essential that the receiver perceives the threat as credible. Credibility highly depends on the particular interaction between the sender and the receiver. There are four key psychological elements and five key contextual elements related to the credibility of a threat to be considered in the forensic assessment:

Psychological elements

- a. **Proportional:** A threat is more credible when proportional. For instance, paradoxically, a very severe threat associated with a minimal demand tends to be incredible, "*I shall kill you if you do not try to sleep*" (Milburn, 1977). A threat that is proportional to the demand, tends to be more credible.
- b. **Irrationality:** A threat is perceived as more dangerous when there is a component of irrationality. If the person making the threat is out of control (or seems to be), it makes the menace more uncontrollable, dangerous and credible. This is part, for instance, of the good guy/bad guy threatening method.
- c. **Plausible:** A threat is more credible when the person explains the *plans and steps* that will follow to make it real, and they are seen as feasible. ("*We will take you in the evening to the XX military unit where they*

will deal with your case from now on”).

- d. Perceived result of compliance and non-compliance:** Credibility is also related to the perception that the menacing person will keep their word if the person is compliant. There is a lack of credibility if the person receiving the threat thinks that being compliant with demands will not mean relieving the threat. For example, if providing any kind of information will ultimately increase and not decrease pressure and threats. The threatened person fears that compliance will make things worst.

Contextual elements:

- a. Historical or political context,** including the evidence or the perception by the alleged victim that threats are being regularly used as a method of social control, punishment or discrimination in the place where the person is held.
- b. Context of impunity,** particularly in relation to the political costs of making the threats real and the perception of permissibility and impunity among political, military, or judiciary authorities. Moreover, the likelihood that the ill-treatment is authorised and protected by the chain of command.
- c. Lack of legal safeguards,** including access to a lawyer during the process of detention. This is linked, among other elements, to the perception of an absence of the possibility of outside help or to have access to any legally regulated protective measures (i.e. Habeas Corpus).
- d. Conditions and place of detention:** Being held in a clandestine place of detention or being under detention for an indefinite time, apparently giving the detaining body full control over the

threatened person.

- e. Cumulative and chronic:** Research shows that threats are more effective when the person receiving the threat is physically, emotionally, or cognitively exhausted. Other physically exhausting torture methods (e.g., hunger, thirst, temperature) might therefore increase the impact of threats and should be considered.

(2) Legal Norms

This section provides an overview of the international legal framework relating to threats as torture and other forms of ill-treatment. It draws on international treaties and case law in assessing threats as prohibited acts. For a fuller discussion, refer to Cakal (2021).

International law, namely articles 1 and 16 of UNCAT, and article 7 of the *International Covenant on Civil and Political Rights* (ICCPR) prohibit threats when amounting to torture or other forms of ill-treatment. It is crucial to understand the scope and the interpretation of torture and ill-treatment in both conventions and to know when any acts might pass the threshold and be considered prohibited under international law. Documenting threats is no different; the main task for legal professionals is to assess whether the acts and factual circumstances present in the specific case fulfill the elements in the international definition of torture.

The legal qualification of threat(s) as torture or ill-treatment centers on assessing how the person who received the threat perceived it together with the context in which it was made (see above).

For the purpose of qualifying threats as acts of torture, the following four elements in the definition of torture need to be considered:

- a. Severe pain:** The assessment of the

impact of the threat(s) is further discussed in the medical section of the protocol (see below) and will be established by the medical and psychological assessment. Be aware that this can be cumulative.

- b. Intention:** The threat(s) need to be intentionally (i.e., deliberately) or (at least) recklessly made to create a threatening situation against the individual, either directly (explicit threats) or indirectly.
- c. Purpose:** Consider if a specific purpose can be identified, such as to coerce confessions, intimidation, punishment, or discrimination.
- d. Official capacity:** Some level of official involvement is required. Threats are often made by individuals with official capacity whose liability could be linked to the forms of liability mentioned in the definition of torture (article 1 UNCAT)².” Threats can also be made by fellow detainees or inmates, however, these will not satisfy the “official capacity” requirement unless the authorities knew or should have known about the situation and did not act adequately to remedy the situation and thus fall within liability of acquiescence, as stated in the definition of torture.

For the purpose of qualifying threats as other forms of ill-treatment, some level of official involvement is required. However, if one of the other three elements in the definition of torture is missing (i.e., severe suffering, intention or purpose), the act could still amount to other forms of ill-treatment if above the threshold. By way of example, an act causing severe

mental suffering but missing either *intention* or *purpose* would likely amount to cruel or inhuman treatment. Threats with official involvement infringing on human dignity (e.g., humiliation) but missing severe suffering would likely amount to degrading treatment.

There are examples of threats, such as mock executions, which would clearly fall afoul of the prohibition. However, there are some situations in which it may prove difficult to document that threats are above the threshold, particularly those which are implicitly made and those of a manipulative nature. In less overt threats we are compelled to appraise impact more carefully. Moreover, context matters, and the alleged victim should be considered in the specific context in which the threat is made. For instance, strong offensive language to a child in custody may be sufficient whereas it may not be in the context of a maximum-security adult prison.

Several cases from the European region provide useful illustrations of when threats have been considered qualifying as torture or ill-treatment. The first, the *Greek Case* at the European Commission of Human Rights (ECommHR) is arguably the first international case which identified non-physical torture to include: “mock executions and threats of death, various humiliating acts and threats of reprisals against a detainee’s family” (ECommHR, 1969, §186). The European Court of Human Rights (ECHR) further articulated its position on threats in *Campbell and Cosans v. United Kingdom* (ECHR, 1982, §26) where it found that: “provided it is sufficiently real and immediate, a mere threat of conduct prohibited by Article 3 [ECHR] may itself be in conflict with that provision. Thus, it established the rule that to threaten an individual with torture might in some circumstances constitute at least ‘inhuman treatment’” (ECHR, *El Masri v The Former Yugoslav Republic of*

2 “Inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity”.

Macedonia (where the applicant was threatened with a gun), §202; ECHR, *Husayn (Abu Zubaydah) v Poland*, (where the applicant was threatened with ill-treatment), §501).

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

The requirement of *real danger* also emerges as a central criterion when surveying Inter-American jurisprudence, where “real danger of physical harm” is held to amount to psychological torture (*Baldeón-García v. Peru*, §119, citing *Maritza Urrutia; Cantoral-Benavides*; see also *Tibi v. Ecuador*, §147).

To conclude on the case law, it is worth noting that courts have found the following categories of threats to violate the prohibition of torture and ill-treatment: threats to life (including non-verbal threats such as a display of torture tools and mock executions); threats to inflict violence; threats to family members;

and, being forced to witness torture, an execution or enforced disappearance.

(3) Medical/psychological considerations

This section will provide an overview of the existing knowledge about medical and psychological aspects of threats with the aim of providing the reader with background knowledge to be used when documenting threats as potential torture. This section draws substantially from a fuller discussion elsewhere (Pérez-Sales, 2021).

Just like when assessing other torture methods, when documenting threats, it is important to understand two different aspects: the method itself and its consequences.

Fear and anxiety are the biological spontaneous mental states that arise as response to a threat. There is a certain confusion resulting from the interchangeable use of these two terms, but most authors propose that the mental state of *fear* be used to describe feelings that occur when the source of harm, the threat, is either immediate or imminent, whereas *anxiety* is used to describe the mental state that occurs when the source of harm is distant in space or time (LeDoux & Pine, 2016). Both fear and anxiety can appear in front of certain and uncertain stimulus. In fact, it has been proposed that *fear of the unknown* may be the fundamental fear in humans and the origin of all other fears (Carleton, 2016). The two conditions are related to different structures and networks of the brain (Gullone et al., 2000; LeDoux 2014, 2020). Basically, fear has its neural nucleus in the amygdala and anxiety in the brain stem. Both interact with the pre-frontal cortex (conscious process) and memory (identification of past instances of danger).

It is often assumed that “it is normal” to be anxious and, for some experts, it does not qualify for “severe mental suffering”. This is a misconception. While it is a normal element

of life to experience moderate levels of anxiety, anxiety that is persistent, seemingly uncontrollable, and overwhelming produces severe suffering and can be extremely disabling.

When documenting and assessing threats as torture, it is important to be aware of the following³:

- a. Fear and anxiety have both physiological and psychological components. Thus, the *conscious* experience of fear or anxiety (what the person “feels”) depends on a set of interacting processes including body response and sensory perception and their resulting emotions, but also on memory, associated feelings and coping mechanisms. It is in the interplay of present and past, and depending on the bodily sensations and the interpretation that the person does, that fear and anxiety appear in the conscious brain. Therefore, a threat will not result in the same reaction in all individuals.
- b. Some individuals are more susceptible to strong fear and anxiety responses than others.
- c. Threats can be presented subliminally (i.e., without the conscious awareness of the person being threatened) *and may still elicit a physiological response* even if the person is unaware of the threat and does not have feelings of fear (LeDoux, 2020; Mertens & Engelhard, 2020). Thus, threats can operate in the background, and the alleged victim might have a bodily reaction without being aware of the reason.
- d. The body has a system of inner receptors that informs the person of negative internal bodily states. For instance, an inner receptor in the heart informs us when the heart is beating too fast. This is how the human being is aware of bodily inner states (hunger, fever, urge to urinate or dyspnea among many others). Perceptions of threats may come from changes in these inner receptors that trigger an alarm in the conscious mind. But there is also the opposite: the perception of a threat might go down from the brain to the receptors and elicit an alarm response that, in turn, potentiates the anxiety and fear response in a *loop process*. A notable example is breathlessness. Experimental evidence shows that just the threat of being submitted to asphyxia elicits a bodily reaction similar to what would be seen if asphyxia actually happened and produces breathlessness. Dry or wet asphyxia are methods of psychological torture in that they trigger this *loop* reaction: fear-breathlessness-fear-more breathlessness.
- e. Threats have a cumulative effect, especially when chronic or combined with other torture methods. There is research, for instance, linking sleep deprivation and the impact of threats (Feng et al., 2018; Tempesta et al., 2020).
- f. Numerous psychophysiological methods to measure body responses to fear and anxiety have been developed (from polygraphs to thermal cameras or special EEG procedures), but so far, they have shown only a low to moderate correlation with the subjective experience of fear. Anxiety is also generally difficult to detect and measure. Psychophysiological methods currently have no place in the forensic documentation of threats as a torture method.

3 The conceptual elaboration of these aspects including academic references can be found elsewhere (Pérez-Sales, 2021).

II. Protocol

This Protocol should be used as a supplement to the IP when specific documentation of threats is required.

It is designed to be used by lawyers and health professionals during interviews in a detention facility or after release. While some information in this Protocol may be collected by both health and legal professionals, some sections of the Protocol require specific clinical qualifications. An organization may consider whether to train staff so that they can be qualified to ask specific questions outside their usual professional skill set. However, this approach has its limitations and should always be guided by the principle of doing-no-harm.

When assessing threats, combined or cumulative effects of the general detention and interrogation context and the various methods used besides threats are of enormous importance. Ill-treatment and torture are often not based on single isolated techniques (which may or may not be damaging if considered one by one) but are the result of the combined interaction of methods or their accumulation in time. Thus, threats are often not an isolated element but part of a wider context that must be also assessed in the interview (see below). Thus, if general information as captured by the IP has already been documented, simply proceed with this Protocol. If not, document the overall context and conditions of the situation in which threats took place following IP guidelines.

The following key aspects of the context should be highlighted in the assessment:

a. Importance of time – Threats over a long period of time: The Protocol is used to assess the consequences of threats after an interval of time following the pertinent event(s). It can be days but more often the interview is undertaken weeks or months after the event(s).

Furthermore, threats can take place over a period of months or years. For instance, a human rights defender may be receiving threats from State actors over several decades. In documenting the case, the evaluator will analyse and decide which is the best approach to take:

- a. Analyse the *main threats* that have been constant over the course of years.
- b. Analyse the *threats by time periods* corresponding to different phases of the person's life.
- c. Analyse threats *by relevant actors* or threatening agents.

In each of these three scenarios, the protocol can be used by adapting the questions to the strategy chosen to best reflect the evolution of threats over time and the combined and cumulative effect.

b. Torturing environment: Threats are usually part of a broad torturing environment. A *torturing environment*, in the context of torture, is defined as “a set of conditions or practices that obliterate the control and will of a person and that compromise the self” (Pérez-Sales, 2017). Examples of elements of a torturing environment are conditions of detention, sleep deprivation, verbal humiliation, deprivation of water/food intake and/or sensory deprivation (e.g., through blindfolding).

c. **Context:** Each country has its specific political and local context, and each detaining institution has its specificities regarding methods. In some contexts, threats may be systematic and last over time, even for years, usually with the aim of intimidation for political purposes (e.g. social leaders, human rights defenders, opposition politicians, etc). The context, then, might also change with time. This should be taken into consideration when applying and interpreting the Protocol, specially to analyse the nature and credibility of the threats.

The Protocol consists of the following six sections:

1. Subjective experience;
2. Medical and psychological consequences;
3. Description of environment;
4. Psychosocial history;
5. Credibility of threats; and
6. Legal assessment.

As the Protocol builds on the IP, it is presumed that informed consent has been obtained and all the ethical requirements of Annex I of the IP have been fulfilled.

Section 1: Subjective experience

This section aims to describe the experience in the person's own words, before introducing specific closed questions in the following sections. Please collect this initial description of events as verbatim as possible.

If the threats have been over a long period of time, consider the best strategy: Analyse the main threats that have been constant over the course of years; analyse the threats by time periods corresponding to different phases of the person's life; or analyse threats by relevant actors or threatening agents.

Both for short term or chronic threats, consider the following questions as a memory aid:

- What were the main threats? Can you provide details about them?
- Who made the threat? In which context or circumstances?
- Which threat affected you the most?

Use the list below as an aid for additional questions during the interview, but not as a questionnaire to be followed to the letter. Please collect responses to your questions as verbatim as possible:

- Did the threat refer to an action that would take place *immediately*?
- Did the person expect or predict the threat and *could be prepared* or have a way to face or cope with it?
- Did the person consider that even if being compliant, there were signs that the alleged perpetrator *would go on with the threat*?

- What did the person think that the alleged perpetrator wanted to achieve with these threats? Which was the alleged *purpose*? (E.g., obtaining information/confession, intimidation, punishment, discrimination).
- How did the alleged victim think that these elements affected them or persons around them? Why?

Please, use the following categories to detail the nature of the threat and whether it was explicit or deduced. Note that these examples are provided only as suggestions of severe threats. They are not meant to be an exhaustive checklist and you might prefer to use a list built for the specific situation of the alleged victim.

- a. Threats against the person.** Note whether the person was threatened with
 - Permanent physical damage or death
 - Severe physical or psychological pain or acts that would produce severe suffering, including torture
 - Prolonged or indefinite detention
 - False charges that would imply an accusation of serious crimes
 - Non-compliance with legal safeguards (i.e., call to family, legal counsel, medical care)
 - Elements that produce mental suffering through deep humiliation and shame, including
 - Threats to use relevant elements of identity in a denigrating, shameful or humiliating way (e.g., ethnic, religious, or political identity)
 - Threats to use cultural taboos relevant to the person (sexuality, food, dressing, prayers, or others)
 - Threats to being exposed or denigrated based on personal characteristics or vulnerabilities (e.g., gender or sexual orientation, physical characteristics, disabilities...)
 - Submission to situations of impossible choice (i.e., forced to harm others)
 - Others (explain)
- b. Threats [communicated to the person] to harm others** including family members, friends, or other inmates
- c. Threats [communicated to the person] to harm property, social standing, livelihood** etc. (Please note if there is use of personal information is of a targeted nature to the alleged victim based on specific knowledge. This is in contrast to general threats where there may not be specific knowledge about the individual.)
- d. Unspecific threats.** Elements that foster fear of the unknown. Including but not limited to the following examples:
 - Darkness, empty rooms, cultural or physical isolation
 - No information – Endless waiting time – Unknown legal status
 - Ambiguous threats that suggest for instance death, pain or unknown but severe consequences (“Better talk and avoid what you have heard from others”; “You will regret what you said”; “The worst is to come”)

Section 2. Medical and psychological consequences

Threats produce negative cognitions and emotions that produce mental suffering. These elements must be explored in order to show the inner logic and causal links between threats and suffering. The following section is to be completed by clinicians only, although basic information can be collected by legal professionals if necessary.

The following issues and questions can assist in making a standard clinical assessment. You do not need to follow them as if it was a questionnaire.

a. Cognitions – thoughts. Explore what came to the mind of the person when they were threatened. Try to reproduce the reasoning from the beginning. Explore if the person

1. Tried to block any reasoning and not think, regardless of whether the person managed or not (coping with threats through Thought Suppression)
2. Tried to keep calm by finding a logic (coping with threats through Reasoning)
3. Was again and again having the same thoughts that ended up being useless (Threats provoking constant Ruminations)

b. Feeling in control.

1. Explore if, in overall, the person felt in control most of the time during the situation or felt like losing control, being defenceless or even giving up (*breaking point*).
2. Explore feelings of helplessness (“I am in their hands, nobody will help”), powerlessness (“There is nothing I can do”) or hopelessness (“There is no hope whatsoever”).
3. Try to determine together the *breaking point* (feeling of being defeated or giving up to any resistance). If that happened, which were the reasons for this feeling.

The following sections are to be completed by clinicians.

Undertake a mental health exploration of the immediate and short-term consequences of the threats. Suggestions of elements to explore:

- Symptoms of fear or anxiety during the events and immediately afterwards and their relation with the threats. Include bodily symptoms if relevant (trembling, shacking, hot and cold sensations...).
- Fear-related symptoms after the situation that can be linked to the characteristics of the threat (e.g., unsurmountable fear of knives or needles if these were used in the context of the threats).
- Unspecific fears that were not present before the situation, not necessarily related to the threat but that were triggered by it (for instance, fear of leaning out of a window or fear of climbing stairs even if this has nothing to do with what happened during the threats)
- Avoidance or conditioned behaviours related to the threats (e.g., avoid films that recall the events).

Explore also long-term symptoms that may include:

- Post-traumatic symptoms related to the threat, especially symptoms of avoidance and hyper vigilance. Collect, if possible, quotations and examples that suggest a causal relationship between threats and the symptoms, including but not limited to:
 - Flashbacks (context and contents)
 - Nightmares (contents and inner logic that the person gives to it)
 - Ruminative thinking
 - Triggering of avoidant behaviours
 - Triggering of emotional fainting / dissociative symptoms
 - Triggering of alarm response or hyperactivity
 - Triggering of panic attacks
 - Contents of delusional symptoms

With all the information collected above, determine if there is one or more of the following categories of consequences:

- a. Sustained anxiety responses including panic attacks
- b. Fear-related symptoms and avoidant behaviours that can be logically linked to the threatening situation
- c. PTSD or Complex PTSD related to the threat, especially symptoms of avoidance and hyper vigilance
- d. Long-term feelings of shame and guilt. Explore suicide ideas linked to these feelings.
- e. Other relevant syndromes (depressive disorder; dissociative or psychotic symptoms) that can be attributed totally or partially to the threats

In all cases, collect verbatim examples that show the connection between contents of the threats and these clinical syndromes.

Formulate a diagnosis according to international psychiatric classifications if this is possible.

(2) Non-clinical consequences

Threats can also have non-clinical consequences, specially in cases of chronic threats. Consider exploring the following:

- a. Changes in cognitions, emotions or attitudes related to activities that the person links to the threats (i.e political or professional activity in activists or human rights defenders). Loss of meaning of their role or activity.
- b. Impact on the relationship with relatives and beloved ones. Impact on parenting, leisure activities and others.
- c. Changes in life priorities. Impact on network of social relationships and significant others.
- d. Changes on worldviews, feelings of security, view of human beings.
- e. Changes in self-esteem and personal sense of value

Section 3. Description of environment

The purpose here is to comprehensively describe the elements of the environment and how the threats interacted with these elements.

Provide a structured description of the main environments in which the person to whom the threats were made was held following a temporal line with a focus on elements that were intimidating, fostered loss of control, or created an atmosphere of fear, including, for instance, the place of initial detention, the mode of transport, and the cell or place of interrogation. Consider drawings and other ways to improve recollection of details.

An abridged version of Section 1 of the Torturing Environment Scale can be used here. The purpose is to describe the conditions in which the threats happened. Tick if any of these apply (Table 1).

Chronic threats. When assessing Chronic or sustained threats, consider a description of how a stressful environment has been created in the person's day-to-day life, including family, professional and community aspects.

Section 4. Psychosocial history⁴

This section is intended to assess the potential psychosocial vulnerabilities plausibly linked to the person's appraisal and reaction to the threat. It is to be completed by a clinician. The purpose is to briefly explore and analyse elements in the life of the person that are potentially relevant in understanding the impact of threats, especially experiences of early loss, trauma, or crisis.

Only describe issues that could help explain the impact of the threats, and do not make a full psychosocial history, as most elements will be unrelated to the purpose of the assessment.

If clinicians are unavailable, legal professionals may choose to ask an open-ended question: *Do you think that there is anything in your past that may explain why you reacted to the threat in the way you did?*

Table 1. Documentation of Torturing Environment		YES
1.	Inhuman conditions of detention according to international standards (e.g. cell size and conditions, overcrowding, lack of hygiene...)	
2.	Environmental conditions (Temperature, humidity, noise, darkness or others)	
3.	Attending basic needs: deprivation of food or liquids	
4.	Sleep deprivation or dysregulation	
5.	Manipulation of the sense of time	
6.	Deprivation of senses (i.e. blindfolds, earmuffs...)	
7.	Medical induction of altered states: use of psychotropic drugs, white noise, monochrome environments, sensory isolation or others	
8.	Other contextual manipulations (specify)	

The following is a list of potential elements to consider. It is focused on elements of vulnerability, although also elements of resilience can be explored and included. Adjust to the needs of the assessment as the list might be too exhaustive for an average report.

- Early childhood traumatic experiences suggesting an insecure or an avoidant attachment style.
- Experiences of trauma, crisis, or loss in adolescence or adulthood that can be logically connected with the fear and anxiety aroused by the situation under analysis.
- Past experiences connected with feelings of fear, terror, or loss of control. Also experiences connected with feelings of feeling in control in front of adversity.
- History of specific phobias (animals, height, blood, needles or others) that might be relevant to the situation assessed.

⁴ [Section IV (Psychosocial history) and VI (History/Psychological Assessment) of Annex IV of the IP

- History of anxiety-related disorders, specifically panic attacks or generalised anxiety disorder.
- Personality traits that are relevant to the impact of threats. Consider giving special consideration to⁵:
 1. Trait and state anxiety
 2. Locus of control under stressful situations
 3. Self-efficacy
 4. Tendency to suppress thoughts
 5. Intolerance to uncertainty
 6. Intolerance to ambiguity
- Worldviews that might impact on fear-processing (e.g., lack of confidence in human beings or institutions due to past experiences)

5 See description of each concept and detailed references in Perez-Sales (2021).

Section 5. Credibility of threats

This section is intended to collect information about what, from the subjective point of view of the person receiving the threat(s), made the threats credible. It is open to be conducted by both clinicians and legal professionals. The information assessed here is to directly inform the legal assessment in the subsequent section. Tick as appropriate (Table 2).

