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Voices From a Long Journey: Introducing the 30th Anniversary Special Issue

Pau Pérez-Sales

This issue is an exceptional one. Coinciding with the celebration of the 30th anniversary of the Torture Journal, we wanted to have a commemorative collection of essays written by authors who have either had a long trajectory in the fight against torture or have uniquely accompanied the history of the Journal.

Our selection, always limited and just a glimpse of the field’s richness, aims to represent very different viewpoints and perspectives - from the anthropological to the epidemiological, the legal to the clinical. Each author contributes to the overall picture from the wisdom of their experience. I would go so far as to say that this collection deserves to be a book, both for its length and depth; it is one of those works that should be read from cover to cover.

We have divided the 25 works into three blocks: 1) Learning From the Past; 2) Understanding the Present; and 3) Preparing For the Near Future

Learning From the Past
Although all three sections are essential and provide relevant food for thought, I would like to highlight this section in particular. It is essential reading for anyone who wants to understand the history and perspectives of the many people who have gathered around and contributed to the Torture Journal.

The monograph - and this section - starts with a text by Hans Draminsky Petersen, a person who has been a true guide and lighthouse for all those breaking new ground in the medical documentation of torture over the last 40 years. Hans is, undoubtedly, one of the souls of the Torture Journal. A gastroenterologist by training, he has been responsible for many pioneering articles since the mid-1970s. Professor Petersen writes his piece about his experience conducting monitoring visits to detention centres in the many countries in which he has worked. In his sober style and with a touch of bitterness, he shares a critical view of the elements that perpetuate torture. Furthermore, he shares the lessons - some from painful mistakes - that are often learned in that complex work. We know this text comes from a long and deep reflection.

The following text by Professor Mahmud Sewail is also exceptional and unique. Born in Ramallah (Palestine), Professor Sewail’s life trajectory is that of someone with a passion for truth and justice, which has been denied to him, and to his patients who live under military occupation and are victims of both individual arbitrary detention, torture, and collective and community suffering. In a moving and profound text, brimming with wisdom and dignity, Professor Sewail writes about some of his childhood memories, including his brother’s death, that shaped his character and the way he advocates the rejection of all forms of violence. As well as the early institutional be-
ginnings of the TRC Center in Ramallah, he describes the subtle forms of daily abuse that a doctor working in Palestine must endure. It is a must-read.

A very different perspective from the following author: Hernan Reyes, a doctor who visited the world’s worst prisons for several decades as a medical coordinator for the International Committee of the Red Cross (ICRC). Those who know Dr Reyes are aware that he is a brilliant speaker. Recently retired and freed from the pledge of confidentiality and silence that followed his visits, Dr Reyes presented us, as editors, with a dilemma: he delivered about 100 pages of memoirs - far beyond what was demanded. Several months of work have resulted in a distillate of 40 pages. Often based on anecdotes and interviews with people in harsh detention conditions, he has recounted lessons and advice for young doctors and researchers.

This is followed by a text previously published in Torture Journal by June Pagaduan Lopez, who unfortunately passed away in November 2021 just as she was correcting the final proofs of her text. Seriously ill, she had started a survivors’ group in her native land of the Philippines to reflect on life experiences and what both torture and the healing process meant from a lifelong perspective: an open and informal space with people she trusted. Her idea was to develop a broader text that combined personal experiences with the voices of those she had worked with throughout her life. We will miss her very much and cherish the good work she did for the Torture Journal.

In her piece, psychologist and feminist Inger Agger gives a brief overview of a career focused on therapeutic approaches in working with victims. Inge discusses the 1980s, a time in which the gender perspective was innovative, and the debates of the 1990s around the concept of trauma and the need for a psycho-social perspective. She explores contemporary reflections on how it is possible to integrate spirituality and culture and new forms of mindfulness-based therapies. Finally, Inger shows us the difficulty of combining a rehabilitative perspective with a holistic view in which, without forgetting the political context of torture, we can develop treatments based on evidence but which avoid reductionist biomedical and behavioural models.

Vincent Iacopino, also recently retired, gives us some flashbacks to the beginning of his career in the anti-torture field, when many people were working against torture in the Global South, but very few in the Global North. He reflects on when the first waves of refugees from Latin American dictatorships were arriving in the United States and all the groundwork was still to be done. It is a text that suggests more than it says.

Continuing on are three texts on the historical origins of the IRCT, albeit with opposing views. In his short text, Dr Peter Vesti reminds us of the origins of the first rehabilitation clinic for torture victims in Copenhagen under the leadership of Inge Genefke, as well as the enthusiastic group of young professionals who discussed how to work in a permanent dialogue with exiles and authorities. He recalls the many difficulties in funding and growing the clinic and the network of associated centers while keeping up spirits and teamwork. The same enthusiasm is also recalled in the following text by Professor Christian Pross, but with a less rosy vision of the past. In a sincere, honest, and sometimes harsh text, he talks about his ambivalent experiences of Dr Genefke’s strong leadership and the problems that arise when, in his words, charismatic historical leaders find it challenging to accept other ideas or are unable to promote a necessary generational change. Professor Pross also discusses the difficulties and dynamics
of burnout in anti-torture organisations and in the supplementary materials of his paper, readers can download a manual on the issue produced at that time at the IRCT under his coordination. Finally, Henri Docker closes this series of connected texts. He was one of those behind-the-scenes figures who are indispensable to the birth and development of any project. A Danish journalist who was recruited to take charge of what was then called the International Newsletter on the Prevention and Rehabilitation of Torture, Henri conducted interviews, wrote editorials, and chronicled congresses and meetings. Now long retired, he still has the sparkle and strength in his eyes. In his concise text, he gifts us some glimpses of what those early, enthusiastic years were like from his point of view.

If there is a famous family in the anti-torture movement, there is no doubt that it is Diana Kordón, her husband, Dario Lagos, and their daughter, Mariana Lagos. Their story is that of the formation of the first support group for the Mothers of Plaza de Mayo and the pioneering Argentinian studies – from a systemic and psychoanalytic perspective) – on the individual and family impact of enforced disappearance and torture, and the therapeutic ways to address it. Writing from the EATIP, the centre they helped create, their texts paved the way for others to come. In their contribution, they recall this path, how networks were woven with centres in other parts of the world, and the beginnings of the IRCT. Diana Kordón was the author of the first article to appear in Issue 1 of the Torture Journal in 1988.

The next article comes from Professor José Quiroga – he was Chilean President Salvador Allende’s personal physician and was at the presidential palace on the day when a United States-sponsored coup d’état ended Allende’s life and ushered in the bloody dictatorship of General Pinochet. José Quiroga was forced into exile that same year. Once in Los Angeles, he started one of the first programmes documenting and caring for victims of torture in the United States. Honorary president of the North American network of centres for rehabilitation of torture survivors and author of some of the most influential theoretical reviews in this field, at 86 years of age he maintains a lucid and unique perspective on the realities of Chile, his native country, and the international context of the fight against torture. His work, the fruit of more than a decade of documentary analysis and personal research, offers for the first time a panoramic view of how the international community and the United Nations reacted to the Chilean military coup. He does this work in partnership with Elizabeth Lira, whose name speaks for itself. She was the author, under a pseudonym, of the first texts written on psychotherapy with victims of political violence from inside Chile during the dictatorship, with all of the risks that this entailed. In an environment of mistrust and fear, Elizabeth developed a theoretical framework on how these elements are introjected into society as a whole and transform it. In the text, together with José, she develops a chronology of the first care centres for victims, mainly under the protection of the different churches in Chile and in conditions of permanent threat, showing that there was a strong rehabilitation movement well before European and US centres began to develop their theoretical models.

Lilla Hardi, former editor-in-chief of Torture Journal and a pioneer in psychoanalytic work since the 1990s, recalls the origins of the Cordelia Foundation in Hungary from an intimate and personal point of view that conveys her deep and exceptional humanity.

Finally, this section closes with a paper from Jorge Aroche and Mariano Coello, migrants who arrived in Australia more than
three decades ago. They have recovered for this compilation an unpublished historical text from 1994 in which they reflect on the conceptual framework of care for torture victims in the then-embryonic Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS). Integrating a Latin American socio-political perspective with evidence-based knowledge, Jorge and Mariano outline a perspective that time has shown to be immensely fruitful and effective.

Understanding the Present

The struggle to consider solitary confinement as a form of torture has been long and complex. There is now widespread recognition of this fact, and different international sets of rules on minimum conditions in detention make this clear. Professor Sharon Shalev, a lawyer by training, has been engaged in a well-known personal battle against solitary confinement for more than 30 years. A prolific author, she reviews the slow progress and challenges ahead in her contribution, specifically from the framework of the Nelson Mandela Rules and the criteria for the UNCAT definition of torture. As she concludes, solitary confinement has been successfully associated with the idea of suffering and harm, but its practice remains extensive and normative in many countries. There is, unfortunately, still a long way to go before it is completely abolished.

In 1998, Edith Montgomery authored a special paper, later reprinted in Torture Journal, on the situation of Middle Eastern refugee children in Europe. Since then, she has regularly published research and reflections on the impact of migration and resettlement on children’s development and mental health. Based primarily on her publications, and in light of available data, Edith gives a comprehensive overview of the different historical paradigms to conclude that today’s situation for refugee children in Europe is the same or worse than it was 25 years ago. She reflects on how the countries of the Global North have increasingly tightened their migration policies and created environments of discrimination and marginalisation. Her text is complemented by that of Mikel Wessels, who reflects on the reality of child soldiers as victims of torture and the need for a psychosocial perspective based on the idea of damage to identity, avoiding Westernised clinical approaches.

Nora Sveass and Felice Gaer present the history of how the gender perspective has made its way into the UN Committee against Torture. Composed chiefly of men, there has been an ongoing open debate in the last decade as to whether gender-specific violence should be covered by the Convention Against Torture and discussed in the Committee, or be left to the deliberations and more general works of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). In their style, and based on their first-hand personal experiences, Nora and Felice illuminate the difficulties of the debates concerning CAT’s General Comment 2 and General Comment 3. The authors warn that with the recent renewal of half of the CAT’s membership, debates that had once been settled have been reopened, and warn of the real risk of regression in women’s rights regarding the fight against sexual and gender-based torture.

Stephen Soldz was one of the psychologists who led the fight from within the American Psychological Association (APA) to ban the involvement of psychologists in the interrogation of detainees at Guantánamo. This struggle has been described in other texts and is well known. In his reflections here Stephen goes further and talks about Operational Psychology, i.e. the use of psychology for military purposes, and the need for clear regulations of professional ethics in this field. He con-
siders that the recent publication of an APA draft ‘Guidelines for Operational Psychology’ has opened up the free participation of psychologists in practices prone to human rights abuses, undoing several decades of work in establishing an ethics-compliant professional regulatory framework. Furthermore, it opens the door to developing similar documents by professional associations in other countries.

Masha Lisitsyna has spent half her professional life doing strategic litigation in her native Kyrgyzstan and later as a Senior Lawyer within the Open Society Justice Initiative. In her brilliant contribution, she reviews some of the cases she has advised on in her long career, highlighting one learning takeaway: many of the organisations that do strategic litigation see domestic courts as a step to be left behind before beginning international litigation, where real success and change can be achieved. Contrary to this view, Masha seeks to show that it is possible to achieve transformative change in national legislative systems and offers some valuable pointers and lessons from her work and perspective.

Preparation For the Near Future
Professor Derrick Silove is the man of a thousand faces. Clear-sighted and multifaceted, his wide-ranging bibliography covers everything from clinical and psychopathology to epidemiological and service planning research. However, there are at least two common denominators in his academic production. First, a holistic vision of the human being, including social and political dimensions; and second, an attempt to push reflections beyond established limits. On this occasion, Professor Silove has produced a methodological text, a dry read, perhaps, for those who work in day-to-day survivor support, but a very timely reflection for those who combine science with service planning in working with victims of torture. Despite all that it seems, epidemiological studies are necessary for service planning, as each social and cultural context and human group is different. It is necessary to hear the voices of survivors each and every time.

