Impact of the COVID-19 pandemic on work with torture survivors: Clinical and community perspectives

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The COVID 19 pandemic is not only changing the social and political landscape but also bringing about important changes in human rights and in work with torture survivors[1], some of which we noted in a first analysis in the last issue (Pérez-Sales, 2020).

Since the first reported cases, there have been a very large number of academic publications on the etiology and impact of COVID-19. Of particular note is the COVID-19 Resource Center launched by The Lancet series, which provides up-to-date information regarding medical impact and treatment[2]. For Mental Health and Psychosocial Work (MHPSS), the open-access on-line monographic issue of Psychological Trauma, an APA-sponsored journal, contains more than 150 peer-reviewed papers[3]. The family of PLOS journals offers free access

to all COVID-related papers, with an important focus on MHPPS elements[4]. Research Gate has also opened a dedicated space on COVID-19[5] with thousands of papers from peer-reviewed journals covering almost all aspects of relevant science.

Some of these have been very premature publications, containing preliminary data that has subsequently been disproved, and which has led to questions surrounding the guarantees offered by fast-track publishing that many scientific journals have opened in response to COVID-19. The considerable quantity of papers requires significant effort to collate the information that is essential and useful for a practitioner. In particular, there is still very little scientific output regarding the impact on the rehabilitation of torture survivors (SoT). We will try, in this editorial, to advance some preliminary reflections and stimulate further research.

Crises exacerbate pre-existing inequality gaps

In June and July this year, the IRCT, as a network of centres for the care of victims of torture, carried out a diagnosis of the situation and an analysis of the practices being carried out by their partner centres to deal with the

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1   For an extensive and comprehensive review of the human rights challenges posed by the COVID-19 crisis, see Ferstman & Fagan (2020), Ayala (2020)

2   https://www.thelancet.com/coronaviru

3   The papers cover potential mental health effects of COVID-19, resilience and positive psychology, living with isolation and uncertainty, covid-19 and pre-existing conditions, children and youth, substance use disorders, suicide, moral injury, vicarious trauma and interventions in health care providers, interpersonal violence, age and disability, impact on refugees, incarcerated, and undocumented people, impact on women and sexual minorities, fostering resilience in communities and interventions .

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4   https://collections.plos.org/covid-19#section-social-issues.

5   At the time of closing this editorial, a total of 2392 articles on psychological impact from 114 different countries were available, and a total of 2129 meta-analyses on all kinds of topics related to medical and psychological aspects of the COVID-19.

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pandemic (IRCT, personal communication). Around 40 centres were directly involved in the survey. In analysing the different experiences, two contrasting realities were observed.

On the one hand, we note the experiences of Sub-Saharan African centres, such as Terres Nouvelles or Fédicongo in the DRC, CAPREC in Senegal or the Trauma Center in Cameroon as examples from organisations in the Global South. For them, the pandemic has placed many torture survivors, and especially refugees and asylum seekers, who live in the informal economy, on the edge of physical survival. Lockdown measures have, in fact, removed their already scarce opportunities to work: temporary agricultural employment, small informal factories or workshops, street vending or domestic work. These organisations provide vivid depictions of individuals in situations of homelessness or confined in shelter; in which essential survival elements are lacking. They describe experiences of starvation and survivors of torture (SoT) resorting to criminal activity or sex work as forms of survival, or an increase in alcohol consumption as a way to escape from reality. In many countries of the Global South, the COVID-19 pandemic is evolving into what was once the Hunger-AIDS complex (De Waal & Whiteside, 2003),[6,7] and, in this respect, torture survivors are one of the most vulnerable populations.

COVID-19 has also meant a lack of access to medical or psychosocial support and freezing of legal processes, including asylum proceedings. In the face of this, centres describe a lack of resources, and emergency measures taken including provision of pre-paid phone cards to some of those most vulnerable in order to avoid losing contact with them, or seeking themselves food support from charities that are already overburdened and overflowing.

These reports sharply contrast with the challenges described by the centres based in the Global North. In their communications, they echo the challenges maintaining the continuity of activities in the context of lockdown: making use of the latest technology (centres in Sweden, Switzerland, Germany, or the UK); the feasibility of telephone counselling, or combining face-to-face interviews with video conferencing; the use of self-help apps; ensuring confidentiality and security in internet communications; the challenges in integrating work with cultural mediators and translators into on-line counselling; and the ethical dilemmas posed by these emerging contexts. These early experiences, along with experiences from the Global South, suggest that, pending sufficient data, suggest that it is possible to maintain forensic evaluations, although with some restrictions (*Freedom from Torture, SiR[a], CSU-Zimbabwe, CCTI-Mexico)*, to provide psychological support and counselling (*Rescue Alternatives Liberia)*, and in some cases, even to maintain on-line family and group therapy (*Restart Lebanon*). There are also on-line ma-

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6   A survey with around 3000 families in rural poor areas of Bangladesh, showed that the median monthly family income fell from US$212 at baseline to $59 during lockdown, and the proportion of families earning less than $1-90 per day increased by a 200%. Food insecurity increased by 52%. (Hamadani et al., 2020).