Table 2. Credibility of the threats		YES
1.	The alleged perpetrator seemed out of control and taking irrational decisions – everything seemed possible	
2.	The alleged perpetrator explained the plans and steps that would follow to make it real, and they are seen as feasible	
3.	The alleged perpetrator showed omnipotence and arbitrariness	
4.	The person <i>receiving the threat(s)</i> knew or was made aware of situations in which the threat was in fact carried out	
5.	The person <i>receiving the threat(s)</i> was forced to witness how the threat was carried out in other persons	
6.	Expected result: The person <i>receiving the threat(s)</i> believed that being compliant with the demand would not stop the threat	
7.	If the person says Yes to any of the above, collect verbatim examples if possible.	

Taking as point of departure the information provided in the interview and the knowledge of the context, the professional conducting the assessment can also consider indicators related to the assessment of intentionality and purpose. (Table 3).

Table 3. Intentionality and purpose of the threats.		YES
1.	There is a similar demonstrable pattern of strategies, behaviours, and procedures against other detainees	
2.	Observing the damage or suffering produced by the threats, no measures were taken that would plausibly have reduced that suffering	
3.	The threat is so severe that unintentionality is impossible	
4.	There is persistence, repetition, or prolongation of the threat over a long period of time	
5.	The alleged perpetrator explicitly expresses the intention to harm, humiliate and/or attack dignity in an unambiguous way	
6.	If the person conducting the assessment considers that any of the above happened, collect verbatim examples from the interview, if possible.	

Section 6. Legal assessment

This section is to be completed by legal professionals based on the information collected in the previous sections. This not to be completed together with the person to whom the threat was made. It is informed by the legal framework as outlined in the previous sections.

The legal qualification of threats (torture per Article 1 of the UNCAT, or other forms of ill-treatment per Article 16 of the UNCAT or below the threshold of Article 16 and not falling within the scope of the two provisions) would depend upon the specific circumstances of the case, including whether other forms of ill-treatment occurred or not. The below questions relate to the key elements to be analysed to distinguish torture and other forms of ill-treatment in the legal domain and are an aid for the legal classification of the case.

- a. **Official involvement:** Do you have information that the threats were made by a person in an official capacity? Do you have information that the threats were made with the consent or acquiescence of a public official? Do you have information that such a person was somehow involved in the situation? (e.g., by consenting to the threat being made)
- b. **Severe suffering:** Do you have documentation that the threat or its consequences were serious enough to amount to torture or ill-treatment? *The clinical assessment of the consequences as made above should be used here.*

1. Objective: What was the nature of the threats?

Note: It is helpful to refer back to the caselaw to appreciate that certain forms of threats are more readily found to be of a serious nature than others. These include but are not limited to threats to kill, torture, or rape the alleged victim or a relative.

2. Subjective: Did the person to whom the threat was made perceive/believe that the person making the threat was willing and able to act upon the threat?

Note: This is an assessment of the person's appraisal of the situation based on their understanding and knowledge of state practice, as informed by any of the following: vulnerabilities, previous experience, membership of a group at particular risk of torture, knowledge of historical patterns, strength of procedural safeguards, credibility and materialisation of threats (see section 5 above), and prospects for impunity.

3. Impact: Does the person report symptoms or has the clinician observed signs that indicate any physical or psychological consequences of the threat? Are they consistent with the threat? (See e.g., section 2 above).

- c. **Intention:** Is there any information indicating that the threat was intentionally made? *Note: The question of intentionality is not necessarily linked to explicitness. It may be circumstantial particularly in the case of contextual or non-verbal threats.*
- d. **Purpose:** Is there any information indicating that the threat was made for a particular purpose (such as punishment, intimidation, coercion, or discrimination)?
- e. **Context:** What were the series of events and stressors present in the environment in which the threat was made?

Note: This alludes to the context and environment in which the threats were made. These circumstances would also help in inferring purpose and intent, if not already explicit (see e.g., section 3 above).

Overall assessment: Is there sufficient credible information at hand to establish that the threats fulfill the requirements set out by the legal definition of torture (Article 1) or fall within the scope of Article 16 (Cruel, inhuman or degrading treatment) of the UNCAT?

Final reflections

It goes without saying that the Protocol might have benefited from being pilot-tested on more individuals. As stated, this plan had to be abandoned due to the war in Ukraine. The Protocol is by no means a fixed document, and in relation to both the questions in the Protocol itself and the conceptual, legal and medical aspects, there is still a lot to be learned. We therefore hope that over time, experience can be collected from those who use the Protocol so that it can be continuously improved.

Annexes

- **Quick Guide:** Annex 1 provides a Quick Guide for Interview. It is a short version, simple, everything in a snapshot guide to the Threats Protocol. The recommendation is to apply the full protocol at the beginning until being confident on its usage, and then resort to the Quick Guide for Interview.
- **Complementary tools:** Annex 2 includes some psychometric instruments that measure specific psychological aspects closely related to vulnerability to or impact of threats. They are included for research purposes or for the forensic documentation of complex cases. Their use exceeds that of a standard threat assessment and are not recommended for regular use.

References

- Cakal, E. (2021). Perception, practice and proximity. Qualifying threats as psychological torture in international law. *Torture Journal* 31(1), 19-36.
- Carleton, R. N. (2016). Fear of the unknown: One fear to rule them all? *Journal of Anxiety Disorders*, 41, 5–21. <https://doi.org/10.1016/j.janxdis.2016.03.011>
- ECHR. (1982). *Campbell and Cosans v. United Kingdom*. 7511/76, 7743/76. ECHR. (1990). *Guzzardi v. Italy*. 7367/76.
- ECHR. (1997). *Raninen v. Finland*. 20972/92. ECHR. (1999). *Selmouni v. France*. 25803/94. ECHR. (2009). *Bouyid v. Belgium*. 23380/09 [GC]. ECHR. (2010). *Gäfgen v. Germany*. 22978/05.
- ECHR. (2012). *El Masri v. Macedonia*. 39630/09. ECHR. (2013). *Strelets v. Russia*. 28018/05.
- ECHR. (2014). *Husayn (Zubaydah) v. Poland*. 7511/13. ECommHR. (1969). *Greek Case*. 12 ECHRYb.
- Fava, G. A., Tomba, E., Brakemeier, E. L., Carrozzino, D., Cosci, F., Eöry, A., Leonardi, T., Schamong, I., & Guidi, J. (2019). Mental Pain as a Transdiagnostic Patient- Reported Outcome Measure. *Psychotherapy and Psychosomatics*, 88(6), 341–349. <https://doi.org/10.1159/000504024>
- Feng, P., Becker, B., Zheng, Y., & Feng, T. (2018). Sleep deprivation affects fear memory consolidation: Bi-stable amygdala connectivity with insula and ventromedial prefrontal cortex. *Social Cognitive and Affective Neuroscience*, 13(2), 145–155. <https://doi.org/10.1093/scan/nsx148>
- Glenn, D. E., Risbrough, V. B., Simmons, A. N., Acheson, D. T., & Stout, D. M. (2017). The Future of Contextual Fear Learning for PTSD Research: A Methodological Review of Neuroimaging Studies. In *Brain Imaging in Behavioral Neuroscience* (Issue November 2011, pp. 207–228). https://doi.org/10.1007/7854_2017_30
- Grenier, S., Barrette, A. M., & Ladouceur, R. (2005). Intolerance of uncertainty and intolerance of ambiguity: Similarities and differences. *Personality and Individual Differences*, 39(3), 593–600. <https://doi.org/10.1016/j.paid.2005.02.014>
- Gullone, E., King, N. J., & Ollendick, T. H. (2000). The Development and Psychometric Evaluation

- of the Fear Experiences Questionnaire: An Attempt to Disentangle the Fear and Anxiety Constructs. *Clinical Psychology and Psychotherapy*, 7(1), 61–75. [https://doi.org/10.1002/\(SICI\)1099-0879\(200002\)7:1<61::AID-CPP227>3.0.CO;2-P](https://doi.org/10.1002/(SICI)1099-0879(200002)7:1<61::AID-CPP227>3.0.CO;2-P)
- IACtHR. (2006). *Baldeón-García v. Peru*. 06 April 2006. Series C No. 147.
- IACtHR. (2000). *Case of Cantoral-Benavides*. Judgment of August 18, 2000. Series C No. 69.
- IACtHR. (2003). *Maritza Urrutia v. Guatemala*. 27 November 2003. Series C No. 103. IACtHR.
- (2004). *Tibi v. Ecuador*. Preliminary objections, merits, reparations and costs,
- IACHR Series C no 114, IHRL 1497, 7th September 2004.
- LeDoux, J. E. (2020). How does the non-conscious become conscious? *Current Biology*, 30(5), R196–R199. <https://doi.org/10.1016/j.cub.2020.01.033>
- LeDoux, J. E. (2014). Coming to terms with fear. *Proceedings of the National Academy of Sciences of the United States of America*, 111(8), 2871–2878. <https://doi.org/10.1073/pnas.1400335111>
- LeDoux, J. E., & Pine, D. S. (2016). Using neuroscience to help understand fear and anxiety: A two-system framework. *American Journal of Psychiatry*, 173(11), 1083–1093. <https://doi.org/10.1176/appi.ajp.2016.16030353>
- Mertens, G., & Engelhard, I. M. (2020). A systematic review and meta-analysis of the evidence for unaware fear conditioning. *Neuroscience and Biobehavioral Reviews*, 108, 254–268. <https://doi.org/10.1016/j.neubiorev.2019.11.012>
- Milburn, T. W. (1977). The Nature of Threat. *Journal of Social Issues*, 33(1), 126–139. <https://doi.org/10.1111/j.1540-4560.1977.tb01872.x>
- Pérez-Sales, P. (2017). *Psychological Torture: Definition, Evaluation and Measurement*. London: Routledge. <https://doi.org/10.4324/9781315616940>
- Pérez-Sales, P., Søndergaard, E., Shir, E., Cakal, E., & Brasholt, M. (2019). Protocol on Medico-Legal Documentation of Sleep Deprivation. *Torture Journal*, 29(2), 28–55. <https://doi.org/10.7146/torture.v29i2.116320>
- Pérez-Sales, P. (2021). Defining and documenting threats in the context of ill-treatment and torture. *Torture Journal* 31(1), 3–18.
- Pryce, C. R., Azzinnari, D., Spinelli, S., Seifritz, E., Tegethoff, M., & Meinschmidt, G. (2011). Helplessness: A systematic translational review of theory and evidence for its relevance to understanding and treating depression. *Pharmacology and Therapeutics*, 132(3), 242–267. <https://doi.org/10.1016/j.pharmthera.2011.06.006>
- Søndergaard, E., Skilbeck, R., & Shir, E. (2019). Development of interdisciplinary protocols on medico-legal documentation of torture: Sleep deprivation. *Torture Journal*, 29(2), 23–27.
- Taylor, S. E. (1983). Adjustment to threatening events: A theory of cognitive adaptation. *American Psychologist*, 38, 1161–1171.
- Tempesta, D., Salfi, F., De Gennaro, L., & Ferrara, M. (2020). The impact of five nights of sleep restriction on emotional reactivity. *Journal of Sleep Research*, January, e13022. <https://doi.org/10.1111/jsr.13022>

Annex 1. Threats as Torture. Quick Interviewing Guide.

1. Fear and anxiety related to threats are enhanced by all other elements of a **torturing environment** involving attacks on cognitive or emotional functions. *Assess threats in the overall framework of the torturing environment and in particular in the interactions with other torturing situations.* Pay special attention to: (a) frightening or intimidating space (b) hunger-thirst and attacks to basic body functions (c) pain-producing conditions including life-threatening conditions (asphyxia...)
2. Ask openly about the **subjective experience** of threats in the alleged victim words: types, relevance, and impacts. Collect answers as verbatim as possible.
 - Who made the threats?
 - What were the main threats?
 - Which one affected the person more?
 - What is the subjective logic behind that?
 - Was it referred to an action that would take place immediately?
 - Could the person somehow prepare or cope?
 - Was there an expectation that the alleged perpetrator would go on and make it real?
 - How affected was the person during the period of torture and at the time of examination?

Chronic threats. When assessing Chronic or sustained threats, consider a description of how a stressful environment has been created in the person's day-to-day life, including family, professional and community aspects.

3. Vulnerabilities:

- Age, physical condition.
- Pay special attention to psychosocial history including experiences of trauma, crisis, or loss that can be logically connected to panic, fear and anxiety responses, and history of phobias.

4. Clinical impacts.

In all cases, collect verbatim examples that show the connection between contents of the threats and clinical symptoms. Assess:

- Sustained *anxiety* responses including panic attacks
- *Fear*-related symptoms and avoidant behaviours that can be logically linked to the threatening situation
- *Postrumatic symptoms* related to the threat, especially symptoms of avoidance and hyper vigilance
- Long-term *shame and guilt* feelings

- Other relevant diagnosis (*depressive disorder; dissociative or psychotic symptoms*) that can be attributed totally or partially to the threats

5. Non-clinical impacts. Threats can also have non-clinical consequences, specially in cases of chronic threats. Consider:

- Changes in cognitions, emotions or attitudes related to activities that the person links to the threats (i.e political or professional activity in activists or human rights defenders). Loss of meaning of their role or activity.
- Impact on the relationship with relatives and beloved ones. Impact on parenting, leisure activities and others.
- Changes in life priorities, worldviews, feelings of security, view of human beings.
- Changes in self-esteem and personal sense of value

6. Legal assessment (not part of the interview):

- Assess direct or indirect official involvement
- Severity of the threat in objective and subjective (alleged victim's perceptions) terms
- Intentionality and purpose of the threats (either explicit or implicit)

7. Credibility

- There is a demonstrable pattern or strategies verified in cases of other detainees
- Observing the damage produced by the threats, no measures were taken by the alleged perpetrator to reduce it
- Threat is so severe that unintentionally is not possible
- Persistence, repetition, or prolongation of the threat over a long period of time
- The alleged perpetrator explicitly expresses the determination to harm or attack dignity.
- The alleged perpetrator seemed out of control
- There was a detailed plan to make the threat happen
- The person was forced to see the threat acted upon others. Collect examples.

Annex 2. Additional questionnaires for experimental use.

The Protocol can be complemented with the following assessment tools.

- *Mental Pain Questionnaire* (Fava et al., 2019). The authors define *Mental suffering* as an intense anguish and despair of ‘feeling broken’, of being emotionally wounded, disconnected or hopeless. It is usually linked to experiences of loss and crisis, quite often with shameful or guilty thoughts, for which the person sees no solution and often thinks in suicide. It is not a clinical disorder, but a measure of psychological and mental pain. A tool linked to the same concept is the *Tolerance for mental pain scale* (Meerwijk et al., 2019)
- *Distress and Control Index; Fear and loss of control scale*: Basoglu suggests elaborating a list of potential torture methods and introducing a measure of distress and control (Başoğlu, 1999).
- *Claustrophobia Questionnaire*: is a 26-item structured questionnaire for the assessment of the fear and anxiety associated to being in closed places. It has been validated in normal and clinical populations. It has two subscales: Fear of Suffocation and Fear of Restriction. The fear subscale has shown to be a good predictor of panic attacks in normal population. There are no studies with survivors of torture. Scores higher than 50 for the overall scale, 27 for Fear of Suffocation, and 23 for Fear of Restriction are highly suggestive of claustrophobic clinical disorder (Radomsky et al., 2001).
- *Anxiety-Sensitivity Index*: is a 16-item questionnaire that measures a general tendency to have fear and anxiety responses in front of a threatening stimulus (Blais et al., 2001). It is associated with a persistent tendency to misinterpret certain bodily sensations catastrophically (anxiety sensitivity) and response with reactions of fear and alarm. It has been widely used in clinical and non-clinical populations. Its last version (ASI-3) has been validated in clinical and non-clinical samples in 5 countries (Taylor et al., 2007). It has 3 subscales: Physical, Cognitive, and Social Concerns.
- *Fear Survey Scale*: The Fear Survey Scale (FSS) is a comprehensive list of 106 items collected amongst the most frequent fears and phobias that appear in the general population (Tomlin et al., 1984). It might be useful as an adjunctive tool to explore comprehensively all possible phobias that a person had previous to torture, and eventually, new fears or phobias appeared and linked to it. (Tomlin, 1984).
- *Fear of Pain Questionnaire* is a measure of the Fear to Physical Pain. It has potential utility as an indicator of persons who have greater psychological suffering with threats. Since the first version, there have been different presentations. A recent 9-item short version, developed from the original 30-item questionnaire, offers strong psychometric properties (Mcneil et al., 2018). It has 3 subscales: Minor Pain, Severe Pain, and Medical Pain.
- *State-Trait Anxiety Inventory*: The State-Trait Anxiety Inventory is a 20-item measure of a general predisposition to anxiety. It is probably the most widely used measure of anxiety responses besides the Hamilton Anxiety Scale. It has been translated to around 30 languages and used in studies all over the

world. It is often included as a routine tool in the forensic assessment of survivors (Spielberg, 1968). However, in the analysis of psychological answer to threats, some evidence suggests that specific measures (like the Anxiety-Sensitivity Index or the Suffocation Fear Scale) might perform better than general measures as the STAI (McNally & Eke, 1996).

- *Feeling Broken or Destroyed Scale*: The concept of mental suffering has been applied to political context. Barber et al. (2016) applied the concept in a mixed-methods study with 68 Palestinian adults from different areas of the OpT. The instrument was then applied to a representative sample (n=1772) of adults. Mental suffering was conceptualized by participants as “feeling that one’s spirit morale and or future was broken or destroyed, and the person is in a situation of emotional and psychological exhaustion”.

Barber, B. K., McNeely, C. A., El Sarraj, E., Daher, M., Giacaman, R., Arafat, C., Barnes, W., & Abu Mallouh, M. (2016). Mental suffering in protracted political conflict: Feeling broken or destroyed. *PLoS ONE*, *11*(5), 1–17. <https://doi.org/10.1371/journal.pone.0156216>

Baçoğlu, M. (1999). *Emotions and Beliefs after War Questionnaire (EBAW)* (pp. 1–4).

Blais, M. A., Otto, M. W., Zucker, B. G., McNally, R. J., Schmidt, N. B., Fava, M., & Pollack, M. H. (2001). The Anxiety Sensitivity Index: Item Analysis and Suggestions for Refinement. *Journal of Personality Assessment*, *77*(2), 272–294. https://doi.org/10.1207/S15327752JPA7702_10

Fava, G. A., Tomba, E., Brakemeier, E. L., Carrozzino, D., Cosci, F., Eöry, A., Leonardi, T.,

Schamong, I., & Guidi, J. (2019). Mental Pain as a Transdiagnostic Patient-Reported Outcome Measure. *Psychotherapy and Psychosomatics*, *88*(6), 341–349. <https://doi.org/10.1159/000504024>

McNally, R. J., & Eke, M. (1996). Anxiety sensitivity, suffocation fear, and breath-holding duration as predictors of response to carbon dioxide challenge. *Journal of Abnormal Psychology*, *105*(1), 146–149. <https://doi.org/10.1037/0021-843X.105.1.146>

Mcneil, D. W., Kennedy, S. G., Randall, C. L., Addicks, S. H., Wright, C. D., Hursey, K. G., & Vaglianti, R. (2018). Fear of Pain Questionnaire-9 : Brief assessment of pain-related fear and anxiety. *European Journal of Pain*, *22*, 39–48. <https://doi.org/10.1002/ejp.1074>

Meerwijk, E. L., Mikulincer, M., & Weiss, S. J. (2019). Psychometric evaluation of the Tolerance for Mental Pain Scale in United States adults. *Psychiatry Research*, *273*(3), 746–752. <https://doi.org/10.1016/j.psychres.2019.01.101>

Radomsky, A. S., Rachman, S., Thordarson, D. S., McIsaac, H. K., & Teachman, B. A. (2001). The Claustrophobia Questionnaire. *Journal of Anxiety Disorders*, *15*(4), 287–297. [https://doi.org/10.1016/S0887-6185\(01\)00064-0](https://doi.org/10.1016/S0887-6185(01)00064-0)

Spielberger, C. D. (1968). *State trait Anxiety Inventory questionnaire (STAI)*. 19–21.

Taylor, S., Zvolensky, M. J., Cox, B. J., Deacon, B., Heimberg, R. G., Ledley, D. R., Abramowitz, J. S., Holaway, R. M., Stewart, S. H., Coles, M., Daly, E. S., & Arrindell, W. A. (2007). Robust Dimensions of Anxiety Sensitivity : Development and Initial Validation of the Anxiety Sensitivity Index — 3. *Psychological Assessment*, *19*(2), 176–188. <https://doi.org/10.1037/1040-3590.19.2.176>

Tomlin, P., Thyer, B. a, Curtis, G. C., Nesse, R., Cameron, O., Wright, P., Thyer, B. a, & Wright, P. (1984). Standardization of the Fear Survey Schedule. *J Behav Res. Exp Psychiatry*, *15*(2), 123–126.

The Spanish and French versions of this paper can be found on <https://tidsskrift.dk/torture-journal>

“The Darkness”: Deprivation of sunlight as a form of torture

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Key points of interest

- Deprivation of sunlight should be considered independently as a method of torture, given its prevalence in detention settings and the harms it can cause.
- Under-documentation presents a challenge in defining deprivation of sunlight as a form of torture, particularly in terms of the purposive element and proving the severity of suffering.
- Medical research suggests that adequate exposure to sunlight is critical to physical and mental health and is necessary to maintain sense of self within a person’s surroundings.

Abstract

Introduction. Deprivation of sunlight (DoS) should be considered independently as a method of torture. We review the definition and the spectrum of DoS, and the harms it causes that may rise to the level of torture.

Method. We review relevant international case law, and highlight how the harms of DoS have historically not been fully considered in torture cases, possibly legitimizing its use.

Conclusion. A standardized definition of deprivation of sunlight be developed and included in the Torturing Environment Scale, we call for an explicit international prohibition of DoS.

Keywords: Sunlight deprivation, torture, no-touch torture

Introduction

Sunshine is embedded in cultural references as synonymous with happiness and life. Without sunlight we wither and die. Depriving a person of sunlight has a host of physical and psychological deleterious consequences. Consequently, deprivation of sunlight (DoS) is employed in torturous environments to induce misery and suffering. DoS features strongly in many torture survivors’ stories of suffering, for example, in the CIA run “Darkness” Prison in Afghanistan (NYT, 2016). Yet it remains a topic that is rarely consid-

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International Rehabilitation Council for Torture Victims.

ered on its own in the psychological and legal literature on torture. For example, it is not included in the *Torturing Environment Scale* (Human Rights Council, 2020).

DoS is sometimes implied among simultaneous conditions. Examples include: confinement in a cell for 23.5 hours a day, light and ventilation being restricted by welding steel sheets to bars outside windows in prisons in Georgia (UN Commission on Human Rights, 2005, § 47), and solitary confinement cells in Israel with a fluorescent bulb as the only source of light (Physicians for Human Rights, 2011). The European Committee for the Prevention of Torture criticised Greek authorities detaining irregular migrants “for weeks... in very poorly furnished and inadequately lit and/or ventilated premises, without offering them either the possibility of daily outdoor exercise or a minimum of activities... is unacceptable and could even amount to inhuman and degrading treatment” (European Committee for the Prevention of Torture, 2011).