Nimisha Patel and Amanda Williams are among the most recognised and cited academic duos in researching the rehabilitation of torture victims. Both have authored and co-authored texts and reviews over the past decades, most notably in psychotherapy, outcomes assessment, and chronic pain management. Their paper here addresses the permanent and challenging dilemma of the type of experimental support that should be given to evidence studies, while trying to dismantle some of the myths that have turned longitudinal case-control studies with standardised protocols into the only tool that would allow solid conclusions to be reached. Their rigour, so necessary in a field where disciplines are often challenging to operationalise, has always been a light.

Professor Metin Basoglu has spent a lifetime proposing and advocating for his therapeutic model for victims of political violence and disasters. This model is centred on the idea of deprivation of control as the critical element in understanding psychological harm associated with torture and takes exposure with response prevention as the therapeutic core of the healing process. He gives us a synthesis of this trajectory and a reanalysis of data, gathering the different samples he has worked with over the years, and seeks to give more robust support to his model by increasing sample size in a meta-analytic exercise. A prolific and essential author, the text is an excellent and necessary synthesis, and a step ahead in providing support to the model.

Finally, we have three short conceptual contributions, sharing ethical reflections on where we are and where we should go next.
Tony Reeler, with his exceptional view from Zimbabwe and his more than 30 years of work as a therapist and researcher, many of them within the IRCT Executive Committee, provides a somewhat bitter reflection on how the organisations in general, and Torture Journal as its expression, he argues, consistently devoted efforts towards the ‘rehabilitation’ component of their mandate. In contrast, the ‘prevention’ of torture component of the mandate - the political and human rights aspects linked to advocacy and policies for change - has been neglected. He reflects that while the focus on healing is legitimate, history shows that changes occur when ‘prevention’ is forefront, and thus challenges the IRCT and Torture Journal to be more clearly involved in the work to denounce perpetrators, support strategic anti-torture work and achieve justice and reparation.

Carlos Madariaga, one of the fathers of clinical work with torture survivors in Chile, and following a recent book he has published, makes a short reflection on the relationship between the impact of torture on society and victims and the realities of the COVID-19 pandemic.

Stuart Turner, a key figure in the origins of the Medical Foundation for the Care of Victims of Torture in the United Kingdom, and a prolific author in the trauma field, reminds us of the barriers and lack of solidarity imposed by the Global North on survivors of torture arriving in Europe and the US. He argues for a more humane and compassionate political position from authorities and the duty of professionals to persevere in lobbying for it.

Finally, Pérez-Sales closes this Section with a review of new technologies as applied to human right abuses and torture: from non-lethal weapons to nanotechnology and neurowarfare, including some of the emerging civil society initiatives to face it.

All of this makes for a unique issue in the 30 year history of the Journal. We are proud that those who are here are here, and even prouder to know that there are a significant number of colleagues who deserve to be in this compilation, which is a small sample of the plurality of voices that have found their space in Torture Journal. This issue represents the many challenges we have overcome together over the past 30 years, and acknowledges the vitality of a field that has countless challenges still to face.
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Looking back at experiences from 30 years with documentation and prevention of torture

Hans Draminsky Petersen

Abstract
The author describes his experience in conducting monitoring visits to detention centres in different countries with an analytical perspective on the elements that perpetuate torture.

Introduction
I am grateful for the invitation to write about experiences from my work against torture for over 30 years. There was a lot to be learned when I started, and there still is. We should analyse our procedures, our operations, and our results in the field to share our learning; successes as well as mistakes and errors acquire reflection to continuously improve our work. The following is not a scientific account, but rather a description of the development of the work I have participated in as well as my reflections on the various mechanisms of societies that either allows or prevents torture. Some of the errors I have committed will be mentioned. Some observations related to my fieldwork have not previously been a part of my publications, but these have influenced my thinking and opinions regarding documentation and prevention of torture and ill-treatment. Under each heading in this paper, my activities as well as facts, information, and observations by others are described, to which I have added my own comments and interpretations.

Spain
From casuistic documentation to preventive approaches and scientific analysis
Organised medical work against torture started in the 1970s. Inge Genefke founded the Danish Medical Group in Amnesty International (AI) in 1974. I joined the group in 1979; after a few months, I went with an experienced colleague on an AI mission to Spain to examine persons who allegedly had been tortured in police and Guardia Civil (GC) stations and assess the veracity of their allegations. We assessed that the alleged torture of 12 examined persons consisting of, among other methods, beatings including falanga, prolonged standing and forced physical exercise, suspension and fixation in awkward body positions, electrical shocks, asphyxiation procedures, threats including mock executions, deprivation of food and access to toilet and hygiene, and humiliations were consistent with the ensuing symptoms described and the result of the clinical examination, i.e., that the allegations were credible. When the AI report (AI 1980, Petersen & Rasmussen 1980) was published and presented at a press conference in Copenhagen, journalists focused on the few physical marks after torture which we described months after the victims’ release from detention.

In those days, the press and the public almost exclusively focused on the physical
aspects of torture. Post-traumatic Stress Disorder (PTSD) had not yet been described, and our psychological evaluation of persons alleging torture was not sophisticated just yet. Moreover, the two doctors did the examinations with an interpreter in the presence of the AI researcher. As seen in the interviewees’ perspective, sitting in front of four unknown persons may not be the best incitement to reveal very private psychological experiences from torture.

The examined persons had been released directly from police/GC stations without charges. They were threatened not to go public with their experiences, e.g., medical documentation of lesions acquired. The intention was to keep the discussion about torture away from the public domain. On the other hand, the victims’ families and friends would know, which one of the objectives of torture was: to intimidate the local community in opposition to the government and authorities.

It is fair to think that persons against whom there was no objective evidence of terrorist activities were less seriously tortured physically than those against whom such evidence existed, which would ensure that they were transferred to prisons without public attention and access to an independent medical examination after the initial detention where the alleged torture and ill-treatment took place. No visiting mechanisms existed in 1979. This selection bias was not part of AI’s agenda that only built on findings from the mission. However, death cases in custody occurred, e.g., one described in Danish Medical Journal (Albrechtsen 1982), constituting evidence that highly dangerous torture happened in Spain.

A few years later, outside AI, we started a controlled study in the Basque country, cooperating with local colleagues. It was meant to be an ongoing health monitoring of persons detained by the police or GC. We wanted to document late sequels of torture and publish our findings in scientific journals and the press to draw attention to the torture problem in Spain, hoping in this way, that there would be added political pressure against the Spanish authorities. A Basque general practitioner assessed a group of healthy persons (controls), and other local doctors examined persons who alleged having been tortured with the same methodology, and we should later re-examine that same group. The security of participants was an issue, but our means were not sufficient. The medical records of the first group of controls were seized in a GC highway control because the word “torture” appeared in the records. Consequently, we cancelled the investigation. The Basque doctors destroyed records of the second group of examinees out of fear for house searches and subsequent reprisals or detention, which was a realistic risk appraisal in those years.

We managed to re-examine ten persons some months after their release from 3-10 days incommunicado detention. The alle-

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1 Control persons, who were in steady employment in the local area, were selected on large industrial plant and examined according to the protocols used for the proband group, except for the information on torture
gations were the same as those documented during the AI mission, but there were also allegations of hyperextension of the spine, “the operating table” (Petersen & Jacobsen 1985). Again, physical findings were scarce and unspecific, as expected, considering the torture methods alleged.

A few days before our return, Felipe González (FG), the Spanish prime minister, heading a socialist government, visited Denmark. In an interview with the Danish press, he stated that since democracy in Spain was introduced, “not one single case of torture had been documented.” He omitted to mention the AI report from 1980 documenting torture in Madrid, Barcelona, and Bilbao in 1978-1979. In addition, many cases had been described in Basque newspapers, most with photos of lesions, and mainly bruises.

We were interviewed by the Danish radio, and our statement was contrasted to that of FG. We described our findings and stated that the loss of 15% of the bodyweight within a week together with the loss of consciousness with possible cardiac arrest caused by asphyxiation or electrical shocks would have led to hospitalisation in an intensive care unit in Denmark. The journalist focused on the flagrant discrepancies between the Spanish Prime Minister and our accounts. However, the program did not get much public attention — even in Denmark — and hardly reached The Prime Minister’s office.

We cancelled a planned inclusion of our findings in the national Danish TV news (with a much broader coverage and impact than the radio program) because it was no longer breaking news. Journalists compete, and once published, a story is no longer attractive.

Spain had gained much prestige through the introduction of democracy. The prime minister could easily get away with arrogance in a complex discussion about torture in the country, which was probably supported by the lack of specific physical torture marks in most cases.

Over the following decades, torture in Spain was documented and commented on by prestigious organisations, such as the United Nations’ (UN) Special Rapporteur on Torture (UN 2004), the UN Committee against Torture (UN 2002), and the European Council’s Committee for the Prevention of Torture (CPT 1996 a,b,c). Felipe González must have known about torture in Spain. His statement showed a lack of commitment to abolish torture after the dictatorship, maybe even as a valuable means of obtaining information in the fight against terrorism. In 1984, Guardia Civil officers were decorated by the Ministry of Interior for their work against ETA. At the same time, they were charged with the torture of two Basques, who later were acquitted because of a lack of evidence of terrorist activities (El País 1984).

It could also be that the government did not have complete control over the police and Guardia Civil. At some point in the 1980s, officers from the Guardia Civil declared publicly that they would go on strike in support of some colleagues charged with torture, arguing that a sentence would put all GC officers at risk of such charges. However, overtime, officers were sentenced for having committed torture.

It is not easy to abolish torture and ill-treatment after a dictatorship with a culture of severe repression. However, the denial of the existence of the problem by the prime minister in the first years of democracy must have contributed to the maintenance of torture and ill-treatment in Spain. A government should signal that torture is a crime that will be punished. Prevention of torture in detention would require a ban on lengthy incommunicado detention, access to a lawyer, and an independent medical examination. However,
the incommunicado detention is unchanged according to the Spanish anti-terrorist legislation, and over the years, Spanish governments have continued to deny the existence of torture. Furthermore, the Spanish National Prevention Mechanism (NPM), a body dependent from the Defensor del Pueblo (Ombudsman), who is elected by the Parliament, has never objected to its use.

A torture preventive approach was adopted years later in cooperation with a group of Spanish doctors when we assessed the quality of 318 medical reports issued in police and GC stations and collected by a Basque NGO (Petersen, Morentin et al. 2002). Theoretically, a medical examination of detainees documenting torture would have a preventive effect, as well as provided reports that are of good quality and that the courts act when torture is documented, inter alia, by initiating an independent investigation. In Spain, both conditions failed.

1: The medical reports did not describe sufficiently the torture allegations and the ensuing symptoms; the clinical examinations were deficient with ill-founded conclusions on the origin of lesions, and an overall conclusion on the consistency of the allegations was absent. 2: No action on reports, e.g., describing multiple bruises and long-term psychological consequences consistent with torture allegations, was taken by the court. International institutions have consistently criticized the Spanish authorities for not acting on allegations and the evidence of torture, e.g., the UN Special rapporteur on Torture (UN 2004).

We published a follow-up examination on another 425 medical records from detention (Morentin, Petersen et al. 2008); the results did not indicate significant improvements in the quality of the medical documents.

Busy doctors working in detentions do not have time and hardly the capacity to assess torture allegations according to international standards, i.e., the UN Istanbul Protocol. An ideal system to prevent torture comprises a specialised independent institution where physical-psychological forensic examinations can occur. Still, no such institution exists in Spain, indicating that the commitment to eradicate torture is not wholehearted.

In the 2010s, a large project on torture in the Basque Country was conducted by a group of Spanish psychiatrists, psychologists, and forensic doctors; 202 persons alleging torture and ill-treatment in the period 1969 – 2014 had their statements assessed as consistent, highly consistent, or maximum consistent according to a validated examination protocol (Pérez-Sales, Morentin et al. 2016).