7   Some authors already speak openly about the COVID World Food Crisis and warn that a sustainable plan is not being articulated on a global scale and the consequences could be devastating (Fleetwood, 2020)

terials related to tele-psychotherapy that can be an essential aid to the centres[8,9].

Some of the partner centres report being very aware of a pyramid of MHPSS interventions; although they are used to providing highly-specialised care and delegating the lower layers of the pyramid to partner organisations, this context has required them to act flexibly and take on atypical tasks related to shelter, food, clothing, communications, access to medication etc.[10,11] The cancellation of therapeutic activities or the temporary disappearance of patients from the consultation room only means, in many cases, that there are other similar or more severe issues to be addressed, and that the organisation must also temporarily shift to other priorities.

Psychosocial perspective: the case of Lesvos
The situation observed in the Moría refugee camp in Lesvos (Greece) paradigmatically demonstrates the dynamics of the pandemic, and the multiple levels and perspectives that are interpolated from a psychosocial perspective. On the island of Lesvos, there was an estimated population of 15,000 people seeking international protection, most of them Afghan nationals but also a number from other areas of the world. They had become stranded in limbo caused by the Greek government's unilateral decision, in March 2020, to suspend all asylum application procedures, which they subsequently recommenced with new requirements, which most of the refugees in the camp could not meet. Among these conditions, documentation of the psychological impact of torture was no longer accepted in hearings for protection assessment. The population was living in extreme conditions of overcrowding, unhealthy conditions, precarious nutrition and with a lack of access to clean water. Violence of all kinds and in particular gender-based violence was prevalent, and refugees faced a situation of global abandonment (Eleftherakos et al., 2018; OXFAM, 2019), in contexts of fear, isolation and lack of social support and community networks (Episkopou et al., 2019). Refugees lacked medical care, and official sources scarcely provided information about COVID-19 that instead mostly came from self-organised groups among refugees with the support of international NGOs (OXFAM, 2020; Greek Council for Refugees, 2020). In this context, there was a steady increase over time in the local population of Lesvos, of those who considered that migrants were not only a threat to the island's economy, but were also responsible for the increase in crime (Annon, 2020) and a threat to the very health of its inhabitants. This situation remained highly tense, but without any outbreaks, because to date there had been no positive cases of COVID-19 on the island as it had been in lockdown and therefore isolated from the mainland. In

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8   For a trans-theoretical comprehensive perspective on challenges in tele-psychotherapy, including current evidences and best practices see an Special Issue of the Journal of Psychotherapy Integration, freely accessible on-line (https://www.apa.org/pubs/journals/special/int-telepsychotherapy-age-covid-19-pdf) and McDonald et al., (2020).

9   For a metanalysis on ethical challenges in on-line therapy see Stoll et al., (2020)

10   Especially interesting is a report on difficulties found by Tamil SoT in UK during the COVID-19 crisis (ITJP, 2020)

11   An example is Freedom from Torture's Emergency Relief Fund, with small grants of 200 to 2000 pounds to support torture survivors or front-line organizations, or the COVID-19 Resources website by Heal Torture, with hundreds of materials, links and resources for torture survivors specific to COVID-19 (https://healtorture.org/resource/covid-19-resources). The Center for Victims of Torture (CVT) also has a website with Mental Health Resources in different languages (https://www.cvt.org/COVID-English).

Table 1. Security and military perspective prevails over psychosocial and community perspective

Refugees	Local population
ENVIRONMENT fostering a lack of control and uncertainty	FEAR conditions
Extreme conditions - Overcrowding	Fear of foreigners in Greece
Lack of medical services	Fear of the refugee population of the disease
No reliable information	Fear of the refugee population of other refugees
No trusted source of information	
Community organisation not allowed	

the last weeks of August and early September however, some symptomatic cases began to appear, and the government decided to forcibly confine and mass test the entire population of the Moría camp, despite the serious issues with reliability of the tests available and the risk to which the population was exposed with the quarantine.[12] These decisions generated fear and conflict, because the process and the way it was put into action was neither seen nor developed as a health intervention, but rather as an action of military confinement. As soon as the results of the tests had arrived, the army entered the camp, located the entire family of the person who had tested positive and moved them, in full view of everyone, to a closed area outside of the camp. These actions caused panic. On the one hand, the families themselves who were transferred were terrified because in most cases they did not have any symptoms and were forced to live with people who did have symptoms. On the other hand, neighbouring families were alarmed by the military deployment and the knowledge that they had been living close to a family who had had COVID-19 contact.