Observations by preventive bodies, such as the Subcommittee for the Prevention of Torture and the European Committee for the Prevention of Torture, show varying approaches to DoS, but recommendations for natural lighting and time outdoors do not appear to be enforced.

While there is a history of deliberate use of DoS in interrogation and detention settings, there is a lack of an explicit condemnation or call for prohibition. This article is intended as an introduction to address the need for a focus on DoS as an independent torture method that should be specifically defined and documented, its effects further researched, and its use condemned.

This review examines the physical and psychological health consequences of DoS and these are placed within existing legal definitions of the prohibition on torture.

Definitions

Torture

This paper focusses on the UNCAT Article 1 definition of torture relating to severe pain and suffering caused by DoS irrespective of purpose or intentionality. This permits examination of detention settings that may not be considered torturous due to the hidden and complex “*institutional and organisational context in which torture occurs*” (Rejali, 2007). This paper rejects definitions of torture such as the legal interpretation posited by the US State Department to legitimise so called “enhanced interrogation” (US Defense Dept, 2003) that state that the psychological impact must result in prolonged mental harm to qualify as torture since such a definition ‘*would disqualify many severely tortured peoples’ experience as torture simply because they did not develop PTSD*’ (Basoglu, 2007). In this paper, we do not distinguish between cruel, inhuman, and degrading treatment (CIDT) and torture.

No Touch Torture

DoS fits within definitions of physical, psychological, and no-touch torture. The authors prefer the term “no-touch torture” because the deleterious impacts are psychological and physical. They are psychological because DoS can negatively impact mood (Borchelt, 2005, p. 101), and has the potential to disrupt temporal and spatial orientation (McCoy, 2006). They are physical because DoS impacts on vital brain and body functioning via sensory organs including the skin. Melzer defines “*no touch torture*” as physical torture “*as long as “no-touch” techniques inflict severe physical pain or suffering of any kind*” situating the technique at “*the very interface between physical and psychological torture*” (Human Rights Council, 2020, § 28:§ 53). The physical effects of DoS

has the potential to inflict severe pain and suffering, however the effects are not immediate.

Deprivation of Sunlight Definition

Various challenges are presented to answering the question of whether DoS is a form of torture. DoS is on a spectrum where a person is in an environment that significantly limits exposure to natural sunlight. Exposure to sunlight is experienced via the eyes and skin. The spectrum of sunlight deprivation involves several factors including the type of deprivation, and duration without exposure or with minimal exposure to sunlight. The harm caused by lack of sunlight is influenced by individual factors such as genetic differences and underlying health conditions. The harms will be enhanced when DoS is combined with other torture techniques. At one end of this spectrum are dark cells. At the other end lies restriction of daylight such as staying inside and being able to observe diurnal rhythms through windows but unable to absorb rays through the skin. Blindfolding/hooding is DoS, but the effects are different if a person is hooded indoors or out. Mid-range on the spectrum is employing unnatural lighting without access to diurnal rhythms.

There is currently little guidance on how to quantify the types of DoS, the harms caused by DoS, and at what point DoS constitutes torture. This paper takes a necessarily broad look at DoS to serve as an introduction to an underexplored topic.

Conceptual questions

We have established that there is a broad spectrum of environments that are classified as sunlight deprived. This article explores what factors should be considered in deciding when DoS becomes torture. To address this we ask: Does DoS cause pain and suffer-

ing? How does it cause harm and how can we measure the harm and severity? What other aspects should be considered to classify it as torture (for example intentionality)? Finally, what do we know about prevalence and how do we document it?

The UN Committee Against Torture has affirmed that both hooding and blindfolding, under certain conditions, constitute torture (Committee Against Torture, 2006). The medico-legal statement on hooding by the International Forensic Experts Group positions hooding (and equivalent practices such as blindfolding) as “*intentional forms of sensory deprivation which constitutes cruel, inhuman and degrading treatment or punishment and should be prohibited in interrogation and detention*” (International Forensic Expert Group, 2011). Ojeda (2008) categorises the phenomenon of torture as intentional infliction of suffering without resorting to direct physical violence to include: spatial disorientation (small, dark cells); temporal disorientation (denial of natural light; erratic scheduling of activity); sensory disorientation, sensory deprivation or under stimulation (hooding, blindfolding, darkness, soundproofing); sensory assault (overstimulation), among other manipulations. This analysis of torture from a psychological perspective presents the core intention of torture as the “*involuntary change or destruction of the subject*” (Doerr-Zegers, Hartman, Lira & Weinstein, 1992).

Discussion

Harm from Deprivation of Sunlight

This article recognises that the harm a practice inflicts depends on the context, intensity and duration a person is exposed to a potentially torturous method, and that attempts to quantify harm of one act in a torture environment is neither credible nor feasible (Başoğlu, 2007).

Furthermore, assessing whether DoS inflicts “*severe physical pain or suffering*” presents a challenge because the immediate and chronic effects of DoS are neither well documented nor studied. One way of making sense of the harm is separating harm caused in the short term from with harm caused due to extended periods of DoS. This helps to conceptualise aspects of the DoS spectrum where some aspects are immediately harmful, such as hooding, compared with other aspects which become harmful over an extended periods, such as restriction from natural lighting and going outdoors.

Short - Medium Term Harm

Completely blocking light through hooding or a dark cell potentially induces helplessness in an unpredictable environment. Decades of research have concluded that unpredictable and uncontrollable environments exert the greatest impact on anxiety and fear (Başoğlu, 2007; Mineka, 1989; Mineka, 2006). Dark cells, with no ability of the detainee to illuminate them, immediately induce fear, when there is the potential for horrific or physically threatening practices (Başoğlu, 1992). Darkness also induces spatial and temporal disorientation (Ojeda, 2008)

DoS is frequently combined with solitary confinement (Pérez Sales, 2017, p. 180). The International Committee of the Red Cross reported that detainees kept “*completely naked in totally empty concrete cells and in total darkness, allegedly for several days*” presented with amnesia, anomia, incoherent speech, acute anxiety and suicidal behaviours (International Committee of the Red Cross, 2004). Detainees in solitary confinement at Guantánamo who were denied outdoor exercise during daylight have described experiences of deteriorating mood, increasing frustration, rage, loneliness, despair, anxiety and depression (Borchelt, 2005, p. 101).

Longer Term Consequences

Sunlight exposure plays a role in healthy sleeping patterns via circadian rhythm. However, Kleitman and Richardson, who voluntarily isolated themselves from sunlight by living in a cave for 32 days, demonstrated that sunlight plays a relatively minor role in maintaining circadian rhythm (Kleitman, 1963). Nevertheless, it has been argued that not having a clear idea of whether it is night or day disrupts a person’s orientation, creating confusion and attacking “*the victim’s sense of time, by scrambling the biorhythms fundamental to every human’s daily life*” (McCoy, 2006). Ojeda categorises denial of natural light under temporal disorientation and refers to “*confinement in small places; small, darkened or otherwise non-functional windows*” as psychological torture (Ojeda, 2008). Survivors of torture have referred to the uncertainty of not knowing the time of day or night as being particularly unsettling (Pérez Sales, 2017, p. 35). Through this disruption of temporal and spatial sensory stimulation, DoS also represents a manipulation of a person’s environment, depriving a detainee of control and therefore “*elevating*” the control of the interrogator (McCoy, 2012). This disruption of a detainee’s temporal and spatial perception contributes to stress and disorientation (Doerr-Zegers, Hartman, Lira and Weinstein 1992).

Sunlight deprivation is associated with depression. It causes disruption to the circadian rhythm through the decrease in melatonin production which is dependent on the intensity of blue light (transmitted by sunlight) absorbed by photoreceptors in the eye (Holick, 2016).

Serotonin is a neurotransmitter with an essential role in regulating mood, sleep (through the production of melatonin) and appetite through the central nervous system, the mucosa of the gastrointestinal tract, blood

platelets and the skin. Lower light levels are associated with lower binding levels of serotonin in the cortical and subcortical limbic regions of the brain (Spindelegger, Stein, Wadsak & al., 2012). Lack of access to sunlight causes a decrease in the production of serotonin as photoreceptors in the eyes as well as the skin, cannot “pick up” enough light (Slo-minski, Worstman & Tobin, 2005). Individuals with pre-existing vulnerabilities including mood and anxiety disorders will be more susceptible to this effect. In addition, in individuals with depression, lower exposure to sunlight may be associated with cognitive impairment (Kent, 2009)

It is a fact that populations with less sun exposure have an increased risk for chronic diseases and mortality (Holick, 2016). Inadequate exposure to sunlight is considered a major cause of vitamin D deficiency around the world, and lack of Vitamin D from sunlight is associated with bone fragility and higher risk of fractures (Holick, 2016). Vitamin D deficiency is also linked to increased risks of colorectal cancer and cardiovascular disease by up to 62%, as well as to autoimmune diseases, infectious diseases and schizophrenia (Holick, 2008). The link between sunlight and a range of physical consequences merits further research with a focus on persons in torture environments.

DoS often occurs in tandem with poor ventilation, so separating the effects of DoS from poor ventilation is not always possible. Sunlight and ventilation are essential to general health in prisons, and to infection control (Møller, Stöver, Gatherer & Nikogolian, 2007). Lack of light in prisons has been linked to higher rates of cutaneous tuberculosis (Møller, Stöver, Gatherer & Nikogolian, 2007, p. 78). Minimum requirements for natural light, ventilation, space, nutrition, heating and sanitation, are all essential to

maintenance of good health (Møller, Stöver, Gatherer & Nikogolian, 2007, p. 11).

A detention setting that does not allow sufficient, consistent access to sunlight deprives a person of the physical benefits of sunlight and in its extreme form prevents a person from creating an accurate spatial and temporal picture of its environment. Further in-depth study is required of all health effects of DoS in torture environments.

Legal standards

International norms

The international prohibition on torture is absolute: the peremptory norm proscribing all situations in which severe pain or suffering is intentionally inflicted on a person by a state representative, though not including “pain or suffering arising only from, inherent in or incidental to lawful sanctions” (UNCAT Article 1; ICCPR Article 7; ECHR Article 3; IACHR Article 5; IACPT Article 2; ACHPR Article 5). The difficulty of quantifying the severity of harm caused by, and the intentionality behind, DoS makes it challenging to automatically categorise it under this prohibition. The harms caused by DoS could be presented as inherent or incidental to sanctions in criminal detention settings.

International norms on detention standards, however, do require adequate levels of natural light. The Istanbul Protocol, a non-binding manual on investigating torture, recognises deprivation of “normal sensory stimulation, such as sound, light, sense of time, isolation, manipulation of brightness of the cell, abuse of physical needs...” as methods of torture (UN Officer of the High Commissioner for Human Rights, 2022). The United Nations Office on Drugs and Crime noted in 2014 that a variety of factors in detention, either individually or cumulatively, could

amount to degrading treatment, including examples of overcrowding, poor sanitary conditions, poor ventilation and lack of natural light (UNODC, 2006, p. 130).

Under the (non-binding) Nelson Mandela Rules on minimum standards for the treatment of prisoners, placing prisoners in dark or constantly lit cells is specifically prohibited when used as a restrictive or disciplinary action (Nelson Mandela Rules, 2016, Rule 42). Rule 14, like the European Prison Rules rule 18.2, considers adequate natural light to be necessary in detainees' living and working spaces as well, though the absolute prohibition applied to restrictive or disciplinary actions is not extended here, resulting in only a partial prohibition. In addition, "adequate" here refers to detainees being able to read and work; the Nelson Mandela Rules do not engage with the mental and physical health benefits of access to sunlight.

The Office of the High Commissioner for Human Rights refers to every person deprived of their liberty's right to enjoy daylight (2003, § 348). The International Centre for Prison Studies recommends a minimum of one hour in fresh air every day for all detainees, specifying that this outdoor time must not be in "small, walled yards" (Coyle, 2002, p. 47). This suggests that not only fresh air is important, but also light and optical stimulation, building a definition of what amount of light might constitute the adequate natural light required by the Nelson Mandela Rules no. 23.

Despite these rules and recommendations, prisons are still built and used without consideration of access to sunlight. In a striking example, CNN coverage of the "Administrative Maximum Facility" in Colorado, USA, details the architecture being used "as control", where prisoners "can't see the sky" from their cells, and where a recreation hour is spent "in an outdoor cage slightly larger than

the prison cells. Inside the cage, only the sky is visible" (CNN, 2015). Clearer international rules and recommendations prohibiting DoS in living areas, including where it is a feature of building design, are needed to prevent harms caused by DoS.

International courts: different approaches to severity

International and regional courts have considered the specific need for sunlight for physical and mental health to varying degrees. This section will consider how DoS has featured in a range of judgements by international courts: rather than compare the approaches of each court, it outlines the scale of attention given DoS in different cases. At one end of the scale, DoS is implied by the detention conditions described, alongside other forms of ill-treatment that amount to a violation of the prohibition of torture. At the other end, DoS is expressly, though briefly, considered in terms of its impacts on health and wellbeing.

Implied DoS

In *M.S.S v. Belgium and Greece*, conditions of detention amounted to a violation of Article 3 ECHR, based on the CPT's description of the victim spending one and a half months in cell with no access to fresh air, and to Amnesty International's description of three small cells with one window each (*M.S.S v. Belgium and Greece*, 2011, § 164 and 165). DoS is implied by the circumstances of overcrowding in small spaces with one window, and no access to the outdoors. UNHCR cited the lack of fresh air or possibility to take a walk in the open air (among other unsanitary conditions) (*M.S.S v. Belgium and Greece*, 2011, § 213). Although there is no direct mention, deprivation of direct sunlight is implied by the impossibility of spending time out of the cell, let alone outdoors. Overcrowding in cells may also imply

difficulty to access adequate indirect sunlight through a window. Similarly, without specifically discussing DoS, The Human Rights Committee found confinement to a tiny cell for 22 hours a day in enforced darkness sufficient to find violations of ICCPR Articles 7 and 10 in *Freemantle v Jamaica* (2000, § 3.5). Similar examples are found in *Kennedy v Trinidad and Tobago* (2002, § 3.10), *Torres-Ramírez v Uruguay* (1977, § 2), *Viollane v Finland* (1989, § 2.6), or *Womah Mukong v Cameroon* (1994, § 9.4).

Explicit mention of DoS

Moving up the scale, international claimants and courts have also explicitly mentioned lack of sunlight or natural light as part of a wider series of conditions and treatments that influence the court's conclusion of a violation. In *Peers v Greece*, the Court makes reference to access to natural light being "at best, mediocre" in the segregation wing under consideration in the case, describing small and high cells, with one window in the roof "that did not open and was so dirty that no light could pass through" (*Peers v Greece*, 2001, § 21 and 133). DoS is clearly a factor in the court's considerations, but its specific harms are not considered in detail.

In a case dealing with incommunicado detention, *Cantoral Benavides v. Peru*, the inter-American Court mentions detention in small cells for 23.5 hours a day, with just half an hour in sunlight, demonstrating a recognition that deprivation of natural light played a part in an environment violating the prohibition on torture (*Cantoral Benavides v. Peru*, 2000, § 43a, 63k, 85 and 89). In *Antonaccio v Uruguay*, the Human Rights Committee explicitly considers how Antonaccio was kept in an underground cell with no fresh air or sunlight, the cell having no window, the door being always closed, and Antonaccio being

blindfolded on the few instances he was taken out of his cell (*Amonaccio v Peru*, 1981, § 2.2 and 6). In *Gomez de Voituret v Uruguay*, the Committee found a violation of Article 10, considering the claimant's detention in cell without natural light on arrest, and being hooded and forced to walk without interruption when allowed outside her cell following her trial (*Gomez de Voituret v Uruguay*, 1984, § 2.2 and 12.2). These cases deal more with the victim's inability to observe sunlight, alongside other ill-treatment, engaging with Ojeda's work on temporal and spatial disorientation, and Başoğlu's considerations of psychological torture. Similar examples include *Polay Campos v Peru* (*Polay Campos v Peru*, 1994, § 2.4 and 8.7), and *Teesdale v Trinidad and Tobago* (*Teesdale v Trinidad and Tobago*, 1996, § 3.10).

Consideration of the impacts of DoS

In a few cases, deprivation of sunlight or natural light is explicitly considered in terms of its impacts on physical or mental functioning. These cases are useful to compile a legal precedent of DoS being a form of torture. However, such examples do not yet consider the short term or chronic health impacts caused by a lack of sunlight. In *Loayza Tamayo v Peru*, the Inter-American Court refers to Loayza Tamayo's deteriorating health as a result of 23.5 hours' incarceration per day without direct ventilation or direct light (*Loayza Tamayo v Peru*, 1997, § 29 and 46k). The Human Rights Committee considered, in *Boodoo v Trinidad and Tobago*, the recommendation by the prison doctor for the claimant to spend at least three hours a day in sunlight for his eyesight (*Boodoo v Trinidad and Tobago*, 2002, § 2.3), considering access to sunlight in terms of its physical health impacts. The role of lack of sunshine in the breakdown of the physical and mental health of the claimant is considered briefly, alongside other ill-

treatment, by the Committee in *Cámpora Schweizer v Uruguay* (1990, § 11).

Through international norms and case law, an awareness that DoS contributes to torturous conditions is visible to varying extents. Deprivation of light is considered as a possible sign of torture or CIDT, but consideration in terms of its specific torturous effects is limited. A common definition of DoS and a body of work exploring its harms could lead to more specific considerations by courts, by addressing under-documentation to create higher awareness of its prevalence and a more specific review of harms. The precedents discussed in this section, and the harms discussed in the previous section, offer a starting point for this work.

DoS in practice

A common definition exploring whether, where and to what extent DoS is a form of torture could have important implications for conditions in all detention settings. A spectrum from zero mention to explicit concern raised about lack of access to direct natural light is found regarding criminal and administrative detention, where DoS can be a byproduct of architecture and other poor conditions. These could impose the same harms to qualify under the UNCAT definition (though if they are undocumented this will be hard to prove) but may face difficulty under the purposive element. Engaging with this element of the UNCAT definition, interrogation practices and protocols can reflect an assumption that the harms caused by DoS may influence the interrogation process.

There are some clear examples of states intentionally depriving interrogation subjects of sunlight to induce a more cooperative state. This section will explore examples from the UK and the USA, looking at how intentional deprivation of light has created a torture envi-

ronment. A torture environment is understood as one in which conditions (of accommodation, of treatment) elevate one actor, giving them control and “significantly increasing the fear level” to break down a second actor, the detainee (McCoy, 2012, p. 106). The temporal and spatial disorientation of acute deprivation of sunlight fit into this definition by restricting a person’s access to the physical changes in their surroundings that enable them to stay orientated, retain control and judge, understand and freely make decisions (Pérez Sales, 2017, p. 8).

Despite the spatial disorientation of darkness being found to be CIDT when used alongside other mistreatment (for example, *Ireland v United Kingdom*, 1978, § 7), states have continued to exploit the use of deprivation of light in interrogations. In 2003, UK forces used the “five techniques” (hooding, prolonged wall-standing, subjection to noise, deprivation of sleep, deprivation of food and drink) on civilians in Iraq, to disorient and prolong capture shock of detainees (McCoy, 2012, p. 45). Newbery refers to support for the “five techniques” in response to security priorities, with a strong emphasis on effectiveness in intelligence gathering (Newbery, 2009).

Among the degrading treatment noted by Mr. Justice Leggatt regarding individual claimants, were “periods of complete deprivation of sight and hearing” (*Alseran, Al-Waheed, MRE & KSU v. Ministry of Defence*, 2017, § 17(ii)(c)). This treatment was at the time “permitted by the MOD but [...] has since been banned by the British army” (§ 668). The Court found that, despite contradicting published military doctrine, this practice was adopted “as a form of deliberate ‘conditioning’, in order to maximise vulnerability” (*Alseran, Al-Waheed, MRE & KSU v. Ministry of Defence*, 2017, § 665). The long-term harm caused by the lack of light did not receive explicit focus, limiting

our ability to quantify the negative impacts of deprivation of natural light.

In the USA a series of leaked memos by the US Office of Legal Counsel on the CIA's interrogation programme in the wake of the "War on Terror" of the early 2000s relied on the distinction outlined by the Court in *Ireland v. UK* between torture and inhuman and degrading treatment (Green, 2018). The CIA's 1963 Counterintelligence Interrogation manual (KUBARK manual), 1983 'Honduran Handbook', the 1987 Army Field Manual and the 21st Century 'Torture Memos' all build a "systematic attack on all human stimuli, psychological and biological" (McCoy, 2012, p. 106). The "Enhanced Interrogation Techniques" endorsed by declassified CIA manuals condemn "physical torture" but advise depriving detainees of sleep, food, water, sunlight and medical attention as legitimate techniques to break detainees' resistance (Van Natta, 2003).

The KUBARK Manual recommends using cells that have "no light (or weak artificial light which never varies), to induce a susceptible state in detainees in which the subject has a growing need for physical and social stimuli, and in which some subjects rapidly lose touch with reality, focus inwardly, and produce delusions, hallucinations, and other pathological effects" (Central Intelligence Agency, 1963, p. 87). The use of goggles, earmuffs, mittens, and darkened cells can quickly create psychotic states that are sometimes permanent in subjects (Pérez Sales, 2017, p. 87). The manual describes the extremes of stress and anxiety that can be induced as unbearable (Central Intelligence Agency, 1983), encompassing a lack of stimulation "impairing the activity of the cortex so that the brain behaves abnormally", or disrupting spatial and temporal awareness (McCoy, 2006, p. 37). Twenty years later, the *Human Resources Exploitation Training Manual* originally advised causing "disorientation re-

garding day and night", which was later annotated with the words "is illegal and against policy to use them to produce regression" (McCoy, 2012, p. 29). Deprivation of light and sleep, and temporarily withholding access to sunlight, medical attention and food and water are said to still be accepted as interrogation techniques by senior American officials (Central Intelligence Agency, 1963, p. 90).

In a recent case in the USA, the dark conditions of detention in *Salim v Mitchell* (2017), alongside under-nutrition, water torture and stress positions were specifically highlighted as means to break him into a "broken", "cooperative" state (*Salim v Mitchell*, 2017, § 104). Salim was detained for four years in a constantly artificially lit cage with no time outside, under the defendant's recommendations for a physical environment designed for disorientation to undermine resistance in interrogations (*Salim v Mitchell*, 2017, § 24-25).

These texts appear to satisfy the purposive and severity elements of the UNCAT definition of torture. However, DoS is a feature not just of interrogation, counter-terror and armed conflict settings, but appears in domestic detention for criminal and administrative purposes through architecture and a lack of attention to adequate living conditions. While causing possibly the same harms, the UNCAT Article 1 exception "it does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions" might restrict its classification as torture, but preventive and judicial bodies should still bear the harms explored in mind. A spectrum from zero mention to explicit concern raised about DoS can be observed regarding criminal and administrative detention settings.

Implied DoS

Slovenia's National Preventive Mechanism notes extremely limited time out of cell - 120

minutes - (Human Rights Ombudsman of Slovenia NPM, 2022). Though not engaging with whether or not prisoners lacked access to sunlight, the very restricted time allowed in fresh air implies that complete immersion in sunlight is not regular or extended.