We developed a scheme for the assessment of the medical services in detention. In cooperation with a forensic doctor from the Spanish group, the detainees’ perception of the medical services in detention based on the 202 testimonies were analysed. The doctors’ professional performance was perceived as grossly insufficient; they did not establish an atmosphere of confidence and were not perceived as neutral, as it was found that they sometimes collaborated with the police (Petersen & Morentin 2017). An obvious conclusion is that the medical institutions in police/GC detentions should be reorganised, ensuring independent and competent examinations, and a smooth procedure for referring cases of possible torture and ill-treatment to an independent specialised institution, cf., above.

Based on the same material, we assessed the physical aspects of torture in the 202 reports and developed a scheme for appraisal of the consistency of allegations of physical torture (Petersen & Morentin 2019).

**Manipulation of public opinion**

In 1998 the Spanish authorities published a letter, reportedly from the Basque terror-
ist organisation ETA. Persons who had been detained were requested to allege exposure to torture methods mentioned in the letter. The publication intended to indicate that torture allegations were fabricated.

However, a vast amount of scientific work put together in a report from the Basque government (Gorostiza 2009) has shown that the prevalence and the nature of allegations of torture and ill-treatment vary significantly with the place of detention from which the allegations stems, i.e., the GC, the national police, or the Basque police, and that the prevalence of torture allegations is related to the length of incommunicado detention. Furthermore, while there were thousands of people alleging being tortured, there was no single allegation of torture with the Basque detainees in France. These and other findings disprove the government’s statement that all allegations are fabricated according to ETA’s instructions and that torture does not exist in Spain. Nevertheless, the letter’s publication seems to have had an enormous impact on a large part of the Spanish population.

During a joint visit with the newly established Spanish National Preventive Mechanism (NPM) in 2010, I participated as a member of the United Nations Subcommitte on Prevention of Torture (SPT) in a visit to a prison in Madrid. I assisted in an interview with a young Basque woman undertaken by a Spanish psychologist with an interpreter. Weeping with running tears, the woman described the psychological and physical abuses she had sustained during detention in the Basque Country. The interpreter commented that all detainees were lying and instructed to allege fabricated accounts of torture without any argument. However, it was hard to believe that ETA’s alleged intentions to defame the authorities included successful training of the population at risk of detention in how to weep with tears on demand. However, the publication of the ETA letter had had a more significant effect on the interpreter than her observations. It appears that part of the public prefers to believe the most convenient version of torture narratives and ignore relevant observations made by themselves or others, including medical-psychological experts and experts from the UN and the CPT.

The ETA letter may be authentic. If so, it has been a highly counterproductive attempt to draw attention to the torture problem in Spain and bring into disrepute the Spanish authorities.

The ETA letter may also be false; in that case, it can be seen as a very successful manipulation of the public by authorities in line with Hannah Arendt’s description of political lies addressed to the public to overcome the clash between truth and policy: inconvenient facts are converted to another narrative through lies, the disregard of facts and documentation by experts, and manipulation depicting a false “reality” that fits the current policy (Arendt 2006). Facts documented by witnesses and experts are substituted with opinion, and the authorities capture the opinion. Governments promote the misconception (opinion) that a cumbersome problem does not exist. Politicians pretend and the public (want to) believe that democracy and rule of law work well.

Kashmir

Challenges in conflict areas

In 1993, I was a member of a small NGO called Physicians for Human Rights, Denmark. I went (poorly prepared) to the Indian part of Kashmir with a colleague. The objective was to find a family in Šrinagar, bring a son out of Kashmir and apply for his asylum in Denmark; he had been a passenger in a bus attacked by paramilitary troops. All passengers
except him were killed. Therefore, he was the only witness to the attack and was at serious risk of being killed.

We went to New Delhi, where we briefed a local NGO working with human rights, including Kashmir. That was an error. The Indian intelligence, without any doubt, surveyed the NGO. Our meeting there announced our presence and made it easy to follow our route to Kashmir, possibly jeopardizing the safety of the team and the people we met with. A small human rights NGO should try to work discretely in the field. However, we were in Srinagar very visible as nearly the only westerners there. Moreover, information spreads rapidly; a British archaeologist who stayed in the hotel told us that people addressed him, believing he was part of the human rights group although our presence had not been announced.

The NGO in New Delhi had persuaded us to cooperate with them and include in our small team one of their staff. That was another error. As the majority in India, all staff members were Hindus. At the same time, Kashmiris were Muslims, and the political and religious tensions were intense, with the Indian military presence in Kashmir visible all over the places we saw. The presence of a Hindu team member during interviews with repressed Muslim Kashmiris could have jeopardized the necessary confidence of the examinees.

From the airport in Kashmir, we were taken by a vehicle of paramilitary forces and escorted by two vans loaded with armed soldiers to the only hotel open in Srinagar. We were informed by this “welcome” that our presence had been noted. In the hotel, the police director approached us and told us that “he could not guarantee the safety of a Hindu team member”, who returned to New Delhi the next day.

We met with the father of the wounded young man, and we gave him money to buy a flight ticket out of Kashmir jointly with us. In the following days, we gathered evidence of torture and other human rights violations committed by Indian security forces. Before the planned departure, the father, ill at ease, came to our hotel with a lawyer; he returned the money because he thought that the whole family’s safety would be put at risk if the son left the country. We learned that human rights activism in conflict areas needed much more preparation and knowledge about the culture and a thorough discussion with all persons involved before obtaining informed consent to any action.

My colleague was later informed that some of the lawyers we had met with had been killed, presumably by Indian security forces. Whether this information was accurate and - if so - whether it was related to the contact they had had with us is uncertain, but I have many times reflected on it. It reminds me that activism in conflict areas implies a severe risk for interlocutors. A small NGO has no means to protect people, and all persons interviewed will most likely be swiftly identified by all parts of the conflict.

In our publication, we triangulated collected evidence (Petersen & Vedel 1994). We documented seven cases of severe and mutilating torture. Local doctors showed us photos of cases of torture produced lesions and local lawyers gave us a list (concerning the period 1990-1992) of names of 92 persons disappeared after being arrested and 98 persons who died during the first days of detention, many of whom “bore marks after torture”. In a hospital, we documented seven cases of gunshots reportedly not related to clashes between the army and militants, and local doctors showed us photos of children shot at close range. The medical evidence fitted with information from the lawyers and information from local newspapers. The Indian gov-
ernment had declared in 1993 (Gossman 1993) that, over the last two years, actions had been taken against over a hundred personnel from the security forces (presumably for torture and killings of civilians). All that evidence and information depicted a pattern of massive human rights violations committed by Indian security forces.

**Controlling the controller. A model for efficient crime prevention**

We could not carry hand luggage when we departed from the airport, and our suitcases were scanned. There was a control post in the airport building where all passengers were thoroughly body searched. There were another three similar posts on the way to the airplane where the body searches were repeated. An old German tourist cried with tears in his eyes that this was madness. He ignored that the searches additional to the first one was meant to control the efficiency of the previous ones that could have been passed, e.g., by way of corruption. If the control posts were staffed with independent officers, i.e., officers who did not know each other, the search system would be very efficient, even in a conflict area with widespread corruption. No aircraft hijacking was reported from Kashmir in those years.

Such a model of independent control of controllers would also work in places of detention where internal mechanisms for the prevention of torture should be overseen by independent controllers, whom the civil society should oversee. Theoretically, it could also be implemented to ensure that judges act on documented ill-treatment and torture in detention following the UN Convention against Torture, cf. the section about Spain.

**Our follow-up**

The following year we went two times to the Pakistani part of Kashmir and visited refugee camps for people who had fled from Indian-held Kashmir. On the first occasion, we examined 65 persons who had sustained different forms of violence. Seventeen adults (Petersen & Wandall 1994) and ten children (Petersen & Wandall 1995) alleged having been tortured, and the majority, inclusive the children, had remarkable scars very highly consistent with their allegations. On the second occasion, we examined in refugee camps exposure to torture and killings of members of 94 families who had fled from Indian-held Kashmir 1989-1994. At least one member in 90% of the families alleged being tortured by Indian security forces (Larsen, Petersen & al., 1995).

Our reports got some attention. We were invited to a parliamentary hearing in London and the Danish parliament to present our findings. In 1996, I presented the results with photo-documentation at an international congress on forensic sciences in Tokyo. Three persons in military uniforms presented themselves as Indian forensic doctors. They declared that torture does not take place in India, that the documentation (published in peer-reviewed scientific journals) was false, that the congress committee should never have accepted the presentation, and that “no such thing as Indian-held Kashmir exists, all Kashmir is Indian” in contrast to the reality. When high-ranking officials deny even the existence of a problem, there is a long way to a solution.

In the following years, we went two times to refugee camps for Burmese in Thailand (Petersen, Lykke & al. 1998; Petersen, Worm & al. 2000). We applied an adapted version of our procedures used in Kashmir and documented massive human rights violations against ethnic groups living close to the Thai border. Our reports got some attention thanks to partners from the Danish Church Aid; we presented our results in the Danish parliament. Some months ago, after temporary democratization,
Myanmar’s military dictatorship returned to full repression against demands for democracy and detained or killed thousands of demonstrators. Furthermore, even during the period of some democratization, there were gross human rights violations against Muslim ethnic groups leading to massive emigration. The military is still in control, but in 2021, there was a releasing of political prisoners (demonstrators) probably because of the decision of neighboring states to exclude Myanmar’s military leader Min Aung Hlaing from the The Association of Southeast Asian Nation (ASEAN) summit. Pressure from actual trade partner states can significantly affect the human rights situation in a country.

RCT/Dignity
The reports on Burmese refugees led to my two years of employment in the international department of Dignity (then named the Rehabilitation Centre for Torture Victims, RCT) - my only full-time anti-torture employment. I advised eight partner NGOs on health issues and monitored their results.

As part of my work, I was in Zimbabwe and participated in the partner NGO’s documentation of massive human rights violations before a presidential election. Among the victims were four villagers known to oppose the government. They had been beaten all over, inclusive with cables and barbed wire, and one had been stabbed with a screwdriver in his eye by “war veterans”. Their ID cards had been seized, impeding them from voting.

We swiftly produced a report (and subsequently an article (Eppel & Petersen 2002)) with photo documentation of remarkable lesions very highly consistent with alleged torture. We distributed it before the elections to London officials and many European, African, and American embassies. I had hoped that our report and interview with BBC would add to the condemnation of president Mugabe’s regime; South African Nobel peace prize winner Archbishop Desmon Tutu had commented in BBC that “Mugabe had gone bonkers in a big way” for disregarding the rule of law. Zimbabwe was deeply dependent on trade relations with South Africa, and closure would probably have led to the fall of Mugabe’s regime. However, nothing happened, and Mugabe stayed in office for many years while the human rights violations continued. The lack of political pressure from neighbor states confirmed that African leaders support each other. An African embassy clearly expressed turning a blind eye to facts: “You should not worry; the voting is free and secret”.

I had come from 25 years of work in medical departments with very sick patients; most were discharged in much improved conditions. A positive outcome of my work was visible practically every day. In contrast, working with documentation and prevention of torture does not produce results overnight. After two years of full-time employment, mostly in offices, I felt burned out. I returned to clinical work but carried on anti-torture work as procurement activities, including as a consultant for Dignity.

Prevention of torture and ill-treatment in the SPT
In 2007 I was appointed as one of the ten members of the newly established UN Subcommittee on Prevention of Torture (SPT), in which I served for eight years, and where I also served the first four as one of the vice-chairs. According to the Optional Protocol (OPCAT) to the UN Convention against Torture, the SPT visits places of detention (PoD), speaks in private with all relevant persons, and makes recommendations for necessary improvements to protect the rights of inmates, and the government should im-
plement the recommendations. The focus of the visits was on all aspects of prison life, intending to safeguard the rights of inmates, including – naturally – the right not to be tortured. Documentation of torture was part of the agenda, and if a case was documented, it was analysed to find out which means of protection had failed. The fight against impunity is closely linked to the prevention of torture – in contrast to the thinking of the Spanish National Preventive mechanism that did not deal with cases of torture alleging that their mission was just “preventive” and contributing to make torture invisible.