Not surprisingly, after a few days, there were riots and attempts to escape from the confinement area, to which the police and military responded with harsh crackdown measures[13]. Eventually, the entire refugee camp burned down in what was, speculatively, a desperate act by the refugees themselves to try and force a move from the lockdown camp. Fear, misinformation, rumours, accumulated hopelessness, trauma, poverty and military responses rather than human rights-based responses to victims of war, torture, exile and loss and who found themselves embroiled in the COVID-19 crisis made up the flame that set the mixture alight.

Making the excluded invisible
COVID-19 has led, at a global level, to the invisibility of victims of torture due to reasons including:

- The situation of the pandemic has meant, in most countries, the complete or partial suspension of monitoring visits to detention

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12 See MSF report: https://www.msf.org/greek-police-enforce-unwarranted-and-cruel-quarantine-moria-camp

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13 12 September 2020. Moria migrants tear-gassed by Greek police in protest over new camp (https://www.bbc.com/news/world-europe-54131212). Riot police deployed to new Lesbos refugee camp after fire (https://edition.cnn.com/2020/09/11/europe/lesbos-fire-migants-moria-camp-intl/index.html).

centres[14], without any epidemiological jus-
tification.

- In most detention centres, family visits have
been suspended, which, in addition to the
psychological impact on the detainees, in-
creases the possibility of abuse.
- Many legal activities are suspended, includ-
ing some involving guarantees and safe-
guards for detainees or trials for human
rights violations[15]. In other cases, trials con-
tinue, but with violations of the right to ade-
quate documentation and defence in cases[16]
- Some associations that look after victims of
torture are forced to restrict their activities
to a minimum, leaving victims without nec-
essary elements of protection.
- The right to rehabilitation risks becoming
a secondary concern in government bud-
getary planning.

A priority task for those working with
torture victims will be to develop strategies to
prevent such invisibility and to maintain mon-
itoring activities of potential rights violations
in closed institutions. Anti-torture organisa-
tions such as the CCTI in Mexico or Restart

in Lebanon have made public statements chal-
lenging their governments on this issue.

Abuse of power under health-based derogations

In various national legal systems, exceptional
measures have been adopted that have effec-
tively restricted freedoms: of assembly, dem-
onstration and expression. The act of protest
itself is penalised or criminalised. Exceptional
powers are given to the police and to the army
to prevent the spread of the disease and con-
tagion, and this gives rise, in many contexts,
to indiscriminate police action[17]. Recent cases
of torture and even death of citizens in differ-
ent countries due to abuse of power are conse-
quences of these policies that use COVID-19
as a guise to establish undemocratic forms
of government, or that require the police to
control preventative health measures without
clear rules. Moreover, the confinement situa-
tion itself has increased the prevalence of all
forms of violence.

Furthermore, the use of apps to control
population movement and to trace persons
with positive COVID tests has raised concern
from organisations like Amnesty International
and others[18].

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14   In a survey in 24 African countries regarding
National Prevention Mechanism to prisons
during COVID-19, in 11 all visits were
forbidden, in 10 were partially restricted or
limited and only in 3 there were no limitations
(Muntingh, 2020)
15   One example is the suspension of restorative
justice processes in Colombia and the difficulties
in resuming them virtually (Sandoval, 2020)
16   Of particular relevance is the report by the
Helen Bamber Foundation and Freedom for
Torture on limited access to justice due to
COVID measures adopted in relation to Pre-
Decision National Referral Mechanism ('NRM'),
Applications to extend time, Review proceedings
and Appeals (Helen Bamber Foundation &
Freedom for torture, 2020).

17   A number of reports exist. One example,
among many, is the National Human Rights
Commission of Nigeria, in a press release dated
14th April 2020, reported 33 cases of torture
(in two cases ending in death) due to unlawful
application of lockdown measures by police
and army (Oboirien, 2020). Similar data comes
from the National Coalition for Human Rights
Defenders in Uganda (https://www.independent.
co.ug/escalation-of-torture-in-covid-19-
lockdown/. For global data see Anderton (2020).
18   https://www.amnesty.org/en/latest/news/2020/06/
bahrain-kuwait-norway-contact-tracing-apps-
danger-for-privacy/; https://www.amnesty.org/en/
latest/news/2020/04/covid-19-surveillance-threat-
to-your-rights/; https://www.amnesty.org.uk/