DoS explicitly noted

A 2016 review of immigration detention in the UK called for a government review into access to natural light and open air in Immigration Removal Centres, and notes that sunlight is an important aspect of welfare (Shaw 2016, § 6.152, Recommendation 33). The 2018 follow-up report notes that “there continued to be no natural light in any of the terminal holding rooms” (Shaw 2018, § 109) in one centre, and windows were still covered in another, allowing very little natural light (§ 317).

Bulgaria’s NPM has registered concern about lack of access to natural light (alongside lack of access to ventilation and of service facilities) in police-department 24-hour detention for ten years (Ombudsman of the Republic of Bulgaria, 2022). Its 2021 report mentioned also a medical centre being found to be unsatisfactory for being underground and with no windows, while a detention centre in Varna had unsatisfactory access to daylight, though there was central ventilation (Ombudsman of the Republic of Bulgaria, 2022). Though not expanding on the exact harms of DoS, the separation from ventilation here goes a step further than the Rules on Minimum Standards for Prisons, highlighting the need for sunlight, rather than its coincidence with fresh air. Natural light was also deemed not to be sufficient in some residential and some so-called “safe and solitary” cells in Georgia, while 15 temporary detention facilities did not have adequate light due to small windows (Public Defender of Georgia, 2022). Recom-

mendations by the Serbian NPM included improving the amount of natural light available in a disciplinary room, while a police station was praised for installing windows that would block a view into a room, without impeding the flow of sunlight (Republic of Serbia Protector of Citizens, 2022). Lack of access to natural light continued to be a “general shortcoming” in detention sites in Spain, despite a 2016 CPT recommendation that all new detention centres make natural light accessible (Defensor del Pueblo, 2022).

DoS considered as torturous

The Austrian NPM’s 2021 report suggests a case of temporal disorientation in the case of a detainee at risk of suicide being held in “a specially secured cell with constant neon light for 19 days, unable to distinguish between night and day”, calling the effects “tantamount to torture” (Austrian National Preventive Mechanism, 2022). In more general detention conditions, the NPM expresses concern over lock-up times of 23 hours a day continuing to be “the depressing reality” (Austrian National Preventive Mechanism, 2022).

Gaps in the legal system

DoS occurs in interrogation, prisons, military detention, police custody, and immigration detention in a number of states, although clinical experience suggests that the issue is more prevalent than these references suggest, and the true prevalence is unknown. The circumstantiality of DoS, both that it can be a product of a restrictive detention regime, of architecture, and that it so often occurs alongside other treatment carrying health risks, can make it difficult to prove as a form of torture. However, the examples of its use in interrogation satisfy the purposive element in such cases. Though arguably incidental to lawful sanctions in prisons, a dedicated documen-

tation tool would help to establish whether the harms are consistent with torture. DoS is matter of concern for preventive bodies, and should receive more attention by decision makers.

Conclusion

This article presents that DoS under certain conditions independently meets the criteria for torture and exacerbates the harm of other torture methods.

DoS appears in cases of torture that reach international human rights tribunals although it is rarely focussed on in depth in case law. Medical research suggests that adequate exposure to sunlight is critical to physical and mental health and is necessary to maintain sense of self within a person's surroundings.

There is limited data on the harmful effects of sunlight deprivation applied in detention settings and torture environments; further dedicated research is needed to describe and quantify both the short and long term effects of all forms of sunlight deprivation.

A standardized definition of deprivation of sunlight should be developed for use by monitoring bodies and included in the Torturing Environment Scale. The definition should include a spectrum of deprivation of sunlight ranging from complete darkness to the use of artificial lighting without natural sunlight and define at what point DoS becomes torture.

Documentation of sunlight deprivation should be performed by all monitoring bodies in places of interrogation and detention and should include detailed conditions of sunlight deprivation along with any reported psychological or physical effects. Stronger prohibition of sunlight deprivation in detention guidelines will ensure that it is investigated in both preventive and *post facto* situations.

References

- Adalah, Al Mazan and Physicians for Human Rights. (2011). *Solitary Confinement for Prisoners and Detainees in Israeli Prisons*.
- African Charter on Human and People's Rights*, adopted 27 June 1981 (entered into force 21 October 1986).
- American Convention on Human Rights*, adopted 22 November 1969 (entered into force 18 July 1978).
- Austrian National Preventive Mechanism. (2021). Annual Report on the activities of the Austrian National Preventive Mechanism (NPM) 2021 Protection & Promotion of Human Rights. https://www.ohchr.org/sites/default/files/documents/hrbodies/opcat/npm/2022-08-04/Austria_NPM_Report2021.pdf
- Başoğlu, M, Livanou, M, Crnobaric', C (2007) Torture vs Other Cruel, Inhuman, and Degrading Treatment Is the Distinction Real or Apparent? *Arch Gen Psychiatry* Vol 64, 277-283.
- Başoğlu, M, Mineka S (1992) The role of uncontrollable and unpredictable stress in post-traumatic stress responses in torture survivors. In Başoğlu, M *Torture and Its Consequences: Current Treatment Approaches*. Cambridge, Mass Cambridge University Press 1992; 182- 225.
- Başoğlu, M. (1992). Torture and its consequences: Current treatment approaches. - *PsycNET*. In Cambridge University Press. <https://psycnet.apa.org/record/1993-97051-000>
- Borchelt, G. (2005). *Break Them Down; Systematic Use of Psychological Torture by US Forces*. Cambridge MA: Physicians for Human Rights.
- CCPR (1979). *Violeta Setelich and Raul Sendic Antonaccio v. Uruguay*. UN Doc. CCPR/C/14/D/63/1979
- CCPR (1987). *Antti Vuolanne v. Finland*. U.N. Doc. CCPR/C/35/D/265/1987
- CCPR (1990). *Cámpora Schweizer v. Uruguay*. Communication No. 66/1980, (1990) UN Doc. CCPR/C/OP/2
- CCPR (1991). *Albert Womah Mukong v. Cameroon*. U.N. Doc. CCPR/C/51/D/458/1991
- CCPR (1994). *Polay Campos v. Peru*. CCPR/C/61/D/577/1994
- CCPR (1996). *Teesdale v. Trinidad and Tobago*. CCPR/C/74/D/677/1996
- CCPR (2002). *Boodoo v Trinidad and Tobago* Communication No. 721/1996 (2002) UN Doc. CCPR/C/74/D/721/1996
- Central Intelligence Agency. (1988). *Human Resources Exploitation Training Manual - 1983'*
- Central Intelligence Agency. (1997). *KUBARK Counterintelligence Interrogation - 1963*
- CNN (2015) What's life like in Supermax prison? |

- CNN. (n.d.). Retrieved February 2, 2023, from <https://edition.cnn.com/2015/06/25/us/dzhokhar-tsarnaev-supermax-prison/index.html>
- Committee Against Torture. (2006). Consideration of Reports Submitted by States Parties Under Article 19 of the Convention; Conclusions and Recommendations of the Committee Against Torture- Guatemala. *UN Doc CAT/C/GTM/CO/4 [18]*
- Committee Against Torture. (2006). Consideration of Reports Submitted by States Parties Under Article 19 of the Convention; Conclusions and Recommendations of the Committee Against Torture- Togo. *UN Doc CAT/C/TGO/CO/ [11]*
- Coyle, A. (2002). *A Human Rights Approach to Prison Management: Handbook for Prison Staff*. London: International Centre for Prison Studies.
- Defensor del Pueblo. (2021). *Informe anual 2021 Mecanismo Nacional de Prevención*. <https://www.defensordelpueblo.es/informe-mnnp/mecanismo-nacional-prevencion-informe-anual-2021/>
- Doerr-Zegers, O., Hartman, L., Lira, E. & Weinstein, E. (1992). Torture: Psychiatric Sequelae and Phenomenology. *Psychiatry*, 55:2, 177-184. <https://doi.org/10.1080/00332747.1992.11024591>
- ECHR (1978) *Ireland v United Kingdom*. A No 5310/71, I.
- ECHR (2001). *Peers v. Greece*. 28524/95
- ECHR (2009) *S.D. v Greece* A No 53541/07.
- ECHR (2011) *M.S.S v Belgium and Greece*. A No 30696/09 [221].
- European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. (2011). 21st General Report of the CPT. 1 (July), 1-82.
- EWHC (2017). *Alseran, Al-Waheed, MRE & KSU v. Ministry of Defence* 3289 (QB)
- GAOR (1984). *Gómez de Voituret v Uruguay* Communication No. 109/1981, (1984) UN Doc. A/39/40
- Green, A. (2018). Ireland v the UK and the Hooded Men: A missed opportunity? *Strasbourg Observers*
- Holick, M. (2008). Deficiency of Sunlight and Vitamin D. *BMJ* 336, 1318, <https://doi.org/10.1136/bmj.39581.411424.80>
- Holick, M. (2016). Biological Effects of Sunlight, Ultraviolet Radiation, Visible Light, Infrared Radiation and Vitamin D for Health. *Anticancer Research*, 36(3), 1345-56.
- HRC (1995). *Freemantle v. Jamaica*, Comm. 625/1995, U.N. Doc. A/55/40, Vol. II.
- HRC (1980). *Torres Ramirez v. Uruguay*. (1977). Comm. 4/1977, U.N. Doc. A/35/40.
- Human Rights Council. (2020). Torture and other cruel, inhuman or degrading treatment or punishment: Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. *Forty-third session, Agenda item 3*.
- Human Rights Ombudsman of Slovenia. (2021). *The Report of the Human Rights Ombudsman of the Republic of Slovenia On Implementing the Tasks of the National Preventive Mechanism*. <https://www.ohchr.org/sites/default/files/documents/hrbodies/spt-opcat/npm/2022-09-15/NPM-Slovenia-2021.pdf>
- ICHR (1997) *Loayza-Tamayo v. Peru*. 6 IHRL 1416.
- ICHR (2000) *Cantoral Benavides v. Peru*. 6 IHRL 1416.
- Inter-American Convention to prevent and punish torture*, adopted 9 December 1985, OAS Treaty Series 67 (entered into force 28 February 1987)
- International Committee of the Red Cross. (2004). *Report by the International Committee of the Red Cross (ICRC) on the Treatment by the Coalition Forces of Prisoners of War and other Protected Persons by the Geneva Conventions in Iraq during Arrest, Internment and Interrogation*. Geneva: International Committee of the Red Cross.
- International Covenant on Civil and Political Rights*, adopted 16 December 1966, General Assembly resolution 2200A (XXI) (entered into force 23 March 1976).
- International Forensic Expert Group. (2011). Statement on Hooding. *Torture*, 3, 186-189.
- Kent, S. T., McClure, L. A., Crosson, W. L., Arnett, D. K., Wadley, V. G., & Sathiakumar, N. (2009). Effect of sunlight exposure on cognitive function among depressed and non-depressed participants: A REGARDS cross-sectional study. *Environmental Health: A Global Access Science Source*, 8(1), 1-14. <https://doi.org/10.1186/1476-069X-8-34/TABLES/4>
- Kleitman, N (1963). *Sleep and Wakefulness*. Chicago, The University of Chicago Press.
- McCoy, A. (2006). *A Question of Torture: CIA Interrogation, from the Cold War to the War on Terror*. New York: Metropolitan Books.
- McCoy, A. (2012) *Torture and Impunity; the U.S. Doctrine of Coercive Interrogation*. London: University of Wisconsin Press.
- Mineka S, Kelly K. The relationship between anxiety, lack of control and loss of control. In: Steptoe A, Appels A, eds. *Stress, Personal Control and Health*. Brussels, Belgium: Wiley; 1989:163-191.
- Mineka S, Zinbarg R. (2006) A contemporary learning theory perspective on the etiology of anxiety disorders: it's not what you thought it was. *Am Psychol*. 2006; 61:10-26.

- Møller, L., Stöver, R.J., Gatherer, A. & Nikogosian, H. (2007). *Health in Prisons: A WHO Guide to the Essentials in Prison Health*. Copenhagen: World Health Organisation Europe.
- New York Times, "After Torture, Ex-Detainee Is Still Captive of 'The Darkness'", <https://www.nytimes.com/2016/10/12/world/cia-torture-abuses-detainee.html>
- Newbery, S. (2009) Intelligence and Controversial British Interrogation Techniques: the Northern Ireland Case, 1971-2. *Irish Studies in International Affairs*, 20, 103-119.
- Ojeda, A. (2008). What is Psychological Torture? In A. Ojeda (Ed.), *The Trauma of Psychological Torture*. Praeger Publishers.
- Office of the High Commissioner for Human Rights in Cooperation with the International Bar Association (2003) , Professional Training Series No. 9; Human Rights in the Administration of Justice: A Manual on Human Rights for Judges, Prosecutors and Lawyers. Geneva: United Nations.
- Ombudsman of the Republic of Bulgaria. (2021). Annual Report of the Ombudsman Acting as National Preventive Mechanism. <https://www.ohchr.org/sites/default/files/documents/hrbodies/spt-opcat/npm/2022-09-12/NPM-Annual-Report-BGR2021.pdf>
- Pérez Sales, P. (2017). *Psychological Torture; Definition, evaluation and measurement*. London: Routledge, <https://doi.org/10.4324/9781315616940>
- Public Defender of Georgia. (2021). *The Report of the National Preventive Mechanism*. <https://www.ohchr.org/sites/default/files/documents/hrbodies/opcat/npm/2022-07-22/Georgia-Report-of-the-National-Preventive-Mechanism-2021.pdf>
- Rejali, D. (2007). Torture Makes the Man. *South Central Review*, 24(1), 151-169. <http://www.jstor.org/stable/40039967>
- Republic of Serbia Protector of Citizens. (2021). *National Preventive Mechanism Report for 2021*. <https://www.ohchr.org/sites/default/files/documents/hrbodies/spt-opcat/npm/2022-11-07/Serbia2021.pdf>
- Shaw, S. (2016). *Review into the Welfare in detention of Vulnerable Persons: a report to the Home Office by Stephen Shaw*. London: Crown copyright.
- Shaw, S. (2018). *Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons; a Follow-Up Report to the Home Office by Stephen Shaw*. London: Crown copyright.
- Slominski, A., Wortsman, J. & Tobin, D. J. (2005). The cutaneous serotonergic/melatonergic system: securing a place under the sun. *FASEB J*, 19(2). Doi: 10.1096/fj.04-2079rev.
- Spindelegger C, Stein P, Wadsak W, et al. (2012). Light-dependent alteration of serotonin-1A receptor binding in the cortical and subcortical limbic regions in the human brain. *World J Biol Psychiatry*, 13(6), <https://doi.org/10.3109/15622975.2011.630405>
- UN Commission on Human Rights. (2005). Civil and Political Rights, Including the Questions of Torture and Detention Torture and other cruel, inhuman or degrading treatment, Report of the Special Rapporteur on the question of torture, Manfred Nowak. *E/CN.4/2006/6/Add.3 UN Convention Against Torture*, adopted 10 December 1984, General Assembly resolution 39/46 (entered into force 26 June 1987).
- UN Officer of the High Commissioner for Human Rights. (2022). Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (2022 edition). *Professional Training Series No. 8/Rev.2*
- UN Standard Minimum Rules for the Treatment of Prisoners (The Nelson Mandela Rules) Rule 42, from https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf
- United Nations Office on Drugs and Crime. (2006). *Module 4; Human Rights and Criminal Justice Responses to Terrorism (Counter-Terrorism Legal Training Curriculum)*. New York: UNODC.
- United States District Court (2017). *Salim v. Mitchell*, 268 F. Supp. 3d 1132 (E.D. Wash. 2017)
- US Defense Department. (2003) Working group report on detainee interrogations in the global war on terrorism: assessment of legal, historical, policy and operational considerations, April 4, 2003. In: Greenberg KJ, Dratel JL, eds. *The Torture Papers*. Cambridge, Mass: Cambridge University Press; 2005:286-359.
- Van Natta, D. (2003) Threats and Responses: Interrogations; Questioning Terror Suspects in a Dark and Surreal World. *New York Times*.
- Williams, B. A. (2016). Older Prisoners and Physical Health Effects of Solitary Confinement. *American Journal of Public Health* 106, 12.

Protocol on medico-legal documentation of solitary confinement

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Key points of interest

- This Protocol summarises the relevant conceptual (legal and health) factors regarding solitary confinement, and it formulates questions for its medico-legal documentation.
- The Protocol is general in scope, with additional specific elements for populations particularly vulnerable to solitary confinement pending to be further developed in future editions after pilot testing.
- This Protocol is a supplement to the Istanbul Protocol.

Abstract

Introduction. This Protocol originates from a joint project regarding documentation of psychological torture initiated by the Public Committee against Torture in Israel (PCATI),

REDRESS and DIGNITY - Danish Institute Against Torture (DIGNITY) in 2015 after the Copenhagen Conference on Psychological Torture. The project is a vehicle to establish a common understanding between health and legal professions as to how to best ensure the most accurate documentation of torture.

The aim of the Protocol is to improve documentation of solitary confinement and therefore to clarify the facts of the case so that stronger legal claims can subsequently be submitted to local and international complaints mechanisms. The Protocol has been developed based on a methodology involving a compilation and review of legal and health knowledge on solitary confinement and discussions among the authors and in a group of international experts.

Methods and Results. This Protocol is cognisant of the significance of the specific social, cultural and political contexts in which solitary confinement is used. We hope that this Protocol will assist in the discussions between the various stakeholders and provide guidance on what can be documented and how to document torture.

Keywords: solitary confinement, documentation, psychological torture, Istanbul Protocol

Introduction

Building on the Istanbul Protocol (IP) and experience among the authors, the aim of this

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Protocol is to improve medico-legal documentation of solitary confinement as torture or ill-treatment so that – inter alia – legal claims submitted to courts and complaints mechanisms can be better corroborated by medical evidence. This Protocol focuses on solitary confinement when used in different settings and forms within national criminal justice systems. The Protocol aims at clarifying the facts of solitary confinement from a multidisciplinary perspective so that stronger legal claims can subsequently be submitted to local and international authorities.

Although it can be used as a stand-alone tool, the Protocol should be better viewed as a supplement to the *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. Therefore, some questions related to describing the events might overlap with those of the IP.

Within a criminal justice system, solitary confinement is applied in places of detention from the moment of police arrest and later during pre-trial stages and criminal investigation and/or during imprisonment. Some countries use solitary confinement towards prisoners who await sentencing and the execution of a death sentence. Solitary confinement is also used during administrative immigration detention, typically for the same reasons as within the criminal justice system, and in care institutions such as psychiatric hospitals, juvenile and child protection centres¹. These

latter institutions fall outside the scope of this Protocol, but its recommendations may still be of value when documenting and assessing solitary confinement used in those contexts.

Methodology

This Protocol has been developed based on an interdisciplinary methodology developed by DIGNITY – Danish Institute against Torture, Public Committee Against Torture in Israel (PCATI) and REDRESS involving the following steps: compilation and review of existing legal norms and standards; review of knowledge found in legal and health practice and research regarding forms and effects of solitary confinement; and discussion in a group of international experts.² This follows the same methodology as per the Protocol on Medico-Legal Documentation of Sleep Deprivation (Pérez-Sales et al., 2019) and the Protocol on Medico-Legal Documentation of Threats. This Protocol has not yet been pilot-tested in cases, but the authors encourage the testing of the Protocol in different contexts and would be happy to collaborate on this in the future.

In those cases where the local legislation allows it, further elements should be considered and explored related to (a) specific health effects on children (b) developmental and neurodevelopmental consequences (c) negative consequences in attachment (d) negative consequences of the use of reward/punishment methods as allegedly pedagogical methods. (Gagnon et al., 2022; McCall-smith, 2022; Royal College of Paediatrics and Child Health (RCPCH); Royal College of Psychiatrists; British Medical Association (BMA), 2018; UN General Assembly, 1990)

1 Although both the Convention on the Rights of the Child and the United Nations Rules for the Protection of Juveniles Deprived of their Liberty state that solitary confinement is strictly forbidden, it is used in many jurisdictions as a sanction for misbehaviours or allegedly as part of behaviour modification programs. Quite often solitary confinement is camouflaged in “stay-in-room” and other similar measures of isolation.

2 The method is described in Søndergaard, E., Skilbeck, R., & Shir, E. (2019). Development of interdisciplinary protocols on medico-legal documentation of torture: Sleep deprivation. *Torture Journal*, 29(2), 23–27.

Conceptual, legal and medical/ psychological considerations

(1) Conceptual aspects

The Protocol refers to the following concepts and definitions:

Solitary confinement: Solitary confinement is defined internationally by Rule 44 of the *United Nations Standard Minimum Rules for the Treatment of Prisoners* (Mandela Rules) as: ‘the confinement of prisoners for 22 hours or more a day without meaningful human contact’.³ This refers to the situation in which a detaining authority has imposed a measure on a prisoner who is forced to spend at least a minimum of 22 hours alone (“solitary”) in a cell without any meaningful contact with other prisoners or prison staff. Three central elements in this definition are *confinement*, *duration*, and *the lack of meaningful human contact*:

- **Confinement:** The prisoner is typically placed in a confined space (most often a cell) for solitary confinement. This could be for example in a special wing of the detention facility or in their everyday cell. The conditions of this cell vary greatly from one country to another and even from one detention facility to another, for example in terms of size, ventilation, lighting, furniture, etc. (see the Protocol, section 3). The regime around solitary confinement also varies, for example in terms of access to outdoor space etc.
- **Duration:** It refers to the total time from the beginning to the end of the confinement

and it will be measured in hours, days up to weeks, months and even years in the worst cases. Depending upon the form of solitary confinement there might be a fixed duration of the isolation whereas in other regimes it may be indefinite or open-ended. Note that duration also relates to multiple consecutive or near-consecutive stays in solitary confinement (see the Protocol, section 3).

- **Without meaningful human contact:** Despite its centrality to the international definition of solitary confinement, there is limited guidance in international human rights instruments. The Istanbul Statement on Solitary Confinement and the Essex Expert Group defined it as “the amount and quality of social interaction and psychological stimulation which human beings require for their mental health and well-being” (Istanbul Statement, 2007; Essex Paper 3, 2017).⁴
- **The term “solitary confinement”.** National prison legislation may specifically refer to “solitary confinement”, but such measures may also be referred to under other names such as ‘isolation’, ‘segregation’, ‘ex-

3 Whilst the international definition of solitary confinement is useful for documentation purposes, as described in this Protocol, it remains important to bear in mind that some national and regional frameworks can differ in the definition of solitary confinement. The European Prison Rules (2020) adopts this same definition however (Rule 60.6.a).

4 It is debatable whether double-celling would amount to ‘meaningful human contact’ according to the Mandela Rules. It is instructive to note that the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment of Punishment (CPT) holds its standards on solitary confinement to equally apply to situations where a prisoner is placed together with ‘one or two other prisoners’ (CPT, European Standards, ‘Substantive sections of the CPT’s General Reports’, CPT/Inf/E (2002) 1 - Rev. 2015, p. 29, para. 54). Haney argues that ‘double-celling’ may even exacerbate instead of mitigate the impact of isolation as a prisoner is not only isolated from the general population but also ‘crowded’ in with another person, with whom they may not be compatible. (Haney, Craig, Expert Report in *Ashker v. Governor of California*, Civil Action No. 4:09-cv-05796-CW (N.D. California, 2012, p. 22).

clusion’, ‘separation’, and ‘cellular’. This Protocol uses the two terms “solitary confinement” or “isolation” interchangeably.