**Bribery, extortion, and confession as fundaments for conviction**

A general problem in low-income countries is corruption. Practically anything may have a price, including Medical services. To the surprise of high-ranking officials during meetings with the SPT in one country, we suggested that the salary of police and prison personnel should be raised to a level that permitted a decent living as part of the fight against the corruption that everybody acknowledged as a severe problem. Their surprise came as a surprise to me. If you pay a meagre salary, the personnel must find other income to make a living. Moreover, the under-paid police and prison personnel are in positions of power over very vulnerable inmates; hence, corruption and extortion are very foreseeable.

During a visit to a large police station in another country, we met a young couple in the yard. The young man was detained, and the woman was his wife; our visit had interrupted their negotiation with the police about the price for his release without charge. His detention had not been registered, and his arrest and release would never be known in case the couple paid the right price. Refusing to pay would put him at serious risk of torture to make him confess, regarded as the solution to a crime. In the same country, I had a conversation with some police officers. They described the chain of events from arrest, initial interrogations, and investigations to transfer to prisons. I commented that some would be released, to which they reacted immediately: “Sir, you have misunderstood. In this country, we only detain the guilty persons”. The two combined observations indicate a long way to justice: laws must be changed, requiring evidence to determine guilt, laws must be rigorously implemented, and institutional cultures must be changed.

Courts’ reliance on confessions as sufficient proof of guilt is a serious problem. In some countries, we learned that police officers were rewarded with a bonus for “solving” a crime, i.e., obtaining a confession – a strong incentive for a poorly paid officer to extort confessions, including ill-treatment and torture.

In many countries, bribery was blatant. In one country, I saw a visitor in a prison handing over money to an officer; it could hardly be for anything but a service that should be free of charge; interchange of money between inmates or visitors and staff should not occur. Theoretically, a ban on cash in the places of detention could be a means to fight corruption. However, other items may be used in exchange for goods and services without money.

I requested an interview with the prison doctor in another country, but he declined, saying that he was too busy. A little later, I saw him in the corridors with four packages of cigarettes in his hands. He did not even care to hide them from me, thereby exposing himself as a cigarette dealer or, more likely, carrying the payment in an alternative currency - cigarettes - for services that should be free of charge. Bribery is a burden for the poor and vulnerable to corrupt officers’ abuse of power and a means for the wealthy to ensure
their rights and obtain privileges, reinforcing the differences in living conditions in places of detention.

_Torture and medical complicity_

In a police station in an African country, we observed long, narrow, recent skin lesions on two detainees in full agreement with their alleged whipped. We found a whip in a drawer; hence the cases were obvious. The attitude of the officers was extremely arrogant, underlining their position of power and an ambience of impunity. The cases were mentioned in the report but never satisfactorily responded to by the authorities, which in the first place would include a criminal investigation. Torture and ill-treatment shall never be eradicated without the wholehearted will of a government in control of the law enforcement bodies.

In a Latin-American country, the head of the institute of forensic medicine (IFM) was present during our initial meetings with authorities. He stated that all specialist evaluations of alleged torture victims were done in the IFM and that there had been no case of documented torture in the country over the last years. During visits to places of detention, we heard many highly credible accounts of torture. In response, we documented torture produced lesions and saw places where victims allegedly had been chained and beaten, i.e., pieces of mutually corroborating information depicting a pattern of widespread torture in sharp contrast with the statement from the IFM head.

The explanation for this discrepancy was the nature of referrals to IFM from custody. Medical examinations were done according to a form containing several items with boxes filled in. Torture, ill-treatment, and violence was not part of the section on the medical history. Logically, there was no space to assess the consistency of torture allegations, which could have been an obvious criterion for referral to the IFM. In this way, torture systematically went undiagnosed in medical examinations and referrals to the IFM were blocked. Furthermore, since torture must be documented in the IFM to be acknowledged, it did not exist officially against evidence that could easily be found in many places of detention (PoDs). The medical establishment can be an efficient tool to conceal facts about torture.

In another Latin-American country where physical torture was documented in many PoDs, we observed an old shabby baseball bat in the reception area of a large prison where initial interrogations of newcomers took place. We were explained that it had been forgotten and was not in use. In the medical clinic, there was a register with names of all newcomers and their diagnoses made at the medical examination upon arrival. I noted two cases of fractured shins. Unfortunately, the visit was brief, and only was it too late where I put the observations together with the possible conclusion that the bat had been used to beat the shins of inmates, causing – probably by accident – fractures in two of them. We did not return to that prison, and I did not manage to speak with those inmates. Had my hypothesis been correct, documentation could theoretically have led to an investigation and changes in the prison’s reception procedures. It could also have been documented that the doctors who treated the fractures did not identify and report torture to higher authorities. Sometimes we need a little time to analyse what we see and hear and put observations together. Visits to problematic institutions should not be too hasty; debriefing with colleagues during the visit may be helpful to put observations together and get things right, and follow-up visits after initial analyses may clarify uncertainties.
Capos and the prison as a marketplace

Walking around in a prison dressed in a UN jacket attracts the attention of prisoners and staff. Furthermore, the identity of interviewed persons will soon be known by staff and fellow inmates. Some of the most relevant persons to interview are the scared and repressed who often refuse to give interviews or disappear when monitors come near. On the other hand, prisoners who offered to show us around were often the capos who shared the interest of the staff to expose the positive elements of prison life while benefitting from privileges such as placement in the most attractive cells and sometimes getting a share of the widespread corruption and exploitation of other prisoners. A capo tried to assist in an interview with a fellow prisoner, thereby controlling the information given to us. I learned that the system with capos and corruption could be identified easily by looking at the vast differences in living conditions in different parts of most prisons in low-income countries. I also learned that ordinary prisoners risked reprisals from the capos if they revealed details about the system of exploitation.

Naturally, reprisals could also come from staff if details about abuse and exploitation were given to us in an interview. We heard several times (through interpreters) that inmates were threatened before an interview not to give us information. We did not receive information that reprisals took place after our visits, but such messages would be very difficult for inmates to convey. Reprisals are a reality that we must address. Our essential precaution was to interview many persons and refrain from giving personal details of victims in our report to make identifying the source of information difficult. Any reporting from an interview requires complying with Istanbul Protocol Ethical principles, among them, consent from the interviewee and a low risk of reprisals.

I believe that we should assume that the capo system is ramified with helpers and informers. Staff and fellow inmates will soon know the identity of all persons interviewed by visiting monitors. We must make sure that our interviews take place out of hearing of staff and fellow inmates who could be capos or informers. Group interviews are sometimes performed under the condition that only general issues verifiable by anybody are discussed, such as the quality of the food. The risk is that the ordinary conversation comes out of control, and some participants give critical information in front of fellow inmates. After one such episode, I did not conduct group interviews at all. Moreover, as far as possible, I did my interviews about available treatment and abuses in the clinic, pretending that I focused on health issues.

The capos’ roles could be official. In a former Soviet republic, I went to a cell to interview some of the eight prisoners in private. When I entered the cell with an interpreter, all eight prisoners stood in a line. The capo responded to all my requests by saying that any question would be answered in the presence of everybody; they had no secrets to each other. He blocked efficiently any private communication. No one consented to an interview in private, indicating the power a capo can have over fellow prisoners.

In many prison yards of low-income countries, there are small shops with food and many other items for sale, filling a gap between the prisoners’ needs and the provisions offered to them. Prison management, as well as shopkeepers, are usually reluctant to explain the financial structures. In essence, the cash flow goes from the bottom to the top, ultimately to the management, with some shares to the shopkeepers and the capos. The poor and the hungry rely on support from their (poor) families to acquire what they, in theory, are entitled to get for free.
**Overcrowding and dysfunctional judicial systems**

In all PoDs in low-income countries, the lack of space was horrendous. In some African prison cells, inmates were lying in physical contact with each other at night like spoons in a box. Since the space was still insufficient for all to lie, prisoners had to stand up in shifts at night in 36 centigrade and extreme humidity. Some of those placed lowest in the hierarchy stood up all night. In an Asian country, many prisoners spent nearly all the time in typical overcrowded cells without any decent activity. More than half of some 20 inmates tested had reduced force of their feet and legs, a sign of insufficient nutrition with a lack of vitamin B1. It is hard to believe that such prison conditions will make prisoners well adapted to the general society.

On the other hand, it is easy to believe that apart from all their direct effects, such conditions will cause intense suffering, tensions, conflicts, and violence among inmates, amounting to cruel, inhumane or degrading treatment.

An African prisoner said that the fundamental problem in his prison was that he and many others should not be there at all. Like many other countries, far more than half of the inmates were on remand, and many could be innocent. Furthermore, many prisoners spend more time on remand than the maximum penalty for the crime they are accused of having committed. A large part of overcrowding stems from a dysfunctional judicial system and the abuse of detention in remand is a worldwide problem.

**Human rights training and problematic quantitative data**

Staff in places of detention must know the rights of inmates and the rules for maintaining security and discipline. In all country visits I have participated in, we recommended such training. The government of one large country responded by sending a long list of training held and participants’ numbers. Such numbers may seem impressive at first glance, but if broken up in a yearly number of training days for each officer in a PoD, the picture may be quite different. Moreover, if the training is not institutionalised by the management of institutions, no effect on institutional practices will be achieved. Quantitative measures of torture preventive efforts may be misleading. Effects should be assessed by necessary changes, e.g., documented implementation of the learning from training.

Another misuse of quantitative data was presented to the SPT by a visiting National Preventive Mechanism (NPM). The NPM had been criticised for doing too few visits but argued that it had visited prisons and other institutions representing tens of thousands of persons deprived of their liberty, constituting a significant percentage of all inmates in the country. However, many enormous prisons with more than ten thousand inmates had been visited, which counts heavily in such a statistic that I consider bloated and meaningless. It does not tell us anything about the quality and impact of the visits.

I have been on visits to large institutions where a team of four was supposed to view the reality in one day. Following the visit, I left with a feeling that we got some helpful information; but also, we most likely missed essential details that could have been grasped with more time. However, our statistic ended up impressing both by counting the number of prisons visited and the number of inmates in those institutions.

Another statistic comes from the number of State Parties to the OPCAT. The number has constantly been growing over the years, which may constantly be growing over the years, which may be a success. However, during visits to several countries, my impression was
that those governments did not understand the country’s obligations prescribed in the OPCAT. The motive for ratification was more likely to brand the country as a human right respecting nation – possibly to obtain development aid – than a genuine wish to reinforce the rights of persons deprived of their liberty. I see the long delay in establishing NPMs and insufficient resources for the NPMs as an indication of that. There is at least one example that the NPM was drained when it became relevant, i.e., rightly pointed to problems to be solved.

The UN Special Rapporteur on Torture (SRT) had visited Jordan. His team had documented cases of torture and concluded that torture was widespread in the country and routine in some places and that impunity was total. He published a report in which he recommended that named officers should be investigated for committing torture as the first step to end impunity (Nowak 2007).

It was said in the UN that Jordan had been at the point of ratifying the OPCAT before the SRT’s visit but refrained from doing so because of his report, and Jordan is still not a party to the OPCAT. A UN official from the middle management commented that the visit of the SRT to Jordan had been a total disaster. It made me reflect on whether a state’s ratification of a treaty is a success, no matter the lack of intentions of the country’s government to comply with it. If good intentions faced the problem (inter alia, torture) and remedy gaps in the protection of persons deprived of their liberty are lacking, ratification of the treaty would not bring any changes, and the number of state parties to the treaty becomes meaningless as an indication of the international community’s commitment and endeavour to abolish torture. Ratifying treaties imply a dialogue between the State Party and the UN bodies based on observations and available information. The state must envisage criticism and comply with the recommendations for changes.