Legislative and administrative measures, and protection of fundamental freedoms

There is undeniable concern that COVID-19 has represented a step backwards in global freedoms at the international level (Council of Europe, 2020). Some 30 countries have decreed states of emergency, alarm or disaster that have served to reduce freedoms. In some cases, these measures have no clear legal basis and are contrary to the international human rights framework. The debate is not so much about their necessity, but rather about their lawfulness, proportionality and duration (Lebret, 2020). There are a vast number of Statements by national, international and supranational bodies with recommendations to States, both in relation to fundamental rights and to groups at particular risk. The International Justice Resource Center maintains a comprehensive database on all of them which is freely accessible and is the most appropriate source of reference[19].

COVID-19 and detention settings

Especially relevant to this matter is the UNODC, WHO, UNAIDS and OHCHR joint statement on COVID-19 in prisons and other closed settings[20]. Jointly, these international organisations urge political leaders to: (1) Reduce overcrowding, limiting the deprivation of liberty, including pre-trial detention, to a measure of last resort, and enhance efforts to resort to non-custodial measures (2) Close compulsory detention and rehabilitation centres, where people suspected of using drugs or engaging in sex work are retained or detained (3) Ensure health and safety measures that are respectful with human dignity, irrespective of any state of emergency, and at the same level that all the population of the country. (4) Provide unrestricted access to prevention measures and treatment of HIV, tuberculosis, hepatitis and opioid dependence (5) Ensure that restrictions that may be imposed due to COVID-19 are necessary, evidence-informed, proportionate (i.e. the least restrictive option) and non-arbitrary. The disruptive impact of such measures should be actively mitigated, such as through enhanced access to telephones or digital communications if visits are limited. Legal safeguards, including the right to legal representation, as well as the access of external inspection bodies to places of deprivation of liberty, must continue to be fully respected.

The Association for the Prevention of Torture (APT) has launched a website with an information hub on the conditions of persons deprived of liberty during COVID-19 worldwide. Data can be searched according to country, relevant institution or body, thematic issue, place of deprivation of liberty, and situation of vulnerability[21]. At closure of this editorial, the database provided more than 2200 news and reports on torture, COVID and detention centres.

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press-releases/uk-privacy-must-not-be-another-casualty-virus.

19   The database includes, when closing this editorial, more than 200 statements from the 56 United Nations special procedures, 10 U.N. human rights treaty bodies, three principal regional human rights systems (each with various components), and their respective "parent" intergovernmental organisations. They urge governments to act to respect human rights during the pandemic. https://ijrcenter.org/covid-19-guidance-from-supranational-human-rights-bodies/

20   https://www.who.int/news-room/detail/13-05-2020-unodc-who-unaids-and-ohchr-joint-statement-on-covid-19-in-prisons-and-other-

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closed-settings

21   https://datastudio.google.com/reporting/c686bea7-3152-4dd2-b483-fce072f3ddbf/page/UkoKB

Epidemiological data, where available, shows that in many countries, there are far more cases of COVID in detention centres than in the population-at-large[22.] The measures proposed by international bodies, including the release of prisoners, should not be considered as compassionate or gracious measures. International Human Rights Law emphasises the "special position of the guarantor" in which states find themselves concerning the rights of people in prison, with a duty to guarantee the health of prisoners and fulfil all health measures, such as those of social distancing (Coyle, 2008; Penal Reform International & Essex Human Rights Center, 2017; United Nations High Commissioner for Human Rights, 2005; WHO-EU, 2007). However, in overcrowded prisons, this can be impossible to achieve. Putting human beings at risk of death, especially when more than half of whom, in most countries, are in pretrial detention and not even convicted, is unacceptable. As some authors have pointed out, denial of proper medical care can amount to torture (Center for Human Rights & Humanitarian Law, 2014; SRT, 2013). Moreover, if there is an increased death rate in prisons and the state does not take any measures to prevent it, the authorities could be prosecuted under international law.