• **Typical use of solitary confinement:**

Within a national criminal justice system, solitary confinement is usually imposed by detaining authorities for the following reasons:

1. To preserve evidence in the interests of the criminal investigation
2. Disciplinary reasons (e.g., for punishment for breach of prison rules)
3. Security reasons (e.g., maintaining prison order and security against danger and disruptions); or
4. Preventive or protective reasons (e.g., separating prisoners at risk of harm from or to others which may even be requested by the prisoner him- or herself).

The rationale and legal basis for using solitary confinement in these situations may differ. Solitary confinement may also occur outside the above-mentioned situations, for example, *de facto* solitary confinement in the absence of a formal decision, or as a result of quarantine/isolation during an outbreak of an infectious disease where community standards of care are not being complied with (Cloud DH et al., 2020).

Categories of vulnerable prisoners:

Vulnerability may relate to the risk of more severe reactions to solitary confinement of certain groups of prisoners. The Mandela Rules (Rule 45 (2)) refer to three such groups:

1. *Prisoners with physical or mental disabilities*
2. *Children:* defined as a person under the age of 18.
3. *Women who are pregnant, with infants*

*or breastfeeding*⁵: This refers to women prisoners who are pregnant or who have recently given birth and who are now the main caregiver for their young child (breastfeeding or not).

Vulnerability may also relate to the likelihood of a prisoner being placed in solitary confinement. For example, a detainee with a cognitive impairment may be more likely to not understand prison rules and thus more likely to break them leading to punishment. Socio-cultural factors such as indigeneity have also been recognised as amplifying the risk of death in solitary confinement.⁶

(2) Legal norms

The Mandela Rules, which reflect international consensus around prison management and treatment of inmates, provide for a legal definition of all forms of solitary confinement in which deprivation of “meaningful human contact” for a specific period of time is key.⁷

5 The Bangkok Rules include specific provisions against the use of solitary confinement in women (rules 23 and 24) in order to *avoid causing possible health complications to those who are pregnant or penalizing their children in prison by separating them from their mothers.* (*The Bangkok Rules. United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders with Their Commentary.* A/RES/65/229, 2011)

6 For an example from Australia, see Royal Commission into Aboriginal deaths in custody, Volume 3 [1991] AUROYALC 3,15 April 1991, para. 25.7.12: “The extreme anxiety suffered by Aboriginal prisoners committed to solitary confinement should be recognised.”

7 See for example British Columbia Civil Liberties Association and John Howard Society v. Attorney General of Canada, 2018, B.C.J. No. 53, 2018 BCSC 62, para 61: I am satisfied based on the evidence that the Mandela Rules represent an international consensus of proper principles and practices in the management of prisons and the treatment of those confined.

The legal interpretation of this aspect of the definition and the maximum duration entails that social interactions cannot be limited to those determined by prison routines, the course of (criminal) investigations or medical necessity. Thus, the notion of meaningful excludes situations in which for example 1) prison staff deliver a food tray, mail or medication to the cell door (Essex Paper 3); 2) investigators or legal representatives incidental and limited to their professional duties and routine matters interact with the inmate; and 3) prisoners have means of communication less than direct and personal (such as where prisoners are able to shout at each other through cell walls or communication solely via technological means such as telephones or computers). It is crucial that the contact provides the stimuli necessary for human well-being and this implies an empathetic exchange and sustained, social interaction (Essex Paper 3). Assessments of the level and quality of contact must be made on a case-by-case basis.

The Mandela Rules provide for prohibitions of solitary confinement in cases of indefinite solitary confinement, i.e., without an end date (Rule 43), prolonged periods (Rule 43) and when used towards specifically children, pregnant women or women with infants or breastfeeding and prisoners with mental or physical disabilities ‘when their conditions would be exacerbated by such measures’ (Rule 45(2)).⁸ The last prohibition, which reflects principles stipulated in the United Nations Convention on the Rights of Persons with Disabilities and in the European Prison Rules (Rule 60.6.b), requires

prison staff to consider whether prisoners suffer from any disabilities and if so, whether their conditions would be worsened by isolation. Regarding children, there are specific international regulations that forbid the use of solitary confinement in juveniles (McCall-smith, 2022; UN General Assembly, 1990), with also recommendations by medical and psychiatric international bodies (Gagnon et al., 2022; Royal College of Paediatrics and Child Health (RCPCH); Royal College of Psychiatrists; British Medical Association (BMA), 2018).

Importantly, the Mandela Rules introduce a time limit for all forms of solitary confinement and ban placing prisoners in solitary confinement for longer than 15 consecutive days (Rule 44). The (prison) authorities’ decision becomes unlawful on day 16 when the prisoner should have been released. This also refers to a situation of solitary confinement for shorter periods than 15 days but where the solitary confinement is repeated frequently. This could happen for example if a prisoner is placed in solitary confinement three consecutive times of seven days as the total duration in solitary confinement exceeds 15 days.⁹

Solitary confinement may cause serious harm, amounting to torture or cruel, inhuman and degrading treatment or punishment (CIDTP). The legal assessment in relation to torture needs to be based on the four elements found in the definition of torture (Article 1 (1) UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment

⁸ See case law from Australia, for example *Certain Children by their Litigation Guardian Sister Marie Brigid Arthur v Minister for Families and Children & Others* [No 2] (2017) 52 VR 441, 554.

⁹ It is also CPT’s practice to require an interruption of several days between such periods (CPT, Report on the Visit to Spain in 2011, CPT/Inf (2013) 6, p. 75). See also CPT 21st General Report, CPT/Inf (2011) 28, p. 56: “there should be a prohibition of sequential disciplinary sentences resulting in an uninterrupted period of solitary confinement in excess of the maximum period”.

or Punishment (UNCAT)), i.e., severity of physical or mental pain or suffering, some involvement of authorities, purpose, and intentionality. Three of these elements under the definition emerge to be particularly significant: *purpose*, *intentionality*, and *severity* of physical or mental pain or suffering. If these elements cannot be identified, the measure cannot be considered torture, but may still amount to CIDTP. This is explored below when reviewing jurisprudence. Specifically with regards to solitary confinement, it is important to note that the infliction of mental pain can constitute torture on its own and need not be coupled with physical pain.

CIDTP, as stipulated in article 16 UNCAT, is also absolutely prohibited under binding international law. It presupposes some involvement of a person with official capacity, with the act falling short on one or more of the three other elements of the definition of torture (severity, intention, and purpose). By way of example, if solitary confinement causes severe pain or suffering, but is not intentional or purposeful, it may constitute CIDTP, rather than torture. Similarly, if such an act is purposeful and intentional, but does not cause “severe” pain or suffering it will not amount to torture but to CIDTP.

The nexus between solitary confinement and torture/CIDTP has become well-established in international and regional jurisprudence:

The European Court of Human Rights (ECtHR) has stated that solitary confinement can ultimately destroy the personality of the detainee and his/her social abilities (*Ramirez Sanchez v. France*) and that “solitary confinement without appropriate mental and physical stimulation is likely, in the long-term, to have damaging effects, resulting in deterioration of mental faculties and social abilities” (*A.B. v. Russia*). The ECtHR has ruled on the excessive use of solitary confinement in numerous

cases.¹⁰ The ECtHR has referred to the principle of proportionality in cases when assessing solitary confinement used as disciplinary punishment. By way of example, in *Ramishvili and Kokhreidze v. Georgia*, the applicant who had been sentenced to four years in prison, was placed in solitary confinement as a disciplinary punishment for using a mobile telephone. The court first observed that, amongst the available disciplinary sanctions, the administration chose the most severe one – confinement in a punishment cell. No consideration was given to such facts as, for example, the nature of the applicant’s wrongdoing and the fact that it was his first such breach. The court found this to be CIDTP with reference to the conditions of the punishment cell (insufficient cell space (5.65 sq. m for two prisoners)); no outdoor exercise; no privacy; shared bed; and inadequate sanitary conditions.¹¹

National courts have also recognised that duration is an important factor when assessing solitary confinement.¹²

Both the Inter-American Commission on Human Rights (IACCommHR) and the Inter-American Court on Human Rights (IACtHR) have similarly recognised the profound effects of prolonged isolation and

¹⁰ *Mathew v. the Netherlands*, 24919/03, 29 September 2005; *A.B. v. Russia*, 1439/06, 14 October 2010; *Piechowicz v. Poland*, 20071/07, 17 May 2012; *Gorbulya v. Russia*, 31535/09, 6 March 2014; and *N.T. v. Russia*, 4727/11, 2 June 2020.

¹¹ For criticism of the use of solitary confinement as a disciplinary punishment for possessing a mobile phone in Danish prisons, see Conference Report 2017 (DIGNITY, Copenhagen), on-line at: [conference-report-solitary-confinement.pdf](https://www.dignity.dk/conference-report-solitary-confinement.pdf) (dignity.dk)

¹² *Ashker v. Governor of California*, Civil Action No. 4:09-cv-05796-CW (N.D. California) and the settlement of the case 1 September 2015. See also dissenting Judge Breyer in *Ruiz v. Texas*, 137 S. Ct. 1246, 1247 (2017).

deprivation of communication. The IACoMHR has absolutely and consistently proscribed prolonged and indefinite detention as a “form of cruel, inhuman or degrading treatment under Article 5 of the American Convention on Human Rights”.¹³ The IACtHR ruled that these measures were “in themselves cruel and inhuman treatment, harmful to the psychological and moral integrity of the person and a violation of the right of any detainee to respect for his inherent dignity as a human being”.¹⁴ Over the years, IACtHR has handed down strong condemnations on solitary confinement.¹⁵

The African Commission on Human and Peoples’ Rights (ACHPR) has too had occasion to consider solitary confinement. On one occasion, three political prisoners were held in ‘almost complete solitary confinement, given extremely poor food, inadequate medical care, shackled for long periods of time within their cells and prevented from seeing each other for years’ and it was held that the breadth of this treatment constituted, amongst other things, violations of article 5.¹⁶ In another, the ACHPR found a violation in a case involving a journalist who was detained for 147 days, physically restrained and kept in solitary con-

finement for some periods.¹⁷ It is difficult to discern the legitimate bounds of solitary confinement from the Commission’s conflated reasoning in these cases.

The UN Committee Against Torture (CAT)¹⁸ and the UN Human Rights Committee (HRC)¹⁹ have interpreted their respective binding conventions in the context of solitary confinement.

To avoid harm generally, the use of solitary confinement – when not prohibited according to hard or soft law (see above) – should be limited to exceptional cases as a last resort and for as short a time as possible (Rule 45 (1) Mandela Rules). Thus, authorities are obliged to, first, consider alternative and less restrictive measures and, second, if these are rejected, ensure that the duration of the solitary confinement be as short as possible. The harm caused by solitary confinement was recognised by a trial court in Canada (the British Columbia Supreme Court) that found that “it causes some inmates physical harm and that it places all inmates subject to it in Canada at significant risk of serious psychological harm, including mental pain and suffering, and increased incidence of self-harm and suicide” (Lobel and Smith, 2020).²⁰ The European and

13 Castillo Petruzzi et al. v. Peru, Series C, No. 52, judgement of 30 May 1999.

14 Velázquez-Rodríguez v. Honduras, Series C, No. 4, judgement of 29 July 1988, p. 156.

15 Loayza-Tamayo v. Peru, Series C, No. 33, judgement of 17 September 1997, p. 58; Miguel Castro-Castro Prison v. Peru, Series C, No. 160, judgement of 25 November 2006; Cantoral-Benavides v. Peru, Series C, No. 69, judgement of 18 August 2000, p. 62 and 104.

16 Krishna Achuthan and Amnesty International (on behalf of Aleke Banda and Orton and Vera Chirwa) v. Malawi, African Commission on Human and Peoples’ Rights, No. 64/92, 68/92 and 78/92, judgement of 22 March 1995, p. 7.

17 Media Rights Agenda (on behalf of Niran Malaolu) v. Nigeria, African Commission on Human and Peoples’ Rights, No. 224/98, judgement of 6 November 2000, p. 70 and 72.

18 Bouabdallah Ltaief v. Tunisia, CAT/C/31/D/189/2001, 14 November 2003; Imed Abdelli v. Tunisia, CAT/C/31/D/188/2001, 14 November 2003; CAT, Report of the Inquiry on Turkey, A/48/44/ADD.1, 15 November 1993), p. 52.

19 Daley v. Jamaica, CCPR/C/63/D/750/1997. 3 August 1998; Evans v. Trinidad and Tobago, CCPR/C/77/D/908/2000, 5 May 2003; Yong-Joo Kang v. Republic of South Korea, CCPR/C/78/D/878/1999, 16 July 2003, See also HRC, General Comment 7, Article 7 (1982), p. 2.

20 See British Columbia Civil Liberties Association

Inter-American jurisprudence also require that solitary confinement be used exception-ally²¹ and, even then, proportionately.²²

Additional requirements are stipulated in the Mandela Rules, including strict medical supervision of detainees in solitary confinement: “health care personnel... shall... pay particular attention to the health of prisoners held under any form of involuntary separation, including by visiting such prisoners on a daily basis and providing prompt medical assistance and treatment at the request of such prisoners or prison staff” (Rule 46(1)). The World Medical Association has noted that, “the provision of medical care should take place upon medical need or the request of the prisoner. Physicians should be guaranteed daily access to prisoners in solitary confinement, upon their own initiative” (World Medical Association, 2019).²³

Solitary confinement should take place in cells that meet the minimum conditions ac-

ording to the international standards, e.g., the Mandela Rules. There are further requirements related to solitary confinement imposed as a disciplinary measure, e.g., regarding the right to complain and judicial review (Rules 36 – 53 Mandela Rules).

Specifically with regards to the right to family life (and private communication etc.), as recognised pursuant to e.g., the International Covenant on Civil and Political Rights (ICCPR), the Mandela Rules require that contact with families cannot be prohibited during solitary confinement and punitive limitations of family contact are prohibited, especially with children (Rule 43(3)).²⁴ This means that the prisoners must be allowed to maintain some degree of contact with their family and friends through visits, as well as through adequate and frequent correspondence. However, due to security concerns, the prison authorities are afforded a degree of control over who is admitted for visits (Rule 60) and communication with family and friends can be ‘under necessary supervision’, usually by visual control (Rule 58 (1)). Moreover, while family contact cannot be prohibited, it can however be restricted for ‘a limited time period and as strictly required for the maintenance of security and order’ (Rule 43 (3)) (see ECtHR, *Piechowicz v. Poland*).

States are obligated under international human rights law to treat all persons equally and without discrimination. This is enshrined in several core international instruments in-

and *John Howard Society v. Attorney General of Canada*, 2018, B.C.J. No. 53, 2018 BCSC 62. The case has been appealed to the Supreme Court of Canada.

- 21 Inter-American Commission on Human Rights, Resolution 1/08, *Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas*, 13 March 2008: ‘Solitary confinement shall only be permitted as a disposition of last resort and for a strictly limited time, when it is evident that it is necessary to ensure legitimate interests relating to the institution’s internal security, and to protect fundamental rights, such as the right to life and integrity of persons deprived of liberty or the personnel.’
- 22 *Case of Montero-Aranguren et al. (Detention Center of Catia) v. Venezuela*, Series C No. 150, Judgement of 5 July 2006.
- 23 The IACtHR views independent and autonomous monitoring as to the suitability of an individual to solitary confinement as essential (IACHR, Report on the Human Rights of Persons Deprived of Liberty in the Americas, OEA/Ser.L/V/II. Doc. 64, 31 December 2011, p. 417 and 418.

- 24 Mandela Rules (43 (3)) also provides that “the means of family contact may only be restricted for a limited time period and as strictly required for the maintenance of security and order”. See also ECtHR, *Ilaşcu and others v. Moldova and Russia*, No. 48787/99, 8 July 2004, §438. With regards to women, see also Rule 23 of the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (Bangkok Rules) (2010).

cluding article 2 of the Universal Declaration of Human Rights and article 2(2) of both the ICCPR and the International Covenant on Economic, Social and Cultural Rights. These provisions explicitly prohibit discrimination based on race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status. This is firmly established in the jurisprudence with respect to children,²⁵ LGTB prisoners,²⁶ and prisoners with disabilities.²⁷

(3) Medical/psychological aspects

Solitary confinement has been shown to have serious and often long-lasting effects on mental

health and psychological and social functioning (Grassian, 2006; Craig Haney, 2018; S. Shalev & Lloyd, 2015; Shalev, 2008, 2022; Siennick et al., 2021; The Lancet, 2018). Physical symptoms may also be seen. The consequences described are surprisingly consistent across a wide range of studies, time, types of prisons, categories of detainees, and locations. This overview aims at highlighting some of the most relevant studies, both the earlier or historic ones and more recent studies.

A range of reactions has been described following isolation in detention facilities. Some relate to changes in mood, some reactions are somatic, and others are similar to or indicative of serious mental distress and illness. Across studies there is strong indication that the longer the isolation, the likelier the adverse reactions.

A few lessons learned from studies on sensory deprivation in experimental settings will be included, as solitary confinement in its strictest forms may to some extent resemble sensory deprivation, given the potential for solitary confinement to limit sensory stimulation including to light, sound and touch by other humans. Deprivation of stimuli can be depicted as a continuum, where different forms of stimulation or sensory input are present to varying degrees and intensities.

Consequences of isolation

The well-known but today highly contested experiments on sensory deprivation carried out in the 1950s showed that after only a few days of severely limited sensory inputs (light, sound and touch), the participants in the research, who were volunteers, well-prepared, and able to stop the experiment at any time, reported inability to think clearly, less control over their thinking, and loss of ability to judge time. They also showed temporary mental impairment, lowered concentration, reduced academic per-

25 The UN Committee for the Rights of the Child has consistently and on a number of occasions emphasised that all forms of solitary confinement of children should be abolished: Concluding Observations on El Salvador, CRC/C/15/Add.232, 30 June 2004, p. 36(a); Concluding Observations on Singapore, CRC/C/15/Add.220, 27 October 2003, p. 45(d); General Comment No. 10, CRC/C/GC/10, 25 April 2007, p. 89). The IACtHR has noted that a vast majority of member States have continued to apply solitary confinement as punishment towards children (IACtHR, Rapporteurship on the Rights of the Child, Juvenile Justice and Human Rights in the Americas, OEA/Ser.L/V/II. Doc. 78 (2011), p. 559) and reiterated in the same report the prohibition of 'any state practice that involves solitary confinement of children held in police premises.', p. 263. See also case law from Australia, for example *Certain Children by their Litigation Guardian Sister Marie Brigid Arthur v Minister for Families and Children & Others* [No 2] (2017) 52 VR 441, 554.

26 ECtHR, *X v. Turkey*. The UN Sub-Committee on the Prevention of Torture has also drawn attention to the plight of LGTB prisoners in isolation observing that they were 'not only likely to serve their sentences in isolation, but also more likely to serve longer time.' (SPT, Ninth annual report of the SPT, CAT/C/57/4, 22 March 2016, p. 64.

27 IACtHR, *Victor Rosario Congo v. Ecuador*, Case 11.427, Report No. 12/97, IACtHR, OEA/Ser.L/V/II.95 Doc. 7 rev. at 257, judgement of 12 March 1997.

formance and more restlessness. Some developed hallucinations, anxiety and even panic (Heron, 1957; Leiderman et al., 1958).

Learning may also be drawn from emergent fields of neuro-research that have linked loneliness with among others poorer cognitive performance, faster cognitive decline and depressive cognition (as an example, see Cacioppo & Hawley, 2009). The need for sensory stimulation for human functioning is well documented also in other types of studies. In one randomised clinical trial a group of prisoners was allocated to solitary confinement for seven days and another group to normal treatment. The former group had decreased electroencephalogram activity and visual evoked potentials latency (impacts to electrical activity in the brain and visual pathways), both indicators of neurological dysfunction. Similar findings are seen in sensory deprivation (O'Mara, 2015). Recent neuropsychological studies further indicate that extended solitary confinement can cause brain damage (Akil, 2019), even irreversible ones (Coppola, 2019, Kupers, 2017).

Psychological reactions: Frequently observed psychological reactions in prison studies, even after shorter periods of solitary confinement, are anxiety, fear, feeling low, depression, and concentration problems (Stang et al., 2003). In one study, as many as 91% were found to suffer from anxiety and nervousness, and 70% described themselves "on the verge of an emotional breakdown" (Haney, 2003). Furthermore, 77% were in a state of chronic depression and two-thirds were suffering from more than one symptom at the same time (Haney, 2003; Smith, 2006). Higher levels of aggression and anger, hostility and withdrawal from other people during and after long-term solitary confinement, have also been described (Jackson, 1983; Miller, 1997). Many report feelings of estrangement from self

and others, and experiences of confusion (Perez-Sales, 2017; Sveaass, 2009).

Physical symptoms: In a study on the use of solitary confinement during pre-trial detention, 94% were found to suffer both psychological and psychosomatic adverse symptoms after four weeks (Gamman, 2001; Smith, 2011), and in another study, prisoners in solitary confinement complained about more health problems than those in regular custody, in particular headache, pain in the neck, shoulders and stomach, anxiety and depression (Gamman, 1995). Those with somatic diseases prior to seclusion deteriorated. The complaints lasted throughout the period of seclusion, but most prisoners recovered when seclusion ended. Skin reactions such as itching and rashes have also been observed in people in solitary confinement (Strong et al., 2020), as have apathy, dizziness and loss of weight (Korn, 1988).

Psychiatric disorders: The relation between isolation and psychiatric disorders is complex. During the first few months of detention, isolated detainees with a pre-existing mental health disorder have been found to maintain their level of disorder, whereas non-isolated detainees improved their situation (Andersen et al., 2003).

In one study following prisoners over time, a significantly higher percentage of prisoners in solitary confinement (28 % vs 15%) developed symptoms, the most common being related to adjustment disorders with difficulty in concentrating, insomnia, irritability, depression and sadness, anxiety, anergia and passivity as common symptoms. Typically, a mixture of anxiety, depressive and psychosomatic symptomatology was seen (Andersen et al., 2000). Uncontrolled thought processes and hallucinations have also frequently been described (Jackson, 1983).

In one study, the proportion of detainees suffering from schizophrenia, bipolar disorder,

generalised anxiety disorder, antisocial personality disorder, posttraumatic stress disorder (PTSD) and panic disorder was higher in the isolated prisoners than in the general population of detainees and the non-incarcerated groups (Hodgins et al., 1991). Detainees hospitalised in a psychiatric clinic have had an over-representation of those who had experienced solitary confinement (Volkart et al., 1983), and prisoners kept in solitary confinement for 4 weeks were found 20 times more likely to be admitted on a psychiatric indication compared to those who had not been in any form of solitary confinement (Sestoft et al., 1998).