**Security on mission**

The UN did not provide a security officer in the first SPT visits. Only in my second country visits, in an area of a prison that was not surveyed by staff, I had an argument with a capo who insisted on talking with me and blocked my way out of the area. I was in a hurry to catch a debriefing meeting with colleagues and stubbornly refused to talk with him, which I later regretted. After a while, he let me leave.

I have never been attacked, threatened, or insulted, even though I have been around on my own without the presence of staff in all sorts of places of detention. When we invited inmates for interviews, we could not promise them anything, and I can only remember very few cases where our interventions gave immediate results. In these cases, very sick prisoners were transferred to hospitals. We informed candidates for interviews that our work would only – hopefully – lead to improvements in conditions and treatment in the long perspective and might be irrelevant to the individual interviewee. However, I am sure that inmates understood that we were there to remedy violations of their rights and that would not be achieved overnight, and that their information did matter.

After some years, all visit teams included a security officer. There was an enormous difference in their modes of operation. In one country, the security officer body searched prisoners who were to be interviewed to ensure that they did not have weapons. However, he declined to that after a discussion in the team, accepting that such a procedure would jeopardize an atmosphere of confidence in our encounters with inmates.
In another visit, I was called as the team’s doctor to an interview undertaken by newly appointed colleagues. A frail older adult with eye problems was being interviewed. He was placed in a tiny room adjacent to a large room but separated with metal bars. The interviewers were placed in the large room 5 meters from the bars, and in between, a UN security officer was sitting together with an interpreter. Just outside in the corridor, there were two guards. The guards said that the interviewee was dangerous, which was why our security officer accepted the security arrangements. I was supposed to assess the eyes of the prisoner without being allowed to approach him. I refused to pretend that I could do medical work under such conditions and brought the issue up in the delegation meeting. The security officer insisted that the arrangement had been agreed upon with the prison authorities and was acceptable. My argument that medical work and confidential interviews do not work in such settings was not accepted.

I think that the reason for setting up such an absurd arrangement was to make sure that participants in the interview spoke so loudly that guards outside the cell could hear what was said. In general, we should assume that requests/orders from prison management to monitors always have a purpose that is not always easy to reveal. When staff members say that an inmate is dangerous, it is often not the security of monitors they have in mind but rather an intention to block their communication with key interlocutors. On several occasions, I have got the most relevant information about torture from such inmates.

In a Latin-American country, we visited a prison where members of an extremely violent gang were placed in a separate area where no staff were let in. Our security officer negotiated with the gang leader and obtained permission to enter the area. There were no incidents, and we had some valuable interviews in private, including an interview with the leader who occupied a space much more comfortable than fellow inmates’, indicating that the usual prison hierarchy also worked there.

Security measures on a mission may facilitate the monitoring work or quite the opposite. The terms of reference for all participants should be adjusted to ensure that monitoring can be safely performed in the spirit of the OPCAT: interviews with all relevant persons must be done in private.

Our interlocutors’ safety has been briefly mentioned above.

**Debriefing**

In the first years of my work, I/we only knew the concept of debriefing intuitively. In principle, we worked in pairs in AI’s medical group, and I think the wrap-up of a day’s experiences usually worked as a kind of debriefing. However, I have been on a mission as the only doctor, and the experiences on some missions were shocking. I believe that I, as well as my family, would have benefitted from qualified debriefing after some missions. When I worked with the 202 Basque medical-psychological reports – each one had many pages of description of interrogations and torture and I had stipulated that I could handle 7-8 cases per day, which would constitute a data-gathering phase of 5-6 weeks. However, after a week, I became grumpy and difficult to live with. My wife and I understood the reason: the psychological impact from the reading. The work plan was changed, and with only two days of work per week, my ordinary mood returned. I believe that we have to become better to take care of ourselves. However, I also believe that still many of us have something to learn about how to make our encounters with victims less uncomfortable for them and how to end the interview in a manner that diminishes as far
as possible the psychological turmoil caused by the recalling of horrible memories. If acceptable for the victim, some basic counselling may be a little helpful. It is not only their security and security that matters and should be balanced with the potential – but often unlikely - benefit from monitoring and research.

First, do no harm – all sorts of harm.

Final Remark
Eradication of torture requires that the government is fully committed to doing it and that the government is in complete control of all security and law enforcement bodies.

It happens when a government changes its positions in situations of crisis. For example, a few years ago, in the “war on terrorism,” the president of the USA distorted the definition of torture permitting, e.g., interrogational waterboarding that clearly is a torture method. It may be supposed that the US government is in (full?) control with its intelligence; hence, torture in such a setting may be abolished by decree from a new government with another approach to torture.

Eradication of “everyday torture” applied to “solve crimes” is more complex. In many countries, the use of torture is embedded in traditions, institutional culture, inequalities, ethnic conflicts, discrimination of certain groups, economic problems, and corruption, resulting to factors that are much harder for the government to control and require much time to change.

In both scenarios, the public opinion matters to influence policy.

International law provides the means to abolish torture, and most countries have ratified conventions against torture. Monitoring places of detention has been established in many countries during the last decades to safeguard the rights of persons deprived of their liberty. The power of monitoring mechanisms to demand improvements in the administration of justice constitutes one of their potentials to fight torture.

Another potential is the transparency inherent in monitoring the informing of the public about the reality for persons deprived of their liberty - i.e., serious human rights violations in places of detention - which hopefully shall lead to better public understanding of the negative effects of a dysfunctional judicial system and thereby a pressure on governments to implement changes.

It is possible to eradicate torture; in some countries, it does not exist. Such countries are characterised by, inter alia, political stability, respect for human rights, the rule of law, well-functioning judiciary, prosperity, relative equality, and (nearly) the absence of corruption. The work against torture is an ever-lasting fight. Society does not achieve all that overnight, and setbacks may come over time. We might assume that nothing (beneficial) will happen, but we must do our utmost to ensure that no harm is done. Nevertheless, if our activities cause harm, we should share our experiences to prevent repetition.

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Personal reflection

Mahmud Sehwail

Adam ate the apple, and our teeth still ache.

Hungarian proverb

Abstract
The author brings an account of his life trajectory as a psychiatrist born and working in Palestine. The author dives in his early memories, including those of his brother’s death, that shaped his character and the way he lives his rejection of occupation and violence. Besides the early institutional beginnings of the TRC Center in West Bank, the author describes the subtle forms of the daily abuse that a doctor working in Palestine must endure.

My brother
In March 1982, I worked as a neuropsychiatrist at a psychiatric hospital in Zaragoza, Spain. As I was leaving the hospital for the psychiatric medical centre, I stopped at a café/restaurant with my colleague, who was a clinical psychologist. The compound was a large centre for all staff where we checked up on outpatients after our shift ended at the hospital. As the waiter brought us our order, I suddenly felt uneasy. A metaphysical state of precognition dominated me that something catastrophic had happened to a family member. I began to sweat and felt like something had gone terribly wrong. At this point, I could not eat. My colleague asked if I was okay. That is when I said I felt a family member had died at that very moment. It was a Monday. My colleague had told me that maybe it was because I received a job offer in Kuwait and was reluctant to accept. I told her no, instead I felt like I had just lost a family member. I did not eat and became very worried.

Afterwards, we went to the medical compound. I sat with a few patients but was anxious the whole time. I went back home after finishing work to rest a bit. There was a long holiday that week, and I had plans to stay in a nearby area close to Barcelona with a few colleagues for some days. I was still preoccupied. We heard on the news that a number of children had died of electrocution in a terrible accident in Barcelona. I felt overwhelmed by that event throughout the week. On Saturday, I had this pressing need to head back to my apartment in Zaragoza. A fellow Palestinian whom I knew coincidentally noticed I was not feeling well. He told me that he would be right behind me in his own car during this 200 km drive, as he feared I would have an accident.

As soon as I opened the door to my house, I immediately knew why I felt so uncomfortable. I found a telegram but refused to open it because I sensed it was about the fate of my younger brother. About 30 minutes later, my friend entered my home. My door was semi-
open, and I was sitting on a chair with the telegram in my hand, hesitant to open it because I knew it was about my brother. My friend took the telegram from my hand and read it. He stared at the telegram while lightly shaking his head. My brother was 17-years old and attended a secondary school in a village close to mine.

As I learned the details later, my brother had disappeared on the same day I had that strange feeling. He did not return home that day. It was an icy week. As he walked out of school, he joined a bunch of other schoolchildren to see what was going on. There was a small demonstration outside the school. My mother was looking for him, asking everyone around about his whereabouts. Someone informed my mother he was detained along with a number of other children, which turned out to be untrue. By the end of the week, particularly on Saturday, his body was found on a nearby mountain punctured with bullets.

I could not believe this was happening. I tried to go back home to occupied Palestine, but due to travel restrictions of the occupation, this could not be coordinated as soon as expected. A countless number of Palestinians from all over the occupied West Bank attended my brother’s funeral. The Israeli military began to throw tear gas canisters and shot at the crowd to disperse the large crowd. That night, the Israeli army vandalized my brother’s grave and took his corpse to the Abu Kabir Forensic Institute for an autopsy. Finding this out was humiliating and traumatizing for all the family. After two or three days, they returned his body and only allowed two people from my family to rebury him, and only at midnight. This was a new re-traumatization on its own.

During this time, I was in a state of shock and in a state of grief for my brother. For at least one week, as I laid in bed at night, I could hear my brother’s voice calling out to me. I would frantically jump out of bed and check all the rooms in my house, searching for him. This would occur two to three times a night. It felt surreal as I was in a state of derealization. After about a month, I began to think of ways to go back to Palestine. At that moment, as most Palestinians studying abroad, I was denied the possibility to go back home.

One month later, a Brazilian psychiatrist was invited by the hospital administration where I was working in Zaragoza as part of staff development and clinical supervision. He informed us he wanted to sit with our team of psychiatrists to have a group therapy session. One of my colleagues told me that the Brazilian was indeed Jewish and that I was sure someone informed him I was Palestinian. We all sat in silence for about 6-7 minutes. No one uttered a word. The Brazilian then said that he was going to start the conversation. He began by telling us a dream he had: he was in his car racing with someone. I suddenly spoke and said he was racing with me. I felt rage deep down within me and started to say that I would collide with his car and damage it. All my colleagues sympathized with me, as they knew about my situation. I remember the Brazilian psychiatrist was perplexed, although he was a psychiatrist and specialised in group therapy. He was surprised at this sudden change of behavior. Afterwards, we were both aware of each other’s past trauma and were deeply moved by the other.

Returning to Palestine
My mother had finally obtained a temporary stay permit for me to return home to occupied Palestine. Shortly after I arrived in Palestine in early 1983, a meeting was arranged with Dr Mohammad Saeed Kamal. He was a psychiatrist and the Mental Health Hospital/Bethlehem director, which was the only mental health
hospital in the West Bank and Gaza Strip. Dr. Kamal was excited that I joined them, as there were very few specialists at the hospital. I received an employment offer from the hospital.

During those early days back in my homeland (Palestine), I met a schoolteacher in a social gathering who spoke about the multiple traumatic stressors among Palestinian children. After some time, we were engaged and finally got married. For four years, I lived without a Palestinian ID in my own country in my parents’ house where I was born. I had to apply for family reunification to live with my spouse, and I had to renew my residence permit every six months.

I remember an incident in mid-1983 when I was required to renew, once more, my residency permit in Ramallah. I went to the Israeli Military Administration for Civil Affairs downtown. An Israeli police officer at the front gate ensured everything was organised. This police officer was yelling at and even kicking people to get them in line. He kicked me in the shin. I was furious and began to yell and curse at him. When I finally got inside, the police officer started to call on those who wanted to apply or extend their residency to enter the room. It seemed the Israeli police officer informed his subordinate about our incident outside because the Israeli officer told me to come back two days later. We argued, and I told him that I was born in 1947; I am therefore inherently and deeply rooted in this land and older than the Israeli occupation of Palestine. He punished me thereafter by postponing my appointment for the next week. He refused to provide me with a definitive appointment. I eventually renewed my residency. This example shows how the Israeli government engaged in the humiliation, ill-treatment, and dehumanization of Palestinians in tiny things of everyday life.