A controversial measure taken by some states, which is particulary prevalent in the United States, is to put migrants with symptoms of COVID-19 in prolonged solitary confinement, which can extend to months in duration[23]. Furthermore, a Physicians for Human Rights (PHR) report has documented cases of forced family separation as part of COVID-19 prevention measures that have no medical justification. Detained migrant parents are faced with forced separation from their children, some as young as six months old and breastfeeding, allegedly to prevent their children from being exposed to coronavirus in adult detention centres potentially experiencing outbreaks. In both solitary confinement and forced family separation, organisations claim that migrants are submitted to situations amounting to torture[24]. The UN Working Group on Alternatives to Detention has issued a specific and very detailed report on COVID-19 and Immigration Detention (WGAD, 2020). Several guidelines have been developed for the management of the COVID-19 epidemic in detention centres. The undisputed reference text is the Guide for Detention Centres of the US Center for Disease Control and Prevention[25] (CDC). There are also specific guidelines on institutional measures to reduce the risk of COVID-19 in prisons (Tulloch, 2020), as well as guidelines for monitoring the situation of COVID-19 in detention centres (ODIHR & APT, 2000). As supple-

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22   The National Campaign against Torture in India reported that 26% of jails in the country had reported COVID-19 cases by August 2020. All prisons were overcrowded, no isolation measures applied and no health care provided, in a situation that was considered by the NGO as amounting to torture (NCAT, 2020)

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23   Research by the International Consortium of Investigative Journalist documented 8,488 incident reports of people kept in solitary confinement for having COVID-19 symptoms, with more than 50% describing stays that lasted longer than 15 days. ICIJ identified 187 cases in which a detainee was held for more than six months. In 32 of those cases, the detainee was confined in solitary for a year or more (see full report at https://theintercept.com/2019/05/21/ice-solitary-confinement-immigration-detention/).

24   https://phr.org/our-work/resources/forced-family-separation-during-covid-19-preventing-torture-and-inhumane-treatment-in-crisis/

25   https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

mentary material to this editorial, we include a short-list of essential topics to be covered in detention centre monitoring, with a focus on COVID.

The individual perspective

Population-at-large
There is, as explained in the introduction, a plethora of detailed materials on the physical and psychological impacts of COVID-19 on people with the disease both symptomatic and asymptomatic,, on the community in general and more specifically on the community in lockdown. The reader can draw on these sources. To summarise the main findings thus far:

COVID-19 causes a multi-systemic disease involving almost all body organs. During the most acute phase of the disease, delirium, anxiety, or confusion occurs in about 40% to 50% of cases[26]. There is however, at the time of writing, insufficient epidemiological data on psychological symptoms in asymptomatic COVID-19 positive patients.

As for the general population, studies in areas of a high prevalence of COVID-19 (China, US), suggest the presence of anxiety symptoms in around 30% of the population, and depression in around 15%. This proportion increases to almost double in health personnel. Between 35% and 50% of professionals present moderate to severe symptoms of post-traumatic stress[27]. There is scarce data on the impact of lockdown, but the best available review studies point to a high frequency

of negative emotions, depressive symptoms and post-traumatic stress (Brooks et al., 2020).[28]

Victims of torture
There are, at the moment, no specific studies on victims of torture and COVID-19. What follows are some insights on positive and negative effects of the COVID pandemic from clinical experience and discussion with colleagues with no more pretense than to serve as an aid and stimulus for future research.

Psychosocial elements
Firstly, victims of torture, who often live in socially marginalised conditions, are at a much greater risk of contracting COVID. This risk exists in addition to the linguistic difficulties they may encounter in understanding norms and regulations, maintaining social distance due to inadequate sheltering and having poor access to the health system on equal terms with the rest of the population. There are, in addition, other specific psychosocial elements (Table 2)

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26   For a free monthly updated review see https://www.uptodate.com/contents/coronavirus-disease-2019-covid-19-psychiatric-illness

27   For a review on impact on health workers and measures for prevention of traumatic symptoms, see Kisely et al. (2020) and Lai et al., (2020).

28   In a review of 24 studies on the impact of quarantine in ten different countries from 2003 to 2014, high numbers of post-traumatic stress symptoms, confusion, and anger were found. This is added to increasing fear, depression, emotional exhaustion, frustration and irritability. These lead, if prolonged in time, to an increase in avoidance behaviors and avoiding others, increase in alcohol usage, suicide attempts, increase in hypochondriac and somatic symptoms and domestic violence. The severity of symptoms related to death rates in affected population (i.e Ebola outbreaks) and economic hardship due to lockdown. The authors strongly recommend limiting lockdown periods to a minimum duration necessary, provide clear information on expected length and public campaigns explaining the rationale of the measure, appeals to altruism and health-related messages to improve well-being (Brooks et al., 2020).

Clinical aspects

There are some specific elements in the experiences of victims of torture in which parallels can be drawn between the impact of COVID-19 cases and its medical and psychological implications with situations of torture or enforced disappearance:

1. The pandemic has meant, for many people (victims, therapists and families), a close **contact with death** as an immediate, direct and present reality. In countries with a high mortality rate, ultimately everyone knows someone who has died. It is, in these cases, not an abstract thought, experienced secondhand through media sources, but rather a reality, experienced through neighbours, relatives and friends. Furthermore, for many victims, this can mean remembering painful moments in their lives, reawakening the fear of death itself or the fear of pain and illness linked to torture. Many victims have recounted how lockdown has reminded them of prison and confinement.