Suicide and self-harm: Suicide and self-harm are frequently observed among those in solitary confinement. 13 % of one group in solitary confinement were found to engage in self-harming acts (Gamman, 2001), and in another study, those in solitary confinement were almost seven times as likely to self-harm and over six times as likely to potentially fatally self-harm as compared to those not in solitary confinement (Kaba et al, 2014). The risk of suicide has been found to increase considerably when comparing isolated with non-isolated detainees (Roma et al., 2013). Even in the first years after release, those who have been in solitary confinement/punishment cell (one form of isolation) have been found to have a higher mortality (Wildeman and Andersen 2020; Brinkley-Rubinstein et al., 2019).

Factors impacting the effect of solitary confinement

The detrimental effects of solitary confinement may be found in most persons who have endured forms of isolation, but several factors may influence the outcome (Haney, 2003; Shalev, 2008).

These factors include individual aspects like age, gender, prior health condition, cultural background, personality, former stress exposure/trauma, former placement(s) in solitary confinement, as well as preparedness, motivation and background. They also include factors related to the circumstances under which solitary confinement occurs, and aspects such as duration, general conditions in the cell, sensory inputs, mitigating factors like access to radio, television, or newspapers, activities and communication. Furthermore, information or knowledge about duration and the degree of control over the duration is important, and the lack of information about duration may affect the person more than the duration itself. Furthermore, the lack of cues to enable orientation was noted as salient (Ruff et al., 1961). Finally lack of access to services, complaints mechanisms etc., must also be considered factors impacting the effect of solitary confinement.

II. Protocol

This is a generic Protocol to guide the part of an interview that relates to documentation of solitary confinement. As such, this Protocol complements the Istanbul Protocol when specific documentation of solitary confinement is required. However, it is worth noting that ill-treatment and torture are often not based on single individual techniques (which may or may not be damaging if considered one by one) but are the result of the combined interaction of methods. Cumulative effects of the general detention and interrogation context and the various methods used are of importance and should be documented according to the Istanbul Protocol. The same is the case for cumulative effects over time of certain methods including solitary confinement.

The Protocol is designed to be used by lawyers and health professionals during interviews in a detention facility or after release. While some information may be collected by both health and legal professionals (i.e., sections 1-4), two sections of the Protocol require specific qualifications (i.e., sections 5 and 6).

The Istanbul Protocol stipulates a number of important general considerations for documentation interviews, including in relation to security concerns. If the prisoner is still held in detention, it is important to remember the person's precarious situation, assess security concerns and adopt mitigating measures if necessary. The Istanbul Protocol also stipulates general considerations for documentation interviews with particularly vulnerable groups, e.g., children. These considerations should be taken into account also when documenting solitary confinement. Moreover, when interviewing a prisoner who has been subjected to solitary confinement – and perhaps even for a prolonged period of time – it is important to remember measures to avoid triggering adverse reactions.

Interviews with children are particularly difficult. Adaptation of the questions will be required depending on the age of the child, and the child's behaviour, cognition and emotion need to be interpreted in light of its age and development. Interviews with children should therefore only be carried out by interviewers with particular expertise, experience and training so that an adequate assessment can be made of which parts of the protocol to use.

It is presupposed that the interviewer has collected personal information about the person, including age, gender etc. This information will assist in the assessment of whether the person falls within one of the categories in relation to which solitary confinement should not be used according to the Mandela Rules (see above and section 6 below) and which specific considerations need to be taken into account during the interview.

The Protocol contains six sections:

1. Informed consent
2. Subjective experience
3. Conditions and circumstances of the solitary confinement
4. Assessing health and functioning prior to detention *and* to solitary confinement
5. Assessing medical and psychological consequences, and
6. Legal assessment of solitary confinement

Section 1. Informed consent

Informed consent involves making sure that when someone consents to an interview (and to the subsequent use of the information that has been provided), the person is fully informed of and has understood the potential benefits and risks of the proposed course of action. The interviewer should obtain informed consent according to the guidelines mentioned in the Istanbul Protocol (Chapter II).

Section 2. Subjective experience

This section includes questions to be asked during the interview in order to obtain the person's description of his/her experience of solitary confinement. The answers should be collected as verbatim as possible. It presupposes that first, the interviewer asks the person to confirm that s/he has been held in a cell or other place without contact with others for a certain length of time (solitary confinement).

If this is the case, follow-up questions should be asked. The following questions may serve as inspiration, but other topics of relevance may arise during the interview.

- Why do you think you were held in solitary confinement?
- *What do you remember from the period you spent in solitary confinement?* Include additional questions about what the person saw, heard, felt, smelled, or thoughts he/she had.
- *How do you think the solitary confinement affected you when it happened and immediately afterwards?*
- If some time has passed since the person was released from solitary confinement: *Does it still affect you today? If yes, can you explain how?*

Section 3. Circumstances and conditions of solitary confinement

With a view to supplement what has already been described in the previous section, this section presents questions that can be asked during the interview to obtain an account of what happened as objectively and concretely as possible. Note that there may be some gaps in the information, but the interview should aim at collecting the facts in as detailed a manner as possible.

- a. The events leading up to the solitary confinement
 - *How were you moved into solitary confinement?*
 - *What was the process leading up to the solitary confinement?* (e.g., if solitary confinement was a disciplinary sanction)
 - *What information were you given and when?* (e.g., about the reason for solitary confinement, expected duration, regime, complaint options, reviews and medical visits)
 - *Do you have any pre-existing health conditions that might affect you during solitary confinement, and if so, were the detaining authorities aware of those, and did they take them into account?* (e.g., claustrophobia, anxiety, depression)
- b. Duration
 - *How many days/weeks/months/years have you been in solitary confinement in total?*

- *Was this one consecutive period, did you have any breaks from the solitary confinement during this time, or did you have multiple stays in solitary confinement? (i.e., a description of length of different stays and breaks)*
- c. Contact with others during solitary confinement
- *Who were you in contact with during your time in solitary confinement?*
 - *How often were you in contact with these people, and for how long?*
 - *What was the purpose of this contact? (e.g., bringing person to the bathroom, serving food, check-in by staff, visits from outside)*
 - *How were you in contact with these people? (e.g., by phone, through door, visit in the cell, access to others outside of cell)*
 - *What was the purpose of the different types of contact you had?*
 - *Did you get a chance to speak with them, were they silent all the time, or were you expected to keep silent?*
- d. Conditions under which the solitary confinement took place
- Try to collect as much information as possible about the room in which the solitary confinement took place and about the general conditions during solitary confinement. This may include:
- *Size and condition of the room*
 - *Type and condition of bed and other furniture*
 - *Access to outdoor air and light in the room (presence and size of windows, doors, ventilation openings)*
 - *Artificial light and switches*
 - *Temperature, dampness and air quality*
 - *Sounds – noise – silence, incl. changes during the day*
 - *Possibilities to indicate time, e.g., clock, watch, prayer calls*
 - *Level of cleanliness including presence of dirt, mould, insects or other animals*
 - *Access to clothes, footwear, covers/blankets*
 - *Access to food, water, and toilet facilities (how often, time between, on demand?)*
 - *Access to warning button/alarm or other means to notify staff in case of need*
 - *Use of restraints (when, which types)*
 - *Access to reading materials, radio, TV, or other activities in the room*
 - *Access to work, open air exercise or other activities outside of the room (what, how often, for how long?)*
- e. Contact with health professionals during solitary confinement
- *Did you receive unsolicited visits by a health professional during solitary confinement?*
 - *If yes, how often did these visits happen? How long did the visits take, and what did the health professional do? Were you able to speak to the health professional in private?*
 - *Did you yourself request to see a doctor or other health professional during the solitary confinement, and was your request granted?*
- f. Access to legal safeguards during solitary confinement
- *Were you able to file a complaint about being placed in solitary confinement or the conditions of the confinement?*
 - *Did you have access to free legal aid or to see a lawyer?*
 - *Did regular reviews of the decision to place you in solitary confinement take place, and did you get a chance to be heard during these reviews? How often did these reviews happen?*

Section 4. Assessing health and functioning prior to detention and solitary confinement

This section is intended to gain information about the person's health status and functioning prior to detention and to solitary confinement. This serves three main purposes:

- Identifying any pre-existing conditions may help when arguing that the person should not have been placed in solitary confinement due to particular vulnerabilities.
- Comparing the person's health status pre and post solitary confinement may assist in assessing the impact that the isolation may have had.
- Determining in court proceedings whether the plaintiff has the burden of proof (see section 6).

Before asking the below questions, the interview should clarify whether previously, the person has spent time in solitary confinement as well as reactions experienced. For each instance, information should be collected about when, where and under which conditions.

Please collect the answers as verbatim as possible.

1. Physical and mental health related problems prior to detention and prior to experiencing solitary confinement (*preferably to be asked by a health professional*).
2. If the person has spent time in detention prior to solitary confinement, ask also about physical and mental health related problems prior to solitary confinement (*preferably to be asked by a health professional*).
3. General level of functioning prior to detention. Issues may include living conditions, educational background, work and other forms of daily activities, financial situation, family situation, plans and aims.
4. If the person has spent time in detention prior to solitary confinement, ask also about the level of functioning in detention prior to be placed in solitary confinement. Issues may include relations to other detainees and staff, and work or other activities.

Section 5. Assessing physical and psychological consequences

This section of the Protocol should be used either by a medical or psychological expert. The following questions serve as inspiration as to what would be relevant to ask to assess physical and psychological consequences, bearing in mind that the specifics of the person and the situation in which the interview takes place should always be taken into account. Please provide a detailed description of the person's responses.

If an interviewer without medical or psychological expertise is not available, and taking into account the experience of the interviewer, the first four questions below might still be asked, but caution should be exercised to avoid intimidating the person interviewed.

- *Did you experience any physical symptoms while being in solitary confinement (e.g., pain, sleeping problems, nausea, dizziness, bodily tension)? Please describe in detail.*
- *Did you experience any mental health problems while being in solitary confinement? Please describe in detail.*
- *Have you ever required medical or psychological treatment for these problems?*
- *Do you currently experience any mental health or social problems that you attribute to having been in solitary confinement?*

Further details about the person's reactions to solitary confinement can be collected using the below two checklists and the additional questions related to the person's interaction with others. The elements of the checklists and the questions are designed to be used after solitary confinement has been terminated. They may also serve as inspiration while interviewing someone who is still in solitary confinement, but the precarious situation and the mental state of the person needs to be taken into account when deciding on the level of detail of the questions asked.

1: Checklist of cognitive symptoms:

This checklist assesses the person's cognitive symptoms during solitary confinement and afterwards.²⁸ When asking questions, please seek details of any of the below items (e.g., circumstances, symptoms, subjective experience or whatever can help to understand the item).

Table 1. Checklist of cognitive symptoms:

	Did any of these symptoms occur while in solitary confinement, and how often?	What was the situation after solitary confinement?
	1. Never 2. Sometimes 3. Often 4. All the time	1. Not applicable 2. Improved 3. Unchanged 4. Worsened
1. Did you ever lose consciousness ? If yes: Reasons for losing consciousness: (a) Beatings to the head or other head trauma (b) Suffocation/asphyxia (c) Emotional fainting due to anxiety or fear (d) Other forms of pain (e) Other		
2. Orientation. Were you able to say more or less how much time you had been detained in solitary confinement?		
3. Orientation. Did you usually know, approximately, the time of the day? (morning, afternoon, evening or night)		
4. Awareness. Did you feel sleepy most of the day?		

²⁸ Items selected and adapted from MOCA and Brief Neuropsychological Assessment questionnaires to a context of detention and solitary confinement.

<p>5. Concentration and Memory. Did you ever notice that you could not remember basic information about yourself (e.g., the name of very close family members, details from your childhood)?</p>		
<p>6. Concentration and Memory. Did it happen that you were not able to understand even simple questions from others?</p>		
<p>7. Concentration and Memory. Were you able to recall, immediately after having been in solitary confinement, how your cell was (do not use if the person was blindfolded)?</p>		
<p>8. Concentration and Memory. Did you notice any difficulties in concentrating on tasks or activities you were engaged in?</p>		
<p>9. Perception. Did you perceive your surroundings altered (e.g., walls, ceiling as moving or as falling upon you)?</p>		
<p>10. Perception. Did you hear voices or see figures outside your head and later you realised that they were unreal?</p>		
<p>11. Judgement. Did you experience any situation where you tried to talk but found it difficult to find the right words and/or you felt blocked?</p>		
<p>12. Judgement. Were your legal rights explained to you, but you were not able to understand the contents of the conversation?</p>		
<p>13. Judgement. Were you presented with documents (e.g., confession, statement, etc.) that you were not able to understand?</p>		
<p>14. Subjective Self-Assessment. Do you think you were fit to make decisions of any kind?</p>		

2: Checklist of emotional symptoms:

This checklist assesses the emotions during solitary confinement and afterwards.²⁹

Questions related to the person's interactions with others:

- *After having been in solitary confinement, have you experienced any changes in your desire to be with others?* (e.g., wanting more or less contact, withdrawing from others or avoiding others altogether)
- *Do you experience any problems when being with others?* (e.g., concentration problems, lack of trust, disturbing thoughts, disturbing emotions (e.g., anger or disappointment), or psychosomatic reactions (e.g., sweating, dry mouth, shaking, or dizziness))
- *Do you feel that being with others can help you?*
- *Is there a difference in your reactions depending on who you are with?* (e.g., family, friends, colleagues)
- *Do you feel that your reactions to being with others make things difficult for you?* (e.g., influences how the person fulfils his/her role in the family or the ability to work or study)

²⁹ Items selected and adapted from the Positive and Negative Affect Schedule (PANAS) and Profile of Mood States (POMS) to a context of detention and solitary confinement.

Table 2. Checklist of emotional symptoms.

	Did any of these emotions occur while in solitary confinement, and how often?	What was the situation after solitary confinement?
	1. Never 2. Sometimes 3. Often 4. All the time	1. Not applicable 2. Improved 3. Unchanged 4. Worsened
Emotions, Feelings and Somatisation		
1. Sadness		
2. Anger (at yourself or others)		
3. Terror, Fear		
4. Anxiety including problems breathing, or panic attacks		
5. Pain without apparent reason (e.g., stomach-ache, headaches or other reactions)		

Acting emotions		
6. Self-Harm. Urge to harm yourself (e.g., cutting or hitting)		
7. Suicide ideation. Thoughts about taking your own life		
8. Suicide plans or actions. You had a defined plan or even tried to kill yourself		
9. Apathy. Feeling abandoned and without hope		
Secondary Emotions – Emotions related to others		
10. Shame. Intense humiliation or degradation		
11. Guilt. Self-accusation or intense remorse		
Detaching emotions		
12. Dissociation. Feeling that everything was unreal. Dazed, as if everything did not really happen to you.		
Positive Emotions		
13. Control. Calm, feeling in charge		
14. Happiness. Moments of joy despite everything		

Further assessments:

Annex A includes a selection of clinical scales that may be used for the full assessment of the person as per the Istanbul Protocol. These scales may be used also *in relation to solitary confinement*. For instance, if the PCL-C-V is used to assess symptoms of post-traumatic stress disorder, explain to the person that each item (flashbacks, avoidance behaviours, intruding thoughts) should be considered in relation to solitary confinement (i.e., flashbacks or recurrent thoughts on the time in solitary confinement, avoidance of being alone etc). When doing the assessment, use the most recent and validated versions of the clinical scales available.

Conclusion:

You should end your assessment with summarizing the findings, if possible using the ICD or DSM diagnostic systems.

Section 6. Legal assessment of solitary confinement

This section of the Protocol should be used by a legal professional. Try during the interview to seek the below mentioned information that will be useful for the legal assessment of the case.

When assessing the measure in light of international law, there are different questions to be considered:

- What type of solitary confinement was imposed in the specific case and why?
- Did the person belong to one of the vulnerable groups who should not be subjected to solitary confinement according to the Mandela Rules?

- Did the measure violate other principles of the Mandela Rules?
- E.g., was the measure in violation of an absolute prohibition?
- Did the measure amount to torture or ill-treatment (Articles 1 or 16 UNCAT)?
- Did solitary confinement violate other human rights norms? This legal assessment would relate to, *inter alia*, freedom from non-discrimination i.e., whether the instance was imposed discriminatorily.

At a procedural level, it is worth remembering that the general rule across jurisdictions is that the plaintiff has the obligation to prove his claims. However, if the plaintiff can document good health when detained whereas this was no longer the case when released, then the burden of proof may change to the defending state, as it happens in European jurisprudence (ECtHR, *Ribitsch v Austria*). If you have managed to collect information about the person's health prior to detention and to solitary confinement (see above), this may prove of relevance for procedural questions.

Interpreting and using medical and psychological assessment results

In light of the above legal discussion, it is likely that argumentation could be supported by assessments undertaken by health professionals.

When assessing the outcomes of such assessments, guidance can be sought in the Istanbul Protocol and the following questions should be raised:

- Do the findings suggest that solitary confinement has led to physical and/or mental health problems?
- May pre-existing mental health problems have increased the risk of exacerbating mental health problems while in solitary confinement?
- May pre-existing mental health problems have led to solitary confinement?

Annex 1. Solitary Confinement. Quick Interviewing Guide.

Quick interviewing guide.

1. Ask openly about the alleged victim's **subjective experience** of solitary confinement. Collect answers as verbatim as possible.

- Why were you held in solitary confinement?
- What do you remember from the time spent in solitary confinement?
- How did it affect you when it happened and immediately afterwards?
- Does it still affect you today? If yes, how?

2. **Circumstances and conditions.**

- What were the events leading up to solitary confinement?
- How much time did you spend in solitary confinement? One or several episodes?
- Who were you in contact with during the time in solitary confinement, how; how often; and for what purpose?
- How were the conditions under which solitary confinement took place, e.g. conditions of the cell and access to a toilet; use of restraints; access to work and activities?
- Did you have access to a health professional?
- Did you have access to a lawyer and was the decision of solitary confinement reviewed regularly?
- Were you able to file a complaint?

3. **Health and functioning prior to detention and solitary confinement.** This section serves to:

- Identify pre-existing health-conditions that indicate particular vulnerabilities
- compare health status pre and post solitary confinement
- determine whether the plaintiff has the burden of proof

Collect information about:

- Previous solitary confinement and reactions
- Physical and mental health related problems prior to detention
- Physical and mental health problems prior to solitary confinement
- General level of functioning prior to detention, incl. living conditions; financial situation; family situation; plans and aims
- Level of functioning while in detention but prior to solitary confinement, incl. relation to other detainees and staff; work and other activities

4. Physical and psychological consequences of solitary confinement.

- Did you experience any physical symptoms while being in solitary confinement?
- Did you experience any mental health problems while being in solitary confinement?
- Have you ever required medical or psychological treatment for these problems?
- Do you currently experience any mental health or social problems that you attribute to having been in solitary confinement?
- In addition to these questions, checklists to explore in depth potential cognitive and emotional reactions can be used by health professionals.

5. Legal assessment (not part of the interview):

- What type of solitary confinement was imposed?
- Did the person belong to a vulnerable group who should not be subjected to solitary confinement?
- Did the measure violate other principles of the Mandela Rules?
- Did the measure amount to torture or ill-treatment?
- Were other human rights norms violated?
- How does the medical/psychological assessment contribute to conclusions?

Annex 2. Additional questionnaires

This Protocol can be complemented with the following assessment tools. Some of these are referenced in the Protocol, others included for information.

Posttraumatic Stress Disorder (PTSD): The Posttraumatic Checklist Civilian Version 5 (PCL-C-5), a 20-item questionnaire that provides a diagnosis of PTSD according to DSM-V Criteria. There are also short screening versions available. The International Trauma Questionnaire is a 12-item measure that provides diagnoses of PTSD and Complex PTSD according to ICD-11. The Dissociative Experiences Scale (DES-II) provides a measure of states of dissociation. Can be tailored to reaction within detention periods.

Daily Functioning: Consider measures that assess the autonomy of the person after release from detention (e.g., work, study, community and family life).

Montreal Cognitive Assessment (MOCA). 30 items assessing neurocognitive functioning. Administration takes around 15'. Ziad S. Nasreddine MD, et al, The Montreal Cognitive

Assessment, MoCA: A Brief Screening Tool For Mild Cognitive Impairment, *Journal of the American Geriatric Society*, 30 March 2005.

Brief Neuropsychological Assessment – Mini Mental State Examination. 30 items measure that screen for cognitive impairment linked to medical conditions. Folstein MF, Folstein SE, McHugh PR. “Mini-mental state”: a practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res.* 1975;12:189-19.

Positive and Negative Affect Schedule (PANAS). Short scale that consists of two 10-item mood scales to measure emotional reactions to a given situation. D. Watson, L.A. Clark, and A. Tellegen (1988). Development and Validation of Brief Measures of Positive and Negative Affect: The PANAS Scales. *Journal of Personality and Social Psychology*, 54, 1063-1070.

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

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

MQPL+: Measuring the Quality of Prison Life (MQPL) and Staff Quality of Life (SQL). Liebling, A., Hulley, S. and Crewe, B. (2011), ‘Conceptualising and Measuring the Quality of Prison Life’, in Gadd, D., Karstedt, S. and Messner, S. (eds.) *The Sage Handbook of Criminological Research Methods*. London: Sage

Beck Depression Inventory: Yuan-Pang Wang and Clarice Gorenstein (2013). Psychometric properties of the Beck Depression Inventory-II: a comprehensive review. *Brazilian Journal of Psychiatry*, vol.35 no.4, <http://dx.doi.org/10.1590/1516-4446-2012-1048>

The Mini-International Neuropsychiatric Interview. (M.I.N.I.) is a short structured diagnostic interview, developed jointly by psychiatrists and clinicians in the United States and Europe, for DSM-IV and ICD-10 psychiatric disorders. (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10 DV Sheehan , Y Lecrubier, K H Sheehan, P Amorim, J Janavs, E Weiller, T Hergueta, R Baker, G C Dunbar. *J Clin Psychiatry* 1998;59 Suppl 20:22-33; quiz 34-57.