Palestinians were required to stand in long rows, in all weather conditions, in unpredictability, and uncertainty whether they would be able to obtain/extend their permits and finish other necessary work. Appointments were postponed regularly, for weeks and even months. They regarded us Palestinians as inferior to them and treated us degradingly, and continue to do so today.

This policy should be considered a way of psychological torture for two purposes: One, to make Palestinians feel their fate lay in the hands of the occupation, and two, to make people feel insecure and fearful most of the time.

My first visits
I began to work at the hospital by the end of 1983. Dr Kamal and I became good friends. In early 1984, he asked me to assess a detainee at an Israeli detention centre in Ramallah suffering from schizophrenia and a resident of the Jalazoun Refugee Camp. I waited for many hours to enter the detention centre. I was about to head back when I was called to go inside. I assessed the detainee, wrote his medical report, and was able to have him released thereafter. I then started volunteering to assess detainees at different Israeli detention centres. I made hundreds of visits to detainees, and every time I would promise myself that this was the last visit I would make because prison visits were an agony. I never actually stopped visiting because I would feel guilty. I would generally arrive at the detention centres very early in the morning upon their request. The Israeli guards would then tell me it was too early to enter, and I could only meet with a detainee after many hours. I would always force myself to wait even under severe climatic conditions, whether in the hot summer or cold winter months. Waiting was and is still part of those subtle ways of psychological torture. There were only a few human rights organisa-
ations in the West Bank. The reason for the long waits was to make me reconsider the humanitarian work I do and force me to voluntarily put an end to it, and in addition, to deepen the collective humiliation of Palestinians.

During an interview with a detainee at Israeli detention centres, there was always someone in the room with us from the Israeli military. In these moments, there would be no privacy and confidentiality between patients and doctors. However, one time, I visited a detainee in Megiddo, located near Nazareth. I noticed that I was alone with the detainee, but a recorder was hidden behind a short curtain at the top corner of the wall. There was, again, no privacy at all. I felt apprehended as if someone was watching me. This has caused some kind of shock and intimidation to this day. I also started to become nervous and impatient; for example, whenever I was going out with my wife or mother, I could not wait for them for too long. I would get furious if they made me wait even for a few minutes. In the beginning, I did not know why I was acting like this. Only years later, I realised it was a reaction to waiting for long hours in front of the Israeli detention centres under all weather conditions to be allowed inside.

I remember when I went to Bir Alsabieh/Be’er Shiva in early 1988 to visit a detainee with severe psychosis. I went in early in the morning as requested, and it was not until around 3:00 pm that the Israeli military allowed me into the detention centre. It was July, and it was extremely hot as Be’er Shiva is a desert. There were no canteens or nearby markets to buy water or other beverages. When I walked inside, an Israeli doctor of Russian descent was amongst other individuals in the room. I protested the long wait, and out of anger, I told them that we Palestinians are suffering because we have no choice; the suffering of Israelis was their choice when they decided to occupy others. They stuck me in a room while they yelled and cursed at me. I suffered a heat stroke, and they feared I might collapse at that moment. They then told me to head back to my car and drive home. I refused and insisted on sitting with the detainee I went to see. I still remember that detainee vividly because the detainee was grossly psychotic and complex to handle. Based on my medical report, I requested the patient be transferred to a mental health hospital, and they granted permission for the transfer a few days later. I was in charge of that department for detainees’ affairs at the hospital. After leaving the detention centre, I got sick for about two days due to dehydration.

I visited all detention centres. I have come across many stories, so many heart-rending stories through which I learned about the suffering of many detainees. Some detainees I visited or treated at my private clinic who attempted to stab Israeli soldiers have had traumatic experiences indeed. Some detainees were transferred to mental health hospitals based on my assessments. Behind every retaliatory act, there is a traumatic story and often a mental illness.

For example, I visited the Mascoubiyah detention centre in occupied Jerusalem to see a female detainee from Jericho. She arrived from the United Arab Emirates (UAE) and was even treated in the UAE for schizophrenia. One day, when she was in Jerusalem, she took her passport and ID and threw them in the garbage. She then proceeded to take out a knife, and once the Israeli military forces saw her with the knife, they immediately shot her in the leg. I visited her at the Hadassah Hospital, where she was medically treated for her wounds and was tied to the bed, and then was transferred to the detention centre in Jerusalem, where she was held. I assessed her, wrote her medical report, and was later re-
leased. What was significant about this visit was the traumatic experience. As I was being led to the detainee, I passed through many doors; one would open and then slam shut. The atmosphere was intimidating and fear generating. My heart felt the pain of the detainees as I was crossing the doors.

Another example, among so many, is one of my patients who was a woman from Nablus. She suffered schizophrenia, was married, and had several children. One day, she argued with her husband and left her house with a knife in her hand. The Israeli military shot her dead at the checkpoint. This patient did not pose any serious threat.

A third example is of a family from Jenin. The Israeli military forces bombed this family’s home. The mother was subsequently killed. The children became reactively aggressive and violent towards each other and at school. Their father could not deal with his trauma or the change in his children’s behavior. As a result, he strapped himself with bombs and blew himself up in Tel Aviv.

About five to six years ago, I had a patient from Jerusalem jailed for many years in an Israeli detention centre that had been recently released. He had schizophrenia and was grossly psychotic. His parents were afraid of him, and they would lock themselves in their room. I treated this patient where his parents began dissolving his medicine in his food. He started to get better. One day he was walking bizarrely in Jerusalem. An Israeli woman looked at him and began to yell out, “terrorist, terrorist!” in Hebrew. An Israeli policeman shot him dead immediately on the spot. I was unaware of this incident until his sister stopped by my private clinic. She came by asking for a medical report for her brother to prevent the Israeli military from demolishing their home. I wrote the medical report and handed it to her.

**Detention centers and military courts**

During the First and Second Intifadas, and even before then, I used to attend military courts. They treated me as an enemy at these military courts, not as a doctor or an expert. They do not trust Palestinian doctors, and they used to interrogate me. They tended to question the validity of our medical reports. I remember one time I went to testify for a detainee from Beitunia; the Prosecutor said to me, “anyone can write up a medical report on a computer”. I requested the trial be postponed, although it was irritating for me to have to go back to court. I informed her I wanted to submit supporting evidence for my testimony, but only to prove to her that I was right. The trial was postponed for another week or two. Upon the evidence I presented, they realised that my medical report was authentic and trustworthy and proceeded with the case.

There was this time when I was treating a patient with epilepsy. One day, Israeli military forces ordered him to climb up a pole to bring down the Palestinian flag mounted on top. While at the top, this patient experienced an epileptic seizure that caused him to lose his grip. He then fell down and died.

Those days, we ran a psychiatric outpatient clinic in Ramallah once a week. The Israeli military ordered me to testify in an Israeli military court in Bethlehem. I was in Ramallah that day. Before the trial, one Israeli officer told me what to say and falsify the events. I, of course, refused to give in to his demands. As punishment, they withheld my documents. It was Ramadan and I had eaten nothing during the day. I was exhausted and I was retained in Bethlehem until about 10 pm. That is when they permitted me to leave.

So many Palestinians are often held in Israeli detention centres without trial, which is considered the so-called administrative de-
tention. Most have not committed any serious crimes or violated any law but are held solely on the hypothetical basis that they may engage in unlawful acts in the future. This grotesque and illegal measure has no time limit. A person is held without trial for indefinite periods. This act is done on purpose, probably to install a state of mind exhausted with unpredictability, a foggy atmosphere, and existential uncertainty for the Palestinian civilians to generate more anxiety and make life unbearable. Also, to reinforce subjugation and lead to a state of helplessness.

Further, the person detained is often not informed why he/she is being held. Palestinian detainees are left unable to adequately defend themselves due to the absence of specific charges. Faced with unknown allegations, Palestinian detainees are usually left helpless as they do not know when they will be released without trial or conviction. They may begin their detention for up to six months, and just before their release date, their sentence may be extended for another six months and so on and so forth.

There is no limit to the overall time a person can be held in administrative detention; therefore, the detention can be extended repeatedly, allowing Israel to detain Palestinians without convicting them for years on end. This practice is considered a form of psychological torture practiced by the Israeli occupation forces. It is considered such because of the psychological, physical, and mental impacts caused by indefinite detention that lead the detainee to live in an uncertain or undecided mental state without knowing what lies ahead. Moreover, Palestinians feel a loss of control over the future and feelings of borderline as they alternate between moments of looking forward to releasing and the actual realization or belief that their detention will be extended. This experience puts detainees under constant stress and anxiety, and they may develop severe depression, disintegrative personality, and dysfunctional cognitive ability. This legislative execution issued by an Israeli military court enabled them to detain whomever they wanted, including human rights activists and defenders.

Several cases, which passed through this bitter experience, declared having been indecisive on several urgent issues or leading to postponement or reckless decisions. This mechanism is a colonial tactic used in similar contexts to break individuals, families, and communities. The inability to plan is oppressive and can lead to deep-seated feelings of frustration. It is worth mentioning that dozens of persons under administrative detention went through a hunger strike extended over long periods to more than a hundred days since 2018 exposed their lives to danger.

Beginnings of TRC

The idea to establish a centre came out of my past professional experience. I remained all these years from late 1983 to 1997, treating patients, including ex-detainees, voluntarily. I resigned from the Mental Health Hospital in Bethlehem in 1996 because it became so difficult for me to drive and pass through the many checkpoints. I treated these patients or ex-detainees at my small private clinic during this time. Of course, I felt that this was not a suitable setting for the proper treatment of victims of torture. We needed a multidisciplinary team and a larger space as there was a massive demand for these services. We are talking about 40% of the male population in Palestine have been detained by Israeli occupation forces at least once in their lifetimes. More than 25% of the general Palestinian population has been detained in Israeli detention centres. Moreover, torture is practiced in every aspect of our lives, not only in Israeli detention centres. Again, all the small elements
that configure a torturing environment are built on every action.

From this experience, I found many reasons to establish TRC. Firstly, I noticed that approximately 40% of detainees and ex-detainees suffer from Post-traumatic stress disorder (PTSD) symptoms. Secondly, the stigma attached to mental illness meant that these ex-detainees were reluctant to seek help from the public sector. Thirdly, the only treatment available was of poor quality. Indeed, some aspects of treatment exacerbated their mental conditions. The environment of these settings reminded them of their past trauma (resembled detention centres). Fourthly, the existing private clinics are few, and the patients could not afford to pay any fees.

In January 1997, a human rights organisation offered us a small room to establish Ramallah’s Treatment and Rehabilitation Center for Victims of Torture (TRC) because I visited detainees voluntarily upon their request. Afterwards, Khader Rasras joined TRC’s team part-time as a senior clinical psychologist. He was working at the Mental Health Hospital in Bethlehem and is currently the General Director at TRC. Myassar Sbeih, a psychiatric social worker, also joined TRC’s team. We then began to root our team spirit on institutionalizing our services. Later, we expanded and recruited new staff to meet the increasing demand for TRC’s unique and integrated services.¹

We attended a training workshop in Denmark in 1997, invited by Dignity, formerly the Rehabilitation and Research Centre for Torture Victims (RCT). At the training, all participants were debriefed in a clinical supervision session by Dr. Inge Genefke, founder of the International Rehabilitation Council for Torture Victims (IRCT). She morally encouraged us to establish TRC and provided us with valuable insights. I met her on several other occasions from then on, and she was always a source of support and encouragement.

On one of these occasions, during a conference held in Germany, we went on a tour to view the Berlin Wall. In my speculation about this, it was not as high as the Separation Wall built by the Israeli authority to separate Palestinians and Israelis. It was stirring and confusing to see how people around the world destroy walls and build bridges of trust and humanity while Israelis build bridges of mistrust and hatred.