2. On the other hand, the **disease and the threat** posed by COVID-19 **are invisible.** It is both everywhere and nowhere. For some SoT, this makes it possible, paradoxically, to deny its existence. In other words, what is not seen simply does not exist, or so they believe. For other SoT, on the contrary, this means seeing the threat everywhere. The unseen enemy is, for them, omnipresent. A polarity of emotions is thus created. Survivors – just as the broader population- tread, at a certain point, a crossroads between those

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Table 2. Psychosocial factors to check and consider in supporting torture survivors during COVID-19 crisis.

1. Absence of essential elements of support: food, clothing
2. Loss of contact with supporting institutions due to lack of or inability to pay for telephone, transport or other means of keeping in contact.
3. No access to specific COVID-19 tests or medical care
4. No access to PPE or other equipment that allow mobility and safety
5. Cultural understanding of the need for social distance measures and practical strategies to make them possible
6. Impact of rumours, fake news or unscientific aetiological hypotheses
7. Fear of infecting family members (children, older adults...)
8. People who are or have been in contact with infected people - managing expectations and practical measures to ease anxiety
9. Impossibility and lack of ritual elements of mourning linked to culture and alternatives from sources of traditional healing.
10. Impact of home lockdown, quarantine and specifically the impact of loneliness
11. Barriers to news about what is happening in the country of origin – facing alarming news
12. Absence of news about family members
13. Impact of the delay in legal procedures
14. Procedures that do not have all the legal safeguards and generate helplessness
15. Forced or voluntary family separation, due to COVID-19, and especially when children and older adults are involved.

who move in a state of psychological denial and with a sense of invulnerability, and those who live in constant vigilance and fear. One of the tasks of support from health professionals is to work on a realistic perspective between helplessness and fear on one side and omnipotence and carelessness on the other.

3. Furthermore, for some victims and their relatives, illness and death constitute new losses that follow previous losses – instances of **grief stacked upon each other -** which therefore sometimes remain unresolved. Moreover, COVID-19, in many cases, has meant individuals suffering **losses without a body to mourn**. Healthcare measures have prevented loved ones from being at the patient's side at the time of death, possibly entailing feelings of remorse and guilt. They also have prevented wakes and funerals. For many people, it has been impossible to say goodbye to the deceased relative, friend or loved one. For the deceased person themself, it has also been a death in solitude. In some places, like in New York, we have even seen images of mass graves that remind us of the experience of many victims of torture and enforced disappearance. These are specific elements to be considered.

4. This situation might deepen, for a large part of VoT, inherent beliefs of **insecurity and distrust** in the world. Living in a threatening world, where new fears only add to those felt previously, added, in this case, to an uncertain and unpredictable future, not least because of illness but also because of economic, social and political uncertainty. These only increase the need for trust and a sense of finitude. Trauma and crisis become cyclical in life.

5. The unique circumstances of COVID can increase feelings of **remorse** and **guilt**

that augment similar pre-existing sensitivities. This involves guilt felt due to present circumstances, because the person had, for example, been unable to take care of their parents, to be by their side, because they had been unable to secure their suffering loved one a place in a hospital, or simply did not understand the severity of the symptoms. Guilt, in this case, is added to previous feelings of guilt and may be linked to a feeling of being unable to protect the family during political persecution, perhaps because of the effects of militancy, personal choices, or because the person had to flee, thus leaving the family in a critical economic situation.

6. Furthermore, there may be a burden derived from the idea that there should be a "**vital justice"** when a community faces death**.** The youngest, the most valuable, or those who fought the most, should, it is said, never be the ones to die. Death should be reserved for perpetrators. Feelings of, "*I am the one who should have died, instead of my brother, my son or my father*". It is difficult to make sense of deaths experienced as absurd and unjust. This has often been part of the experience of victims of torture or enforced disappearance. And it is now part of the experience of COVID-19 affected communities. In contexts of therapy, it may be discussed with survivors that human beings have far less **control over their life** than that which we are usually taught and that this may be a source of anguish or a source of wisdom. In many countries, this will mean looking to one's own god and spirituality. In others, it means accepting reality as something inevitable that we must shoulder in order to move forward and learning to life in uncertainty. The victims, who have already experienced

these feelings and dilemmas on other occasions, perhaps have much to teach the population, and this role of sharing their experience can be a healing one.

7. Moreover, for young SoT, a form of **"empathetic horror"** is sometimes perceived in cases of people who, because of their age or their personal situation, may have never considered that death could affect them, and now see that the person who died was of a similar age, and may experience feelings of "that could have been me". This is a shattering experience.