References

- Akil, H. (2019). The Brain in Isolation: A Neuroscientist's Perspective on Solitary Confinement'. In Jules Lobel, and Peter Scharff Smith (eds), *Solitary Confinement: Effects, Practices, and Pathways toward Reform*. New York, 2019; online edn, Oxford Academic, 19 Dec. 2019. <https://doi.org/10.1093/oso/9780190947927.003.0012>
- African Commission on Human and Peoples' Rights, Krishna Achuthan and Amnesty International (on behalf of Aleke Banda and Orton and Vera Chirwa) v. Malawi, No. 64/92, 68/92 and 78/92, judgement of 22 March 1995.
- African Commission on Human and Peoples' Rights, Media Rights Agenda (on behalf of Niran Malaolu) v. Nigeria, No. 224/98, judgement of 6 November 2000.
- Bottom of Form
- Andersen, H.S., Sestoft, D., Lillebaek, T., Gabrielsen, G., Hemmingsen, R., & Kramp, P. (2000). A longitudinal study of prisoners on remand: psychiatric prevalence, incidence and psychopathology in solitary vs. non-solitary confinement. *Acta Psychiatr Scand.*, Jul 102(1), 19–25.
- Andersen, H.S. et al. (2003). A longitudinal study of prisoners on remand: repeated measures of psychopathology in the initial phase of solitary versus non-solitary confinement. *International Journal of Law and Psychiatry*, 26, 165–177.
- Ashker v. Governor of California, Civil Action No. 4:09-cv-05796-CW (N.D. California), settlement of the case (1 September 2015).
- Brinkley-Rubinstein, L., Sivaraman, J., Rosen, D.L., Cloud, D.H., Junker, G., Proescholdbell, S., Shanahan, M.E. & Ranapurwala, S.I. (2019). Association of Restrictive Housing During Incarceration With Mortality After Release. *JAMA Network Open*, 2(10).
- British Columbia Civil Liberties Association and John Howard Society v. Attorney General of Canada, (2018), B.C.J. No. 53, 2018 BCSC 62.
- Bronwyn, N. & Shalev, S. (2022), Solitary Confinement and the Meaning of “Meaningful Human Contract”, Chapter 10, Herrera, C.B and Haeck, Y (eds), *Human Rights Behind Bars: Tracing Vulnerability in Prison Populations Across Continents from a Multidisciplinary Perspective*, Springer Cham.
- Cacioppo J.T. & Hawley L.C. (2009). *Perceived Social Isolation and Cognition*. *Trends Cogn Sci*. 2009 Oct; 13(10): 447–454.
- Certain Children by their Litigation Guardian Sister Marie Brigid Arthur v Minister for Families and Children & Others [No 2] (2017) 52 VR.
- Cloud, D.H., Ahalt, C., Augustine, D., Sears, D., & Williams, B. (2020). Medical Isolation and Solitary Confinement: Balancing Health and Humanity in US Jails and Prisons During COVID-19. *J Gen Intern Med*; 35: 2738–2742.
- Coppola, F. (2019). The brain in solitude: an (other) eighth amendment challenge to solitary confinement. *Journal of Law and the Biosciences*, 1–42 doi:10.1093/jlb/lasz014 Advance Access Publication.
- DIGNITY – Danish Institut against Torture, Conference Report 2017 Solitary Confinement used as a Disciplinary Measure
- European Committee on the Prevention of Torture. (2011). Standards: Solitary Confinement of Prisoners.
- European Committee on the Prevention of Torture. (2011). Report on the Visit to Spain, CPT/Inf (2013)/6.
- European Committee on the Prevention of Torture. (2011). 21st General Report, CPT/Inf (2011).
- European Committee on the Prevention of Torture. (2015). General Reports, CPT/Inf/E, 1 - Rev. 2015.
- ECtHR. (2005). *Ribitsch v Austria*, 18896/91
- ECtHR. (2006). *Ramirez Sanchez v. France*, 59450/00
- ECtHR. (2005). *Mathew v. the Netherlands*, 24919/03
- ECHR. (2010). *A.B. v. Russia*, 1439/06
- ECHR. (1997). *Raninen v. Finland*. 20972/92
- ECHR. (1999). *Selmouni v. France*. 25803/94
- ECtHR. (2004). *Ilaşcu and others v. Moldova and Russia*, No. 48787/99
- ECtHR. (2009). *Ramishvili and Kokhreizde v. Georgia*, 1704/06
- ECtHR. (2011). *Payet v. France*, 19606/08
- ECtHR. (2012). *Piechowicz v. Poland*, 20071/07
- ECtHR (2014). *Gorbulya v. Russia*, 31535/09
- ECtHR. (2020). *N.T. v. Russia*, 4727/11
- European Prison Rules (2020), Recommendation Rec(2006)2, revised and amended by the Committee of Ministers of the Council of Europe on 1 July 2020.
- Gagnon, J. C., Kern, L., & Mathur, S. R. (2022). The Council for Exceptional Children, Division of Emotional and Behavioral Health's Position Statement on Solitary Confinement. *Behavioral Disorders*, 47(4), 282–291. <https://doi.org/10.1177/01987429211063625>
- Gamman, T. (1995). Solitary Confinement and Influence on Inmates Health. *Tidsskr Nor Lægeforen*. 1995: 2243–6.
- Gamman, T. (2001). Om bruk av isolasjon under varetektsfengsling. *Nordisk Tidsskrift for*

- Kriminalvidenskab* 2001: 88.
- Gendreau, P. et al. (1972). Changes in EEG Alpha Frequency and Evoked Response Latency During Solitary Confinement. *Journal of Abnormal Psychology*, 79 (1): 54-59.
- Grassian, S. (2006). Psychiatric effects of solitary confinement. *Journal of Law and Policy*, 22(617), 325-383.
- Haney, C. (2003). Mental Health Issues in Long-Term Solitary and "Supermax" Confinement. *Crime Delinquency*, Vol. 49 (1): 124-156.
- Haney, C. (2012). Expert Report in Ashker v. Governor of California, Civil Action No. 4:09-cv-05796-CW (N.D. California).
- Haney, C. (2018). The Psychological Effects of Solitary Confinement: A Systematic Critique. *Crime and Justice*, 47(1): 365-416. <https://doi.org/10.1086/696041>
- Hebb, D. (1961). Introduction to Chapter 2, Cognitive and Physiological Effects of Perceptual Isolation. In Ph. Solomon et al. (eds). *Sensory Deprivation. An investigation of Phenomena Suggesting a Revised Concept of the Individual's response to His Environment*, pp. 6-33. Cambridge: Harvard University Press.
- Heron, W. (1957). The pathology of boredom. *Scientific American*, Vol. 196: 52-56.
- Heron, W. (1961). Cognitive and Physiological Effects of Perceptual Isolation. In Ph. Solomon et al. (eds). *Sensory Deprivation*, pp. 6 - 33. Cambridge: Harvard University Press.
- Hodgins, S. & Cote, G. (1991). The mental health of penitentiary inmates in isolation. *Can J Criminol*. 33(Apr 91):175-182.
- Inter-American Commission on Human Rights, Resolution 1/08, Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas, 13 March 2008.
- Inter-American Court on Human Rights, Velázquez-Rodríguez v. Honduras, Series C, No. 4, , judgement of 29 July 1988.
- Inter-American Court on Human Rights, Victor Rosario Congo v. Ecuador, Case 11.427, judgement of 12 March 1997.
- Inter-American Court on Human Rights, Loayza-Tamayo v. Peru, Series C, No. 33, judgement 17 September 1997.
- Inter-American Court on Human Rights, Castillo Petruzzi et al. v. Peru, Series C, No. 52, judgement of 30 May 1999.
- Inter-American Court on Human Rights, Cantoral-Benavides v. Peru, Series C, No. 69, 18 August 2000.
- Inter-American Court on Human Rights, Miguel Castro-Castro Prison v. Peru, Series C, No. 160, judgement of 25 November 2006
- Inter-American Court on Human Rights, Montero-Aranguren et al. (Detention Center of Catia) v. Venezuela, Series C No. 150, Judgement of 5 July 2006
- Inter-American Court on Human Rights, Report on the Human Rights of Persons Deprived of Liberty in the Americas, OEA/Ser.LV/II. Doc. 64, 31 December 2011.
- The Istanbul Statement on the Use and Effects of Solitary Confinement (2007).
- Jackson, M. (1983). *Prisoners of Isolation: Solitary Confinement in Canada*. Toronto: Toronto University Press.
- Kaba, F., Lewis, A., Glowa-Kollisch, S., Hadler, J., Lee, D., Alper, H., et al (1972). Solitary Confinement and Risk of Self-Harm Among Jail Inmates. *American Journal of Public Health* | March 2014, Vol 104 (3).
- Korn, R. (1988). The Effects of Confinement in the High Security Unit at Lexington. *Social Justice* Vol. 15, No. 1 (31), Struggles for Justice (Spring 1988), pp. 8-19, <https://www.jstor.org/stable/29766384>.
- Kupers, T. A. (2017). *Solitary*. University of California Press.
- Leiderman, P.H., Mendelson, J., Wexler, D., & Solomon, P. (1958). Sensory deprivation: Clinical aspects. *AMA Arch Intern Med*. 1958;101(2):389-396, doi:10.1001/archinte.1958.00260140221032.
- Lobel, J. & Smith, P.S. (eds.) (2020). *Solitary Confinement, Effects, Practices, and Pathways towards Reform*, Oxford University Press.
- McCall-Smith, K. (2022). *Solitary Confinement, Torture and Children: Applicable minimum standards*. University of Edinburgh.
- Mc Coy, A.W. (2008). Legacy of a Dark Decade: CIA Mind Control, Classified Behavioral Research, and the Origins of Modern Medical Ethics. In A.E. Ojeda (ed). *The Trauma of Psychological Torture*, pp 40-70. London: Praeger.
- Miller, H.A., & Young, G.R. (1997). Prison segregation: administrative detention remedy or mental health problem? *Crim Behav Ment Health*. 7(1):85-94.
- O'Mara, S. (2015). *Why torture doesn't work: The neuroscience of interrogation*. Harvard University Press.
- Perez-Sales, P. (2017), *Psychological Torture. Definition, evaluation and measurement*. New York: Routledge.
- Pérez-Sales, P., Søndergaard, E., Shir, E., Cakal, E., & Brasholt, M. (2019). Protocol on Medico-Legal Documentation of Sleep Deprivation. *Torture Journal*, 29(2), 28-55.

- Penal Reform International and Essex Human Rights Centre, Essex paper 3: Initial guidance on the interpretation and implementation of the UN Nelson Mandela Rules (2017).
- Roma, P., Pompili, M., Lester, D., Girardi, P., & Ferracuti, S. (2013) Incremental conditions of isolation as a predictor of suicide in prisoners. *Forensic Sci Int.* (2013 Dec 10);233(1):e1-2.
- Royal College of Paediatrics and Child Health (RCPCH);Royal College of Psychiatrists;British Medical Association (BMA). (2018). *Joint position statement on solitary confinement of children and young people.* https://www.rcpch.ac.uk/sites/default/files/2018-04/solitary_confinement_position_statement.pdf
- Royal Commission into Aboriginal deaths in custody. (1991). Volume 3 AURoyalC 3, 15 April 1991.
- Ruff, G.E., Levy, E.Z. & Thaler, V.H. (1961). Factors Influencing the Reaction to Reduced Sensory Output. In Ph. Solomon et al. (eds). *Sensory Deprivation. An investigation of Phenomena Suggesting a Revised Concept of the Individual's response to His Environment*, pp. 72-91. Cambridge: Harvard University Press.
- Ruiz v. Texas, 137 S. Ct. 1246, 1247 (2017).
- Sestoft D.M., Andersen H.S., Lillebaek T, Gabrielsen G (1998). Impact of solitary confinement on hospitalization among Danish prisoners in custody. *Int J Law Psychiatry*, Winter 1998;21(1):99-108. doi: 10.1016/s0160-2527(97)00025-3.
- Shalev, S. (2008). *A sourcebook on solitary confinement.* Mannheim Centre for Criminology. London School of Economics and Political Science.
- Shalev, S. (2022). 30 years of solitary confinement : What has changed, and what still needs to happen. *Torture*, 32(1-2), 148-162.
- Shalev, S., & Lloyd, M. (2015). Detention: Solitary Confinement. *Encyclopedia of Forensic and Legal Medicine: Second Edition, November 2017*, 248-255. <https://doi.org/10.1016/B978-0-12-800034-2.00139-7>
- Siennick, S. E., Picon, M., Brown, J. M., & Mears, D. P. (2021). Revisiting and Unpacking the Mental Illness and Solitary Confinement Relationship. *Justice Quarterly*, 39. 1-30. <https://doi.org/10.1080/07418825.2020.1871501>
- Smith, P.S. (2006). The Effects of Solitary Confinement on Prison Inmates: A brief history and review of literature. *Crime and Justice*, vol. 34, 441-528.
- Smith, P.S. & Koch, I. (2019). Isolationens følgerknninger – fra 1800-tallet til i dag. In M. Rus & P.S. Smith (2019). *Isolasjon – et fengsel i fengslet*. Pp. 109 – 139. Copenhagen: Cappelen Damm Akademisk.
- Stang, J., Moe, J, Teigst, I.A., Østberg, B., & Moger, T. (2003). Fanger i sikkerhetscelle – en utfordring. *Tidsskr Nor Lægeforen* nr. 13-14, 2003; 123: pp. 1844-6.
- Stang, J. & Østberg, B. (2006). Innsattes forslag til å forebygge isolasjon i sikkerhetscelle. *Tidsskrift for Norsk psykologforening*, Vol 43, nummer 1, 2006, pp. 30-33.
- Strong, J.D., Reiter, K., Gonzalez, G., Tublitz, R., Augustine, D., Barragan, M., et al. (2020) The body in isolation: The physical health impacts of incarceration in solitary confinement. *PLoS ONE* 15 (10): e0238510. <https://doi.org/10.1371/journal.pone.0238510>.
- Sveaass, N. (2009). Torture – a Crime against Humanity. In A. Lothe, M. Daniel, M.B. Snipstad & N. Sveaass (eds). *Strength in Broken Places. Marginalisation and Empowerment*, pp. 179-197, Oslo.
- Søndergaard, E., Skilbeck, R., & Shir, E. (2019). Development of interdisciplinary protocols on medico-legal documentation of torture: Sleep deprivation. *Torture Journal*, 29(2), pp. 23-27.
- The Bangkok Rules. United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders with their Commentary.* A/RES/65/229, 1 (2011) (testimony of UNODC). https://www.unodc.org/documents/justice-and-prison-reform/Bangkok_Rules_ENG_22032015.pdf
- The Lancet. (2018). Solitary confinement of children and young people. *The Lancet*, 391(10131), 1638. [https://doi.org/10.1016/s0140-6736\(18\)30943-7](https://doi.org/10.1016/s0140-6736(18)30943-7)
- UN General Assembly. (1990). United Nations Rules for the Protection of Juveniles Deprived of their Liberty. In *Resolution 45/113*. <https://doi.org/10.18356/9789210582872c010>
- United Nations Committee against Torture, Bouabdallah Ltaief v. Tunisia, CAT/C/31/D/189/2001, 14 November 2003.
- United Nations Committee against Torture, Imed Abdelli v. Tunisia, CAT/C/31/D/188/2001, 14 November 2003.
- United Nations Committee against Torture, Report of the Inquiry on Turkey, A/48/44/ADD.1, 15 November 1993.
- United Nations Committee on Human Rights, Daley v. Jamaica, CCPR/C/63/D/750/1997. 3 August 1998
- United Nations Committee on Human Rights, Evans v. Trinidad and Tobago, CCPR/C/77/D/908/2000, 5 May 2003
- United Nations Committee on Human Rights, Yong-Joo Kang v. Republic of South Korea, CCPR/

- C/78/D/878/1999, 16 July 2003.
- United Nations Committee on Human Rights, General Comment 7, Article 7 (1982).
- United Nations Committee for the Rights of the Child, Concluding Observations on El Salvador, CRC/C/15/Add.232, 30 June 2004.
- United Nations Committee for the Rights of the Child, Concluding Observations on Singapore, CRC/C/15/Add.220, 27 October 2003.
- United Nations Committee for the Rights of the Child, General Comment No. 10, CRC/C/GC/10, 25 April 2007.
- United Nations Convention on the Rights of Persons with Disabilities (2006).
- United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women (2010).
- United Nations Sub-Committee on the Prevention of Torture, Ninth annual report of the SPT, CAT/C/57/4, 22 March 2016.
- Volkart, R., Rothenfluh, T., Kobelt, W., Dittrich, A., & Ernst, K. (1983). Solitary confinement as risk factor for psychiatric hospitalization (in German). *Psychiatr Clin (Basel)*, 16(5-6): pp. 365-77.
- Wildeman, C. & Andersen, L.H. (2020). Solitary placement and post-release mortality risk among formerly incarcerated individuals: A population-based study. *Lancet Public Health* 5(2): e107-e113. doi: 10.1016/S2468-2667(19)30271-3.
- World Medical Association, (2019). Statement on Solitary Confinement, adopted by the 65th WMA General Assembly, Durban, South Africa, October 2014 and revised by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019.

The Spanish and French versions of this paper can be found on <https://tidsskrift.dk/torture-journal>

Remote evaluations for humanitarian parole of asylum seekers to the United States - The case of MA

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Guest editors: Ben McVane³ and James Li⁴

Introduction to the reader:

This case seeks to demonstrate the value of remote evaluations conducted by health professionals for the purpose of applying for humanitarian parole. In this case, a survivor of labor trafficking, kidnapping, and sexual violence in her home country endures additional physical and psychological suffering after experiencing physical and sexual assaults while awaiting entry into the United States to seek asylum. As increasing numbers of migrants seeking protection arrive at the United States' southern border, immigration enforcement deterrence policies keep many asylum seekers in limbo. Remote evaluations conducted by health professionals to document physical and psychological disorders for the purpose of applying for humanitarian parole can help to prioritize the most vulnerable cases (Mishori et al, 2021).

Background

Patient MA is a female in her mid-30s seeking asylum in the United States. As a child in her home country in the Caribbean, her biological mother offered her as payment for a debt to a wealthy woman. Through her childhood, she provided uncompensated household labor to this woman until MA became an adult and married a man with whom she had a son. Later, MA and her son were kidnapped and held for ransom. When her husband was unable to pay the ransom, she was repeatedly sexually assaulted in retaliation and her son was deprived of food and water. When they both were finally released, MA's husband and his family rejected her after she disclosed the episodes of sexual violence. Fearing for her life and safety, she flew with her son to South America and travelled north to seek asylum in the United States. During the journey, she was exposed to significant secondary trauma. At the US-Mexico border, MA was assaulted by two men, both physically and sexually. She received only limited care following the attack. A medico-legal evaluation of MA was conducted using remote communication technology by a physician as part of her humanitarian parole application while she remained in Ciudad Juárez with her son. In contrast to asylum evaluations, which may correlate past trauma to physical and psychological signs and symptoms, the purpose of humanitarian

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International Rehabilitation Council for Torture Victims.

parole evaluations is to document ongoing medical vulnerability as a compelling basis to be allowed to temporarily enter the United States on humanitarian grounds.

Ethical considerations

Verbal informed consent was obtained from the patient for the publication of this case report.

Psychological signs and symptoms

As a child, MA had been told that she had been orphaned and was not aware that her mother had voluntarily relinquished her for financial benefit. The arrangement of poor children living with wealthy families and performing unpaid housework was somewhat normalized in her culture, despite meeting international definitions of child slavery (Blagbrough, 2008). As an adult, she enjoyed a relatively stable and happy relationship with her husband and son and endorsed no history of depression or anxiety. However, she began to exhibit active symptoms of severe PTSD following the kidnapping and sexual assault in her country of origin.

Her PTSD symptoms included (but were not limited to) intrusive and unwanted memories from the episode; physical and emotional reactions to these memories; avoidance of trauma reminders (such as interaction with men); diminished interest in activities; feelings of detachment; irritability; hypervigilance; problems with concentration; and sleep disturbances. She also developed various symptoms of severe major depression, including impaired sleep, loss of interest, guilt, low energy, difficulty with concentration and decreased appetite. Her symptoms initially started to improve when she was able to leave her country of origin with her son. However, they acutely worsened when she witnessed numerous acts of sexual violence while crossing through the Darién Gap of Panama.

Once she reached the US-Mexico border and became temporarily settled in Ciudad Juárez while awaiting legal processing to cross the border, she remained highly symptomatic as she did not feel safe in her environment. She experienced significant emotional volatility and became increasingly depressed. Her state of constant fear then became unbearable after she was abducted and physically and sexually assaulted by two men. She was thrown into a car, bound, blindfolded, and taken to an undisclosed location, where she was raped and punched in the face. At the time of the medico-legal evaluation, which was several weeks after the assault, she scored a 58 on a version of the PCL-C in her native language, indicating a high severity of PTSD. On a culturally and linguistically appropriate validated depression inventory she scored within the severe range for depression.

Physical signs and symptoms

By the time of the remote evaluation, MA's immediate wounds from the assault were no longer visible, but she possessed contemporaneous time-stamped photos of her injuries for review. She further endorsed intermittent acute-onset episodes of shortness of breath and pleuritic pain. These episodes were becoming more frequent and she expressed an intense fear that she could be gravely ill or dying when these pain episodes occurred.

Interpretation and conclusion

MA's physical and psychological findings are consistent with the traumatic experiences she reported. MA suffered from serious and chronic PTSD and major depression due to the compound trauma she endured, made worse by the persistent insecurity she felt while she remained in Ciudad Juarez, where she had been recently raped and assaulted. Additionally, her report of intermittent transient pleuritic chest

pain and shortness of breath associated with feelings of impending doom was suggestive of panic disorder, though this would be a diagnosis of exclusion and was felt to merit additional workup. Following the remote medical evaluation, these findings were reported in a letter documenting her physical and psychological vulnerability and she was granted humanitarian parole and allowed entry into the United States, where she has now settled and is receiving appropriate care.

Discussion

Increasing numbers of humanitarian parole evaluations are being conducted remotely by clinicians in the United States. MA's evaluation began with a group discussion thread with all those involved over a secure chat platform (WhatsApp). The evaluator first provided a clear overview of the logistics of the evaluation (e.g., start time and expected duration, participants present and their roles, need for adequate signal/data, importance of being in a private location, inability to provide treatment). Once it started, the evaluation initially took place with video enabled, but it was quickly converted to audio-only due to limi-

tations with the client's data network speed. The lack of a video stream for the majority of the encounter was not felt to have compromised rapport-building and, based on the client's account, may have made sharing some of the details of her past assaults less difficult.

MA's case highlights the utility of using remote evaluations to provide a prompt assessment of the psychological and physical symptoms of trauma victims residing in triggering and unsafe environments. Such an assessment can support an application for humanitarian parole, which has become an increasingly important legal mechanism to allow asylum seekers to enter the United States in the setting of recent border policies of deterrence (including metering, Migrant Protection Protocols, and Title 42). Remote psychiatric evaluations using a telephonic format have been shown to allow clinicians to obtain complete histories and make equally satisfactory diagnoses and recommendations (Bayne et al, 2019). While there are challenges to remote evaluations (such as those cited pertaining rapport building or technical difficulties), clinicians surveyed have consistently noted that they are able to achieve the goals of the eval-

Table 1. Advice in documenting physical and psychological trauma during remote evaluation (Raker and Niyogi, 2022; Tertsakian, 2018)

Psychomedical/Legal Considerations	Technological Considerations
Allocate longer period for establishing trust	Ensure adequate connectivity and charge of devices
Clarify the relationship of the referring attorney to the client and the limitations of their legal assistance	Choose a secure platform and consider attaching to an evaluation-specific number (e.g., Google Voice)
Be aware of the limitations that can accompany remote evaluations (e.g., not being able to observe body language in audio encounters)	Establish alternative plan in case of technology failure
Identify follow up plans in case patient demonstrates risk of danger to self or others	Confirm client is in a safe and private space for the duration of the interview

uation within the remote setting (Mishori et al, 2021). Of course, there are important practical measures to consider when conducting these evaluations. An overview of these best practices can be found in the attached table.

MA's case, where her environment had already put her at significant risk and was continuing to trigger her PTSD and depression, exemplifies the benefits of a prompt evaluation. At the same time, it also identifies potential risks in conducting them in the cross-border setting, particularly when interviewing clients in a city where you have not worked directly or are not connected to any local partners. Indeed, it is important to consider potential action plans in the case of a client's reporting active suicidal ideation, developing a panic attack during the encounter, or divulging medical issues requiring exigent response. Furthermore, referrals for these evaluations often come from attorneys or legal service organizations that are not fully or even partially representing the client, but rather providing limited supportive services such as preparation and filing of initial paperwork. As such, there is often much less information on the client provided up front than in the case of forensic evaluations of clients referred by their full legal representatives. While these considerations must be weighed carefully, the need for remote evaluations of cross-border clients seeking entry through humanitarian parole is great, highlighting the

need to identify best practices and provide a pathway for formal training and mentorship for interested providers.