In 1997, I was introduced to Helen Bamber, founder, and Rami Heilbronn, psychotherapist of the Medical Foundation for the Care of Victims of Torture, based in London. They accompanied us in one of our first outreach visits to two families. One family was living in the northern part of the West Bank. They lived in Algeria when a group of masked men decapitated one of the sons in front of the whole family. The boy was about 18 or 19-years old and was in the Algerian National Navy. His father was a schoolteacher in Algeria. After the boy’s death, the family moved back to Palestine. The whole family was involved in the treatment. We also visited a woman living in downtown Ramallah. The Palestinian National Security Forces were searching for one of her relatives around their house at night, and they had aimed a pistol at her through the bedroom window. She was traumatized by this event.

¹ We created the first Board of Directors. Members included Dr Heidar Abdel-Shafi, Dr Iyad Al-Sarraj, Mr Ahmad Al-Sayyad, Dr Ahmad Dawood, Miss. Rana Nashashibi, and me. I was also on the Board of Trustees at Al-Makassed Islamic Charitable Society Hospital in Jerusalem, along with Dr Heidar Abdel-Shafi, who later became a member of the Palestinian Legislative Council and the head of the Palestinian negotiation team in Madrid. Dr Abdel-Shafi was nominated as President of the Board of Directors at TRC.
I started searching for funding opportunities. We received a small grant from the Norwegian People’s Aid. It was good to start forward. Later, I was introduced to Annick Tonti, the head and founder of the Swiss Agency for Development and Cooperation (SDC) in occupied Palestinian lands, who signed an agreement in 1999. We could rent new premises, and TRC could begin to grow with their support. Their efforts helped us provide mental health care to countless torture survivors and individuals with mental disorders. We recruited a larger team of psychologists, which was challenging to establish. Helen Bamber, Rami Heilbronn, and I trained the new team. I contacted psychologists on a 24-hour basis to avoid burnout from exposure to complex and catastrophic cases.

Although the office was small, there was a huge opening ceremony for the TRC inauguration in 1999. The ceremony was well attended by many local, regional, and prominent international figures; there were professors from several universities and numerous consuls representing their countries. I gave an opening speech inspired by a detainee at an Israeli detention centre I visited between 1985 and 1986. This detainee exhibited weird behaviors because he was suffering from a delusional disorder. The other detainees even suspected him to be a collaborator with the Israeli security forces, and under pressure, he admitted to killing a person (which was untrue). When I visited this detainee, he said something I would never forget. He said, “Please do not forget me”.

After his release, we treated him at TRC. He later began his studies at Birzeit University in English Literature, where he eventually graduated and was hired as an English schoolteacher. He became one of many of TRC’s success stories. Dr. Abdel-Shafi also gave a speech, as did Dr. Iyad Al-Sarraj, the Gaza Community Mental Health Program founder. Ex-detainees and their families were also invited to the opening ceremony.

TRC started to provide services for increasing torture victims in Israeli detention centres. The centre also received victims from different perpetrators. We do not consider the perpetrator or the victim’s identity, colour, or religion. We treat all those in need and those who ask for help.

We treated Palestinians who were tortured in numerous Arab states. In addition, we treated a white American whom the FBI tortured in the United States. He was working as a visiting lecturer in one of the local Palestinian universities. Arab Americans were also treated. We treated a Spanish woman married to a Palestinian doctor whose son was killed by the Palestinian Security Forces after the establishment of the Palestinian Authority. We treated two German women and an Egyptian woman as well. We also treated an Israeli woman who claimed having been tortured by Israeli intelligence. It is worth mentioning that this woman was married to a Palestinian ex-detainee.

Since TRC’s establishment, I began to understand where to transfer my patients. For example, I had a patient who came to my private clinic in the mid-1980s referred to the Ramallah district psychiatric outpatient clinic. His story was that in the 1980s, he was sitting next to his brother on a bus. Israeli settlers were attacking Palestinian cars and shooting randomly at Palestinian civilians. His brother was shot and killed in his arms. In retaliation, he burned an Israeli officer’s car in front of an Israeli police station in Ramallah. The Israeli forces seized him and began to beat him on the head, and he suffered from head trauma (brain concussion). This patient started suffering from impairment of memory. Dr. Kamal and I began to treat him. We wrote his medical report right after. One day, this
patient fled to Jordan. On his way, he was subjected to a thorough inspection on the Allenby Bridge Crossing. The Israeli military seized his medical report.

Afterwards, the Israeli intelligence service periodically questioned me at the Sheikh Jarrah Interrogation Centre in Jerusalem. They would show up at the mental health hospital where I was working to interrogate me. They wanted to know about my relationship with this patient.

In another incident, a few years later, this patient went to Jerusalem on Laylat Al-Qadr (the Holiest night in Ramadan). After finishing his prayers, he made a small demonstration and began making a slight disturbance. The Israeli police saw him and immediately beat him, fracturing his skull. I later transferred him to TRC in the late 1990s. In parallel to his treatment, this patient began to receive vocational training and rehabilitation at TRC. We bought him the tools and equipment he needed to begin. Finally, he moved to Jordan.

As we continued to receive funds from other donors, we began to get involved in documentation, treatment, rehabilitation, training, awareness and advocacy programs, and the bulk of our work was the outreach visits. Furthermore, 10,000 field visits were carried out by TRC’s team on an annual basis through our offices in the whole West Bank, as we also involved families in treatment. We used different treatment modalities, including dynamic psychotherapy, cognitive-behavioral therapy (CBT), narrative therapy, crisis intervention, and eye movement desensitization and re-processing (EMDR) therapy. It was tough for torture victims to express themselves. It was easier for bereaved families to talk about their loved ones and their emptiness within themselves. However, ex-detainees who were subjected to torture do not disclose any information. Shame is a cardinal symptom of torture.

The objective of torture is not to kill the body but to kill the soul and spread fear within the individual, families, and the whole community.

Hidden secrets and unexplained symptoms
There was a 17-year old child who was detained by Israeli armed forces. After her release, her family began to notice a change in her behavior. She even burned down her house one time. She was transferred to the Mental Health Hospital/Bethlehem and assessed by different mental health workers over the years. At one point, she was transferred to TRC. During one of our sessions, she revealed what had happened to her. Before being transferred to an Israeli detention centre, she was sent to an Israeli prison with Israeli female criminal prisoners. While detained with these prisoners, she claimed that they attempted to sexually assault her, as Israeli correctional officers did as well. She was heavily traumatized, and her behavioral change resulted from unspoken and undealt with trauma.

A similar story happened with another 17-year old boy that was detained, and after his release, his behavior changed a lot. His mother came to seek psychiatric help as she could not deal with her depression. She revealed her sons situation and the circumstances leading to his current behavior. She explained that his premorbid personality was intact before...
his detention, and he was very sociable and energetic. Afterwards, he became isolated and very reserved. Years later, in his mid-20s, his parents suggested he married, hoping that this would change his lifestyle and get him out of his current mental state. However, his response was, ‘I am not fit to get married’. Later, he revealed that the Israeli interrogators in the detention centre raped him. His parents were shocked and in a state of disbelief. He started therapy at TRC and got improved.

B’Tselem, an Israeli human rights organisation, transferred an ex-detainee with severe trauma and suffering from complex PTSD to the centre. We treated him, and his situation improved. He later got married, and after about two or three days, he dropped by TRC. He revealed what he had done to his new bride. He forced her to sit with him outside in freezing temperatures, utterly naked at midnight! He did what had been done to him during his torture at an Israeli detention centre, as it was part of his interrogation process.

**Psychological torture and the role of the Israeli medical profession**

Torture methods have slightly shifted over the last few decades. In the 1980s, physical torture was prevalent. In the 1990s, a new method of torture was introduced, referred to as the ‘Shaking’ method, probably developed by Israeli doctors based on the ‘Shaken Baby Syndrome, as it does not leave visible physical scars. B’Tselem describes this method as such: «The interrogator grabs the interrogee, who is sitting or standing, by the lapels of his shirt, and shakes him violently, and his head is thrown backwards and forwards» (B’Tselem, 1998). It causes a rupture in the small blood vessels in the brain. Common consequences of shaking are dizziness, vertigo, behavioral changes, impairment of memory, and disorientation. If this continues longer than one minute, the person might pass away due to diffuse brain damage (British Medical Journal, 1995), and some cases have been reported (The American Journal of Forensic Medicine and Pathology, 2022).

I remember when a Danish doctor visited us. We explained to him about the shaking method, but he did not quite understand it. He requested a demonstration to imagine the experience. There were two ex-detainee students from Birzeit University working with us. At first, they were hesitant, as they knew first-hand the consequences of shaking, being ex-detainees. One of the students shook the Danish doctor and applied it on him based on his demand about two or three times, and he was about to faint and told them to stop.

However, torture methods were shifted more towards psychological methods, which are more painful, harmful, and have long-term consequences.

One of the most damaging torture methods is solitary confinement. It is common for the Israeli military to put detainees, even minors, in solitary confinement for extended periods, and the consequences are well-known. The cells in which detainees are solitarily confined are minimal in size, extremely filthy, with no windows and dim lighting. A detainee would be very isolated from the world without knowing the time or whether it is day or night.

The denial of family visits reinforces isolation. Furthermore, family members are often subjected to psychological torture during their visits, forcing them to wait for long hours, being subjected to lengthy and humiliating inspections, and being forced to pass through naked inspections. This adds pressure to the detainee, that often begs the family not to come.

Detainees are also exposed to sleep deprivation and constant yelling. Sleep deprivation adds to the torturing environment of isolation and causes severe psychological damage.
The Israeli army also introduced the well-known ‘shabeh’ position. According to B’Tselem, “regular shabeh entails shackling the detainee’s hands and legs to a small chair, angled to slant forward so that the detainee cannot sit in a stable position. The interrogee’s head is covered with an often filthy sack, and loud music is played non-stop through loudspeakers”.

Additionally, there is the practice of medical neglect. Contrary to what is stipulated in the Tokyo Declaration of 1975 issued by the World Medical Association, a physician must treat his patients with dignity and without discrimination and maintain their mental and physical health to relieve their pain and suffering. I remember a detainee with a disc problem suffering from back pain. He was treated at the Israeli detention centre’s clinic. It seemed the medical staff communicated this weakness to interrogators because they began using this detainee’s pain as a torture method after a few days. They would make the detainee stand on one leg with his arms upwards. His testimony, among many others, indicated the involvement of Israeli medical staff in the torture of detainees.

The detention centres’ clinics were used to gather collaborators with Israeli security forces. Therefore, some detainees refrained from going to these clinics for fear that other detainees would suspect them. Israeli physicians wrote medical reports in favor of the detention centres. The medical staff filled out a medical form before, during, and after torturing a detainee that was used to examine the detainee whether he was fit to continue being submitted to further torture. However, detainees are not referred to the clinic except in critical condition. Detention staff does not comply with medicinal prescriptions or dispensing of medications. Clinics lack specialists. The doctor’s visit is brief and in military uniform, which constitutes a psychological obstacle for the detainee. It is difficult for Palestinian doctors to visit detainees because of Israeli restrictions.

Legalization of torture
In 1987, an Israeli government commission of inquiry, the Landau Commission, authorised torture and ill-treatment through the interrogation of Palestinian detainees by the Shabak using the term ‘moderate physical pressure’. In 1999, the Supreme Court of Israel permitted specific methods of torture. They kept a legal loophole for the use of torture by justifying it according to the well-known and unreal ‘ticking bomb’ scenario under the pretext of ‘necessity’. The Committee Against Torture clearly stated that this legal “exception” was a grave violation of the Convention. The fact is that it is not an exception, and the so-called “necessity” criteria is applied to all cases where there are complaints against the Israeli investigators; in other words, there is a law architecture to ensure impunity for the investigators practicing torture.