8. For some VoTs, the experiences they have lived through allow them to develop a **more resilient outlook** than that of the general population. It has not been uncommon to see many VoTs who are far more resilient than the professionals with whom they work. In the COVID crisis, the level of suffering and pain is often incomparable to that that was once suffered from torture and prison. Furthermore, there is far more than the person is able to do taking into account the absolute defenselessness experienced in torture.

9. The COVID-19 crisis has forced people– and VoTs are no exception- to be more aware of **human relationships**, of the people we live with and how we relate to them, and to become cognisent of one's strengths and weaknesses. While for some people, this has meant a period of calm, for others, it has meant anguish, especially for those who may have been balancing their shortcomings with work, activism or hyperactivity. The crisis has also given rise, in some cases, to the need to make critical decisions in a short time, which has led to emotional overload.

10. The pandemic also has brought about **an increase in violence**. The data is incontrovertible. Gender-based violence, family breakdowns and violence against children and the elderly have increased since the lockdown began (Anderton, 2020; Hamadani et al., 2020; IFRC, 2020; Peterman & Donnell, 2020; UN Women, 2020). Fear sometimes brings cohesion. In other situations, it generates division and fracture among more general issues, both in organisations and other social groups. Social psychology dictates that there is a period, usually 4 to 6 weeks, of a particular "honeymoon", when solidarity and possibilities of facing problems in a communitarian way dominate. After that, for many reasons too lengthy and complex to review here, signs of lack of solidarity gradually appear. A challenge is how to prolong and sustain support networks and solidarity responses in the face of exhaustion, uncertainty and tiredness.

11. Finally, there is the most critical factor: **loneliness**. For many people, and this includes many family members, who are older people, the experience of the pandemic has been further served to increase challenges of communication, isolation and loneliness[29]. Loneliness has been recently documented as a neglected condition that severely increases mortality and mental health problems in the population-at-large (Cacioppo et al., 2015; Holt-Lunstad et al., 2015).

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29 In a study based on telephone calls to the general population in a COVID-19 confinement situation (n=432) in Hong Kong, it was found that 60% presented symptoms of anxiety or depression and that the perception of loneliness was the main predictor of psychological distress, regardless of the size of the social network (Tso & Park, 2020).

Table 3. Interventions of support

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1. Develop self-help systems : (a) adapt brochures or guides with advice from the many existing ones (b) try group interventions via on-line that create virtual communities in which patients can share how they are coping, their needs and develop forms of mutual support (c) introduce, where possible, apps with programs of emotional regulation, stress management, anger management and others, from the many currently available[*]
2. Strength mutual support actions: common pots, home help by volunteers and others.
3. Address mourning and especially mourning associated with the premature death of healthy people
4. Address mourning for the loss of people who were social leaders in the struggle of the victims or for human rights and which have a relevant collective impact
5. Address psychosocial problems associated with the lockdown. Ensure support for basic needs, especially for older adults. Adopt strategies to support people who are particularly vulnerable in their families or communities
6. Manage risk of detention or deportation
7. Address Conflicts within family and community. Saturation of personal relationships.
8. Address loneliness and Fear
9. Monitor possible situations of gender violence, violence against children or older adults.

One of the paradoxes of COVID is the experience of social saturation and forced coexistence for some people faced with the experiences of loneliness and lack of support of others.

In this context, the experience of torture victims can provide valuable lessons about how to deal with the demands of this crisis. Hopefully, from the rehabilitation centres, VoT will not be seen only as fragile members of society to be protected, but as people who have faced hunger, loneliness, displacement and trauma and in many cases have developed wisdom and individual and collective practices from which the society can learn today.

In this issue, we present the first part of a Special Section on Physiotherapy for Torture Survivors, with the help of Eric Weerts, Guest Editor, as a response to a call-for-papers that had a very significant response.

Inge Genefke, in one of her first writings on the rehabilitation of torture victims wrote: "*Torture may be characterized as physical and/or psychological; most commonly victims have been exposed to both forms of torture. As a consequence hereof, the treatment specially designed for torture victims is a combination of psychotherapy and physiotherapy, commonly known as multi disciplinary treatment*" (Danneskiold-Samsøe et al., 2007). The treatment of torture victims at the RCT center in Copenhagen was based on five

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[*]   There are hundreds of apps freely available for patients. A good selection can be found in these non-commercial reliable websites
    https://www.nhs.uk/apps-library/category/mental-health/;
    https://psychiatry.ucsf.edu/copingresources/apps;
    https://nycwell.cityofnewyork.us/en/covid-19-digital-mental-health-resources/

pillars, the second of which was "*Simultaneous start of both physical and mental treatment with physiotherapy as an important element of the physical treatment*". Physiotherapy was always one of the fundamental elements of the therapeutic programs that the IRCT promoted throughout the world which was more or less universally adopted (Bloch, 1988; Kastrup et al., 1986; Reid & Strong, 1988). It was also considered synonymous with the treatment of physical symptoms and one of a number of historically important areas in work with torture survivors.