References

- Bayne, M., Sokoloff, L., Rinehart, R., Epie, A., Hirt, L., Katz, C. (2019). Assessing the efficacy and experience of in-person versus telephonic psychiatric evaluations for asylum seekers in the U.S. *Psychiatry Res.* 282:112612.
- Blagbrough, J. (2008). "Child Domestic Labour: A Modern Form of Slavery." *Children & Society* 22: 179-190.
- Mishori, R., Hampton, K., Habbach, H., Raker, E., Niyogi, A., Murphey, D. (2021). "Better than having no evaluation done": a pilot project to conduct remote asylum evaluations for clients in a migrant encampment in Mexico. *BMC Health Serv Res.* 26;21(1):508.
- Neusner, J., Kizuka, K. (2022). The Nightmare Continues: Title 42 Court Order Prolongs Human Rights Abuses, Extends Disorder at U.S. Borders. *Human Rights First*. Retrieved from <https://humanrightsfirst.org/wp-content/uploads/2022/09/NightmareContinues.pdf>
- Pogue, M., Raker, E., Hampton, K., Saint Laurent, M.L., Mishori, R. (2021). Conducting remote medical asylum evaluations in the United States during COVID-19: Clinicians' perspectives on acceptability, challenges and opportunities. *J Forensic Leg Med.* 84:102255.
- Raker, E., Niyogi, A. (2022). Performing Remote Asylum Evaluations. In K. C. MacKenzie. *Asylum Medicine: A Clinician's Guide*. New York: Springer Cham.
- Tertsakian, Carina. "A Guide for the SOS-Torture Network on Investigating and Documenting Torture Remotely." OMCT SOS-Torture Network, 2018, https://www.omct.org/site-resources/legacy/Guide-OMCT-Print_FINAL.pdf.

New appointed Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment

On July 8th of 2022, the UN Human Rights Council announced the new assigned special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment: Dr. Alice Jills Edwards, member of this Journal's Editorial Advisory Board. We celebrate and congratulate her!

As an qualified barrister, published author, competent lawyer, scholar, diplomat and negotiator, Dr. Edwards has over two decades of professional experience in human rights, international law, UN mechanisms and academia. Throughout her career, Dr. Edwards worked with different actors such as national and international bodies, CSOs, and governments to enhance mechanisms within police and law enforcement, discrimination law, criminal justice, prison and correctional standards, as well as immigration, asylum, statelessness and human trafficking concerns.

Dr. Edwards holds a PhD in Public International Law from the Australian National University; a Master of Laws in Public International Law awarded with Distinction from the University of Nottingham; a Diploma in International and Comparative Law from the René Cassin International Institute for Human Rights in France; and a Bachelor of Laws (with Honours) and Arts from the University of Tasmania in Australia.

While having engaged with world-leading universities, her academic path results in over

50 publications and reports. Among these, she authored and co-edited *Human Security and Non-Citizens: Law, Policy and International Affairs* (2010), *Violence against Women under International Human Rights Law* (2011), *Nationality and Statelessness in International Law* (2014), and *In Flight from Conflict and Violence: UNHCR's Consultations on Refugee Status and Other Forms of International Protection* (2017). She also published empirical case studies on legal angles concerning the application of the UN Optional Protocol to the Convention against Torture (OPCAT) to immigration and refugee detention centres. These publications have been used by governments, courts, CSOs, UN bodies and international organisations.

While Dr. Edwards has engaged in advisory committees for the revision of the Istanbul Protocol (OHCHR, 2022) and the Méndez Principles, she has also contributed to drafting the underpinning CEDAW General Recommendation N° 32 (CEDAW, 2014), the UNHCR's detention guidelines (UNHCR, 2012) and the first guidelines on gender-related persecution (UNHCR, 2002). Being the first woman in this role, she also brings a significant focus on gender. Her dedicated work to ensure adequate compensation for female who suffered sexual violence during the Bosnia and Herzegovina conflict, was later adopted as State policies and UN

operational practice, and informed her book, *Violence against Women under International Human Rights Law* (Cambridge University Press, 2011). Her cutting-edge legal argument alleging that sexual violence and rape are forms of torture and persecution is now widely accepted, allowing hundreds of thousands of survivors to claim protection under the 1951 Convention relating to the Status of Refugees.

In her early international relations career, she worked for Amnesty International and a development NGO in Mozambique. During her tenure as Head of the Secretariat of the Convention against Torture Initiative (CTI), 15 new States ratified the UNCAT and initiated their implementation processes.

With such demonstrated commitment and engagement to improve the lives of individuals who have been subjected to torture and other human rights violations, her mandate will put the rights of survivors and their families at centre, advocating for their right to rehabilitation, restoration and engaging them in decision-making. While adopting a clear community-led approach, she also brings a feminist and egalitarian perspective to matters of prevention, consequences and accountability of ill-treatment and inhumane practices.

Again, we celebrate and congratulate Dr. Edwards, and we are sure her rapporteurship will bring solid and pragmatic advice on international law and best practice and contribute to long-term and substantial change in the fight against torture and ill-treatment worldwide.

Congratulations, Alice!

References

- Office of the United Nations High Commissioner for Human Rights (OHCHR) (2022) *ISTANBUL PROTOCOL*. Professional Training Series No. 8/Rev. 2 Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. New York and Geneva 2022. Available at: https://www.ohchr.org/sites/default/files/documents/publications/2022-06-29/Istanbul-Protocol_Rev2_EN.pdf
- United Nations Committee on the Elimination of Discrimination Against Women (CEDAW), General recommendation No. 32 on the gender-related dimensions of refugee status, asylum, nationality and statelessness of women, 5 November 2014, CEDAW/C/GC/32, available at: <https://www.refworld.org/docid/54620fb54.html>
- United Nations High Commissioner for Refugees (UNHCR) (2002) *Guidelines On International Protection: Gender-Related Persecution within the context of Article 1A(2) of the 1951 Convention and/or its 1967 Protocol relating to the Status of Refugees*. Available at: <https://www.unhcr.org/3d58ddef4.pdf>
- United Nations High Commissioner for Refugees (UNHCR) (2012) *UNHCR's detention guidelines: Guidelines on the Applicable Criteria and Standards relating to the Detention of Asylum Seekers and Alternatives to Detention*. Available at: <https://www.unhcr.org/en-us/publications/legal/505b10ee9/unhcr-detention-guidelines.html>
- Principles on Effective Interviewing for Investigations and Information Gathering (2021). Available at: https://www.apt.ch/sites/default/files/publications/apt_PoEI_EN_08.pdf

Thematic briefing: strengthening the recognition and protection of relatives of disappeared persons

On September 22nd, the International Rehabilitation Council for Torture Victims (IRCT) and the World Organisation Against Torture (OMCT) held a briefing with the United Nations Working Group on Enforced or Involuntary Disappearances (WGEID) to endorse effective recognition and protection of relatives and secondary victims of those who are forcibly disappeared around the world.

As documented by the WGEID, enforced disappearances is a global problem, with hundreds of thousands of individuals disappeared during conflicts or periods of repression.

The medico-legal community has recurrently acknowledged the need to recognise the suffering inflicted on relatives of those forcibly disappeared as a form of torture. Nonetheless, family members continue to be systematically neglected, coerced and intimidated by

their States and criminal justice systems in the process of searching for their loved ones.

In this briefing, the main findings published in the special sections on Enforced Disappearances of the Torture Journal: Vol. 31 No. 2 (2021) and Vol. 31 No. 3 (2021) were presented by Pau Pérez-Sales, Psychiatrist, Editor-in-Chief of the Torture Journal and Clinical Director at SiRa, and Bernard Duhaime, Professor of international law at the Faculty of Law and Political Science of the University of Quebec in Montreal and former member and Chair of the WGEID. Followed by the recommendations addressed to the WGEID presented by Helena Solà Martín, Senior Legal Advisor with OMCT. A briefing note was drafted as a result of this thematic briefing presenting a summary of key findings and recommendations shared with the WGEID.

World needs leadership and greater political will to combat torture

Dr. Alice Edwards¹



Nearly four decades on since the mandate of UN Special Rapporteur on Torture was established, we are still far from a world where all persons can live freely and peacefully without the risk of private or public forms of harassment, abuse or torture.

Despite the longstanding and universally accepted prohibition of torture, and the obligations on states to prevent such ill-treatment, the practice persists. Inhuman or degrading harm is carried out every day and at times routinely.

That is why I will be making leadership a central plank of my mandate as UN Special Rapporteur on Torture, and am calling on greater political will to better combat torture, including everyday forms of inhuman treatment and punishment. In order to bring about sustained and long-term changes, leaders at all level are required to be involved in identifying the problem and being part of the solution.

Tackling root causes to prevent torture and promote accountability are equally crucial, and I will also take action to reinforce the international legal framework and safeguard it against attack.

The rights of victims and survivors and their families must be put centre-stage. This includes their right to speak and be heard, the right to take part in decisions affecting them, the right to rehabilitation and a remedy. While avenues of justice for victims of torture and similar crimes have become more available over the past thirty years, and the sophistication of interviewing, evidence collection, documentation and preservation, including through implementing the Istanbul Protocol, remedies for hundreds of thousands of

1) New UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, outlines her vision, approach and priorities

them remain remote and unattainable. For this reason, too, my mandate will pay particular attention to gathering and sharing national practices of torture investigations and prosecutions, with the hope to expand the number of survivors achieving a restorative and just future for them as well as their children, families and communities.

It is imperative to focus on discriminatory causes of torture and ill-treatment and push for changes that include the rights of the women and girls, and other marginalised, under-represented and disadvantaged. A number of studies carried out in different countries have documented that vulnerable people and communities are at greater risk of being subjected to abuse and oppressive practices and unfairly treated within criminal justice systems.

Building safer, torture free and more just societies cannot be done successfully without engaging with governments through constructive dialogue and by providing pragmatic advice. This is because perceived externally imposed solutions rarely achieve the buy-in necessary to activate necessary reforms.

Fact-finding country visits are an important part of the Special Rapporteur's mandate, as are responding to urgent actions and allegations of torture and ill treatment. In all this work, a victim- and survivor-centred approach will be taken. Sharing good practices drawn from diverse regions and country experiences will aim to encourage positive cooperation from states in addressing allegations of torture.

Small as well as bold actions are being taken by a wide number of countries and their officials - supported by civil society - to enforce human rights-based societies. These examples of progress are symbols of hope and ought to be acknowledged. However, new global challenges highlight more than ever the need to counter complacency or tolerance of torture and ill treatment. Reports from human rights groups suggest that among ordinary people there have been at times misunderstandings of what torture is and a growing tolerance for it. Thus, raising awareness with relevant stakeholders and the general public about their right to be treated humanely in all interactions with the state is essential.

The work ahead requires a collective drive. We all have a role to play, from academics and practitioners researching and putting into practice groundbreaking new ways to rehabilitate and heal from torture, to national human rights and preventive mechanisms keeping a spotlight on misconduct, to police, judges, lawyers, health and prison officials working in at-risk systems and striving to do better, through to parliamentarians, militaries and governments with ultimate responsibility and accountability. Let this be the start of a period of renewed action.

END

*Dr. Alice Edwards was appointed by the Human Rights Council in July 2022 and took office in August. She is the first woman to hold office as the UN's torture expert. Dr. Edwards is a board member of Torture Journal.

Prof. Henrik Marcussen (17 January 1938 - 22 February 2023)



Prof. Henrik Marcussen, former Editor-in-Chief of the Torture Journal passed away on the 22nd of February 2022. We had the joy to share with him the 30th anniversary of the Journal last November, where he addressed some words to the readers and colleagues. Prof. Marcussen led the process of transformation of the Journal from an international bulletin that aimed to denounce the situation of torture in the world and the efforts in the fight against it of the different centres worldwide, into a modern academic medical Journal. Furthermore, Prof. Marcussen was key, from his role, in pushing for strengthening the development of medical research and rehabilitation programmes. He managed to give the Journal a unique perspective and style where readers were at the centre. The Journal was conceived as a practical tool for practitioners that combined science and activism in a unique way.

We want, in these pages, to honour his memory through the words of those who knew, worked with him and loved him.

Henrik Marcussen licensed from the University of Copenhagen in 1964, specialised in internal medicine, and obtained his PhD in 1979 with the thesis »Ulcerative colitis and colony antibodies«. He published many scientific articles, especially on gastroenterological topics. He was chief physician at Ringsted Hospital from 1979 to 2004, and chief physician at Slagelse Hospital, Department of Gastroenterology, from 2004 to 2010.

Henrik held a number of positions of trust, including chairman at Yngre Lægers Fællesråd, Kbh./Frb. (1973-79), member of the board of the Copenhagen Medical Association (1973-79), chairman of the medical council at Ringsted Hospital (1982-90) and chairman of the County Medical Council, Vestsjællands County (1997-2001).

But most of all, Henrik Marcussen was one of the pioneers of international work against torture. His fight against torture began in the 1970s with his committed work at Amnesty International's medical group.

He was member of the boards of the Rehabilitation and Research Centre for Torture Victims (1991-96) and the International Rehabilitation Council for Torture Victims (IRCT) (1988-2002). He also worked as a consultant for the IRCT until 2011.

From 1991 to 2011, he was Editor-in-Chief of the Torture Journal, the International Journal

on Rehabilitation of Torture Victims and Prevention of Torture, which is a great inspiration for doctors and health professionals working with the treatment of torture victims and documentation of torture, as it seeks to produce state-of-the-art knowledge on methodologies and approaches on health-based rehabilitation and educational and preventive aspects of torture. Moreover, he was also member of the board of the Inge Genefkes & Bent Sørensen Anti-Torture Support Fund (ATSF) until 2019.

Henrik Marcussen also made his mark in a field quite different from medicine and the fight against torture: music. As a young man, he won the main prize in ‘Double or nothing’ on the basis of his extensive knowledge of the composer Carl Nielsen. He was also a co-founder of the Carl Nielsen Society (1991). His interest in music continued throughout his life. He was a member of the Society’s board for several years and a member of the editorial board of the opera magazine *Ascolta*, to which he contributed numerous articles. Henrik Marcussen was also revered as a doctor and was known for his constructive and result-oriented approach to the difficult challenges in the fight against torture and for his humanly positive approach to colleagues and patients.

Stine Amris¹

Bente Danneskjold-Samsøe²

Morten Ekstrøm³

Anders Foldspang⁴

Marianne Kastrup⁵

Hans Draminsky Pedersen⁶

Ole Vedel Rasmussen⁷

-
- 1 Former Chief Medical Officer at the IRCT
 - 2 Consultant, Bispebjerg and Frederiksberg Hospital, The Parker Institute
 - 3 Chief Psychiatric Consultant at Competence Centre for Transcultural Psychiatry
 - 4 Aarhus University. Former Consultant RCT

By the end of a lifelong friendship, it is difficult to sum up the essence of it in a few words. However, there will always be episodes you do not forget, and such an episode was my first meeting with Henrik. I was in the south of France with my French fiancé in the summer of 1970.

Henrik was in France with his wife, Marianne, the daughter of close friends of my parents. Marianne and I already knew each other, and very soon the four of us discussed Mstislav Rostropovich’s first performance in Aix-en-Provence of the cello concerto of Henri Dutilleux written for Rostropovich. So it continued for many years to come. For a long time, we were deeply fascinated by Maria Callas and spoke few words apart from the appraisal of her incredible interpretations. Later on, Kathleen Ferrier and Dietrich Fischer-Dieskau became the focus of our interest. I was fascinated by Kathleen Ferrier’s interpretation of Schubert’s “An die Musik” (Du holde Kunst, in wieviel grauen Stunden, etc.) and so was Henrik, indeed. Henrik was a man of very few words when it came to expressing the emotional impact of music. Perhaps the modesty between friends which is not between men and women. It leaves the expression of emotions to poetry set to music and to wordless music by great composers.

You might get the impression that Henrik was not a man of strong emotions, but it wasn’t so. Not many years ago I invited Henrik and Marianne for dinner with my former professor of literature, who was also a composer.

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- 5 Former Head of the Department of Psychiatry of Copenhagen University and Former Medical Director of the Danish Rehabilitation and Research Center for Torture Victims
 - 6 Former member and vice-chair of the UN Subcommittee on Prevention of Torture (SPT)
 - 7 Former member of CAT & CPT, Senior Medical Advisor to the IRCT

He brought a CD with his latest composition, which we heard a part of. Since it was a complex one, he tried to explain to Henrik what it was about. Henrik listened but did not say much, to which my professor said: “Perhaps you do not understand it at all.” It triggered a reaction on Henrik that I’ll never forget. It showed a very characteristic trait of him - an amazingly disciplined way of expressing strong emotions which was also the signature of his commitment to the rehabilitation of torture victims.

Besides this, he was also a very hospitable person who for many many years brought together his friends for Christmas-dinners with all pertaining to the flavour and essence of Christmas. He was a loving husband to Marianne and father of his sons, Anders and Torben, and cared very much for the cats they had for years, perhaps too much according to modern veterinarians. At least they never missed anything.

I feel confident of saying we will all miss him very much.

Carl Kähler⁸

In his role as editor-in-chief of the Torture Journal, Henrik managed to balance between two competing concerns: he wanted to ensure that the quality and recognition of the Torture Journal was at the same level as other medical journals, and at the same time it was important for him that the main stakeholders – the rehabilitation centers and programs – had a place to publish their research, even if it was undertaken under different circumstances and showed signs of that. As we all know, Henrik solved that task excellently, and he managed to have the journal indexed with Index Medicus – the basic quality mark of medical journals. Henrik had noble motives for his work with the journal, and this is likely why his success was so evident.

Jens Modvig⁹

⁸ Lecturer Emeritus, MA

⁹ Medical Director at DIGNITY - Danish Institute Against Torture. Former Member and Chair. United Nations Committee Against Torture.

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

Torture in prison

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

About the call

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 contributions related (but not limited) to:

1. Conditions of detention as environments of torture: overcrowding, food, inhuman treatment...
2. Carceral geographies: emotional cartographies in detention spaces.
3. Impacts of isolation and closed regime units. Alternatives.
4. Use of mechanical restraints, chemical restraints and other methods of control and coercion. Intervention programs to abolish restraints.
5. Challenges of forensic documentation in prisons and other closed institutions.
6. Studies on reprisals against persons deprived of their liberty following monitoring visits to investigate allegations of torture.
7. Violent institutional cultures. Generating and perpetrating factors, and intervention programmes on violent milieu.
8. Violence by other inmates and staff. Methods of detection and prevention.
9. Effectiveness of torture prevention measures: videotaping, civil-society monitoring, medical documentation of injuries and others
10. Sexual torture and abuse in closed institutions.
11. Short or adapted forms of the Istanbul Protocol for documenting torture during monitoring visits or short-time evaluations in closed institutions.
12. Self-harm and suicide. Self-inflicted violence in closed institutions.
13. Severe Mental Illness and Torture in closed institutions.
14. Legal contours of torture in detention centers: legal reviews with a special focus on the intentionality and purpose criteria

Deadline for submissions

30th June 2023

Submission guidelines and links

- **Submit your paper here:** <https://tidsskrift.dk/torture-journal/about/submissions>
- Author guidelines can be found here: <https://irct.org/uploads/media/2eefc4b785f87c7c3028a1c59ccd06ed.pdf>
- Read more about the Torture Journal here: <https://irct.org/global-resources/torture-journal>
- For general submission guidelines, please see the Torture Journal website. Papers will be selected on their relevance to the field, applicability, methodological rigor, and level of innovation.

For more information

Contact Editor-in-chief (pauperez@runbox.com) if you wish to explore the suitability of a paper to the Special Section.

About the Torture Journal

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

Call for papers. 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

30st June 2023

Submission guidelines and links

- **Submit your paper here:** <https://tidsskrift.dk/torture-journal/about/submissions>
- Author guidelines can be found here: <https://irct.org/uploads/media/2eefc4b785f87c7c3028a1c59ccd06ed.pdf>
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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 March 2023

Submission guidelines and links

- **Submit your paper here:** <https://tidsskrift.dk/torture-journal/about/submissions>
- Author guidelines can be found here: <https://irct.org/uploads/media/2eefc4b785f87c7c3028a1c59ccd06ed.pdf>
- Read more about the Torture Journal here: <https://irct.org/global-resources/torture-journal>
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About the Torture Journal

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CTI Prize to the best paper published in the Torture Journal in 2022

Pau Pérez-Sales¹ and Berta Soley²

The Convention Against Torture Initiative (CTI) giving out the second year of the annual prize for the best article published in Torture Journal in 2022, with an economic endowment of 1000 dollars.

CTI is an intergovernmental initiative to strengthen institutions, policies and practices and reduce the risks of torture and ill-treatment by promoting universal ratification and implementation of the UN Convention against Torture by 2024. (<https://cti2024.org/>)

The selection process began with a short-list by the Editorial Advisory Board of 2 papers from the 33 contributions published during 2022, in Vol. 32 No. 1-2 (2022) and Vol. 32 No. 3 (2022). The selection was based on innovation, methodological and scientific relevance, and the number of citations as indicators of impact. The list was intended to be a first selection effort to limit the papers included for voting to a manageable volume.

These 2 papers are now to be voted by all readers and members of the IRCT. Hence, we kindly ask you place your vote to the paper you think deserves to be awarded with the 2022 CTI Prize.

How to vote?

1. Enter this link to the Survey Monkey: <https://www.surveymonkey.com/r/TTX2MPJ> or scan this QR code



2. Place your vote!
3. Click 'submit'

Thank you for participating.

1 Editor-in-Chief, Torture Journal
2 Editorial Associate, Torture Journal

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IBAN DK90 3000 4310 8211 52

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Account No. 3001-957171
IBAN DK69 3000 3001 9571 71

U.S. Dollars (USD) account

Registration No. 4183
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Detection and assessment of victims of ill-treatment and torture in Primary Health Care. Quick guide including developments in the 2022 updated version of the Istanbul Protocol.

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Exploratory study on the quality of forensic assessments using the Istanbul Protocol in a virtual versus face-to-face environment

The effectiveness of psychoanalytic psychotherapy in individuals diagnosed with PTSD due to torture and severe human right violations

SPECIAL SECTION: FORENSIC DOCUMENTATION OF PSYCHOLOGICAL TORTURE

Protocol on medico-legal documentation of threats

“The Darkness”: Deprivation of sunlight as a form of torture

Protocol on medico-legal documentation of solitary confinement

CONTINUOUS EDUCATION: **Remote evaluations for humanitarian parole of asylum seekers to the United States - The case of MA**

NEWS:

New appointed Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment

Thematic briefing: strengthening the recognition and protection of relatives of disappeared persons

World needs leadership and greater political will to combat torture

IN MEMORIAM: **Prof. Henrik Marcussen (17 January 1938 - 22 February 2023)**

Subscription:

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

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

The Torture Journal is published by the

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

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