Unfortunately, there has been minimal research tradition in physiotherapy, and after almost forty years of work with VoT, physiotherapy has gradually declined as a discipline within organisations, until it became an accessorial subject within general health care. Several factors have likely played a role in this. On the one hand, there was a trend within various IRCT centres, especially in Latin America, that so much emphasis on physiotherapy represented a biomedical and de-politicised model of treatment for victims. In contrast, these centers advocated community-based or psychosocial approaches with a much clearer political focus that understood the therapy with torture survivors as part of a global political fight of which the survivor was still part. On the other hand, research on pain management showed the need for multidisciplinary approaches and that physiotherapy alone, in its classical sense, was insufficient. The use of massage, hydrotherapy or postural therapies were shown to be ineffective if they were not part of an overall integrated treatment that used body manipulation as a therapeutic element within body-based psysiotherapy or somatosensory therapies. Finally, the very challenges encountered by professionals in producing academic research to probe its usefulness and refute the claim that physiotherapy requires high resource investments as

compared with community approaches in environments where resources are scarce. In this Special Section we have attempted to discuss contemporary ways of understanding physiotherapy work with torture survivors, discussion on indicators of efficacy and increase and strengthen the number of studies available to support its use as part of multidisciplinary programs. The work received, however, has placed more emphasis on protocols and education than on outcomes.

In this issue, Iselin Dibaj, Joar Halvorsen, Leif Ottesen Kennair and Håkon Stenmark contribute a narrative review on challenges in trauma-focused therapy for torture survivors with PTSD and chronic pain, showing that there is still not enough support to the widely accepted assumption that addressing trauma can improve chronic pain. April Gamble, Salah Hassan Rahim, Ahmed M. Amin Ahmed and Jeff Hartman present the results of a pilot study on the Effects of a Combined Psychotherapy and Physiotherapy Group Treatment Program for Survivors of Torture with very preliminary, although promising results. Especially interesting is that the intervention is done with incarcerated survivors in an Adult Prison in Iraq, showing the feasibility of working in complex contexts. Tanju Bahrilli and Hamiyet Yüce present a study on Basic Body Awareness Therapy in hunger strike victims with Wernicke Korsakoff Syndrome, showing improvement in different quality of life indicators in survivors that had been severely handicapped for years.

Overall the three papers presented here will help the reader to capture that while physiotherapy might not be a generalised treatment for all torture survivors as it was initially proposed in the early works in the 1980s, there are specific profiles of survivors that might benefit from physiotherapy as an adjunctive treatment, especially if this is combined and integrated

within psychotherapy work. The discipline must evolve to better define who can benefit, which the best combinations are and how outcomes can be reliably measured.

Additionally, Paula Suárez-López presents a review on the potential of epigenetic methods to provide evidence of torture. Genetic markers, now still at an early stage of development, show enormous potential to detect long-term and trans-generational impacts of chronic trauma in general. The question addressed here is whether there can be specific markers for torture as a shattering trauma experience. The author suggests that there is a strong potential for that.

Marie Brasholt, Brenda van den Bergh, Erinda Bllaca, Alba Mejía, Marie My Warborg Larsen, Anne Katrine Graudal Levinsen, and Jens Modvig present results on a study conducted in Albania and Honduras on the risk of sanctions following visits by monitoring bodies to detention centers, that shows that this is a relevant and neglected area in the prevention of torture. The results are alarming and show that a very significant percentage of people interviewed suffer some kind of harassment or reprisal following the visits.

The reader will also find a Debate section. Sara López poses a complex question: What are the ethical dilemma and proposed criteria when a (potential) perpetrator asks for forensic documentation of his own alleged torture. The author proposes three criteria that can be applied by forensic experts and documenting organizations. Four world-leading authors, Juliet Cohen (Head of Doctors at Freedom from Torture, UK), Elizabeth Lira (Professor of Psychology at Universidad Alberto Hurtado, Chile), Henry Shue (Professor of Philosophy at Oxford University, UK) and Onder Ozkalipci (Forensic Expert, Turkey), provide insights on the proposal with a final wrap-up and answer from the author.

As the reader will see, this issue includes multiple and complex themes, which we are sure will stimulate reflection and debate.

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