In 1999, we held a joint international conference with the Medical Foundation in London well attended by prominent local and international figures. The Gaza Community Mental Health Program (GCMHP) and the Palestinian Medical Association were among them. The Medical Foundation suggested that Physicians for Human Rights Israel (PHRI) also participated. I first asked about their political position on human rights violations towards Palestinians. They replied that they firmly believed in the right of return of all Palestinians, in addition to the two-state solution. The conference was successful and lasted for three days. The conference’s topics revolved around torture methods used against detainees’ and the general population and the involvement of Israeli medical staff in torture.
We wrote a letter to the Israeli Medical Association. We also began to create partnerships with the IRCT, Dignity, and other local and international human rights organisations. We began to commemorate the International Day in Support of Victims of Torture, held annually on June 26th, the Palestinian Prisoners’ Day on April 17th and the Human Rights Day on December 10th.

Several international figures visited TRC as we became very well established globally. To mention one, Dr. Perez-Sales, Chair of the World Psychiatric Association Section on Psychological Consequences of Persecution and Torture, visited TRC in 2018. We went, among other things, to visit TRC programs in East Jerusalem. In my infancy, my father used to bring me to the Old City Market and religious sites. Now it was forbidden for us to cross, and it was more than ten years since I had not been there. We went on Friday because Israel allows Palestinians over the age of 65 to enter that day to pray at Al-Aqsa Mosque. Dr. Perez-Sales noticed how, as a foreign citizen, he was granted full access to any place in Jerusalem while I could not go to the place of my childhood. During this visit together, I began to reminisce about the early 1960s when the West Bank and East Jerusalem were free. They were occupied in 1967. I visited family members residing in East Jerusalem, particularly in Wadi Al-Joz. We moved freely within East Jerusalem and the West Bank without needing a special permit from the Israeli authorities. Now, everything has changed. Things are, every time, more difficult for Palestinians.

**Continuous Traumatic Stress Disorder**

Oftentimes, PTSD treatments were complicated with challenging cases, especially on those who suffered constant traumatic stress. The reason was and is the result of living under repeated and ongoing trauma. Based on research we conducted at TRC in 2011, the vast majority of the people we treated suffered from more than one trauma. Palestinians are constantly exposed to violence (home demolitions, the Israeli military’s killing of a family member, being re-detained for no reason but to intimidate and break life projects). Most of our patients suffer from *Continuous traumatic stress disorder* (CTSD), a terminology that came out of my clinical practice. In western countries, a person has PTSD and usually lives in a protected environment. However, Palestinians continue to suffer from traumatic experiences and are not protected within their environment; on the contrary, they are recurrently exposed to traumatic events and situations of politically motivated violence. In several cases, victims demonstrate having been exposed to multiple traumas. A case recently reported at TRC informed that her house was demolished for the second time, one of her sons was killed, and the other got arrested, and she was extremely frightened at night, fearing invasions any time. In DSM-V, this is considered under Complex trauma. However, the expression does not capture these ongoing traumas, recurrent, expected all the time and yet not ended even periodically. Continuous trauma is embodied almost in every aspect of Palestinian people everyday life.

In Palestine, compared to other contexts, traumatic experiences and trauma-related consequences are always there. In epidemiology, aetiology and therapy: when looking at our clinical situation here, one can sense the suffering in all aspects of Palestinian citizen’s life. Living under occupation is an agony generating pain and sorrow. Hardship is always there. It is not a transient state that one can accommodate with or cope with, but rather a debilitating condition that needs endurance, tolerance, and perseverance. The resilience expressed by the general Palestinian population comes from
the competent level of endurance they developed over time, from their unquestionable right to self-determination. Endurance means that people endured unendurable hardships that they faced all through their life under occupation. They developed coping strategies based on their unquestionable and unshakable belief that this atrocity and tyranny should vanish and justice will one day prevail.

Final remarks
This paper and the stories in it are only a glimpse of the suffering of every Palestinian home.

I always believed that all people should receive appropriate health services. The right to health is included in the Universal Declaration of Human Rights as an essential and unconditional right. I believe that mental health is strongly linked to human rights. It is not only the Palestinians’ responsibility to end the occupation and achieve peace. It is also a regional and international responsibility and commitment.

In the end, TRC’s work contributes effectively to the relief of people’s pain and sorrow, helps maintain their desire for life, instils hope in their hearts, helps develop coping strategies, and creates a strong sense of resilience, tolerance, and perseverance.

TRC is the voice of the voiceless that cannot portray their bitter experiences and a channel to express their conflicts and complicated hardships.

Finally, ‘as I could not save the life of my own brother, I have to make a positive difference to the lives of others.’

References
Medical meanderings of the mind, looking back at 30 years of experience visiting victims of torture in custody

Hernán Reyes

Abstract
The paper summarises some highpoints from my past field experience of thirty years, to illustrate different issues, difficulties and best practices when visiting prisoners. I recount some of my most relevant experiences, both positive and negative, with individuals who had been tortured, interviewing and examining them whilst they were still in custody. They might be of interest to younger generations of physicians working on these issues.

The examples, all from the field, should demonstrate the importance of showing true “empathy” for the victims, so as to obtain their trust – and hence their stories. The examples are as varied as have been the different settings and encounters with both victims and perpetrators. I have tried to illustrate the many pitfalls to avoid, and provide suggestions on how best to avoid them.

Introduction
My connection with documenting torture relates to my many years visiting prisoners of war and political prisoners as a physician for the International Committee of the Red Cross (ICRC), and reporting back the information obtained in the somewhat ambitious endeavor to put a stop to torture. Although initially trained as a clinical Ob/Gyn, I eventually ended up changing my field of work, and becoming a full-time physician visiting prisoners. I have tried my best to share my thus acquired experience through articles and publications, as well as contributing to the first version of the Istanbul Protocol on the documentation of Torture.

This will not be just another piece on “torture documentation”. The context I was privileged enough to work in is quite different from usual ones, where “torture survivors” are debriefed after having been released from custody, and are in safe, literally post-traumatic settings, weeks, months, sometimes years, after their torture experience. My visits were to women and men in custody, who remained in custody after the visits. (Reyes, 2002) Hence my deliberate use here of the term “victims” and not “survivors”.

While prisoners are still in the hands of the perpetrators who have tortured them, they have not yet survived. They are in a stressful situation still, and may fear, rightfully so, being tortured again. This difference of context needs to be understood.

The role of the ICRC when visiting prisoners is not only to document torture, but to assess all aspects of being in confinement.

The term prisoner shall generally apply to all persons in custody – detainees, internees, prisoners on remand or sentenced. In specific cases, the additional term detainee or internee may be used as well as POW for prisoners of war.
However, when torture is the main concern, establishing rapport with, and demonstrating empathy towards, the prisoners, so as to obtain their trust, will be the most important first step – before beginning to inquire about any possibility of maltreatment or torture.

The examples that follow illustrate best practices and best approaches, as well as some pitfalls often encountered, with suggestions on how to avoid them.

First visits to prisoners in Latin America, first dilemmas

My first field mission for the ICRC was in 1982-83, based in Buenos Aires, covering three countries: Argentina, Chile and Uruguay. The prisoners visited were “political” in all three countries, although of course this label was not the one used by the detaining authorities, who considered them as agitators, radicals or terrorists. For memory, this was during the period of the Latin-American military regimes, each dictatorship different from the others.

At the time, the ICRC was one of the few organisations allowed to enter prisons and speak to prisoners in private – not only in Latin America but worldwide. One sine qua non ICRC condition for visiting prisoners is to be able to speak in private to prisoners of our choice and not just those chosen by the authorities. The price to pay for this exceptional access to prisoners in such settings is that all findings, submitted to the authorities in a Report, are to remain confidential.

Torture was reportedly widespread in all three countries, and I was thus immediately confronted during my interviews with the prisoners with allegations of torture, in its different forms and with varying consequences.

When interviewing prisoners, it was primordial to immediately reassure them than anything they said would not be relayed to the prison authorities. Besides the recommendations already mentioned, the time factor had to be considered for the interviews. Many prisoners obviously needed more time than others to get their thoughts together and be able to converse without any stress. How much time should be allotted to each interview will depend on different factors, and the degree of communication with outside sources, such as family members, prisoners have. The main point is to take whatever time is necessary to establish rapport and understand their situation.

The torture methods used in Chile and Argentina were brutally physical and similar to methods used in many other countries. Submarino torture, electric shocks, brutal suspensions and beatings were just some of the ones most commonly used. Very early on, I was to learn from the victims themselves, that the psychological sequelae of torture, the disturbances of the mind and soul, were profound, and very often lasted much longer than the physical pain and suffering (Reyes, 1995).

I also examined the prisoners to understand the effects of torture on their bodies and check for muscular, skeletal or other sequelae. More often than not, however, there were no visible scars or signs left on the body, as the maltreatment inflicted had taken place weeks, sometimes months ago or more. Functional sequelae (shoulders blocked at a certain angle; internal pain related to certain movements...) were sometimes present, but there were very few “visible” signs that could be de-

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2 The physician also has to have access to the prisoners’ medical files and be allowed to examine them in private as well.
3 This principle is often misunderstood, as many think it would be more useful for the ICRC to publish its reports. This would of course put an end to all or most visits, and the key advantage of someone being able to visit these prisoners, in often very repressive conditions, would be lost.
scribed as typical, or pathognomic\(^4\) of torture, which was not surprising. I relied mostly on the description of what “had happened” to the prisoners, confronted to what effects they described and what state they were in, for my assessment. In some cases, prisoners showed me what they had been through, mimicking for example, forced positions they had been coerced into, or how a certain blow had been given – and received.

The visiting team always gave a final summation up to the local authorities at the end of the visit, before writing up the official report. At this local level wrap-up, the authorities listened attentively, sometimes less so, to what was reported. As expected, they inevitably gave blanket denials of any use of coercion, let alone torture. Even the medical argumentation was rejected, which was my first confrontation with “absence of evidence” being considered “evidence of absence”.

The allegations of torture received during these visits, to me were indubitably credible, mainly because the same methods producing the same effects concurred between different people, at different places and different times, and in some cases produced similar functional, objective sequelae. Apart from what the prisoners actually described, their demeanor in describing what had happened to them gave me sufficient “confirmation until proven otherwise”. This reasoning was however the one rejected outright by the authorities. They insisted on inquiring whether there was any proof for any of the allegations, meaning whether there were any “scars or signs” that would confirm the prisoners’ stories. As in most cases there was nothing of the sort, all allegations were summarily dismissed as “mere hearsay”, or worse, were said to be “lies meant to tarnish the reputation of the Armed Forces”. We were accused of “being naïve” in believing what the “terrorists” had invented.

In Argentina and Chile, the military applied brutal methods when interrogating, punishing and extrajudicially executing political prisoners and opponents. In the 1980’s, torturers were beginning to realize that brutal, scar-leaving, forms of torture were to be avoided, which merely meant replacing iron batons with wet-towels for beatings, or using electrodes sparingly or replacing them with a grid-iron bed for electric torture. Uruguay was a case apart, and is discussed in detail further on.

I need not explain to seasoned workers in the field of Human Rights that physical forms of Torture have physical as well as psychological consequences and sequelae, and vice-versa. The term “psychological torture” can relate to two different aspects of the same entity. On the one hand, it can designate methods – that is in this case the use of “non-physical” methods. While “physical methods” of torture can be more or less self-evident, such as thumbscrews, flogging, application of electric current to the body and other similar techniques, “non-physical” means a method that does not hurt, maim or even touch the body, but touches the mind instead. Just as readily recognizable as methods of torture in this category are prolonged sleep deprivation, total sensory deprivation or having to witness the torture of family members, to cite only three examples. On the other hand, the term “psychological torture” can also be taken to designate the psychological effects (as

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\(^4\) Pathognomonic is a term, used in medicine, that means characteristic for a particular disease or aggression. A pathognomonic sign is a particular sign whose presence means that its cause is self-evident, beyond any doubt. Such is the case with so-called “tram-line” scars, pathognomonic bruises inflicted by beatings with a blunt, elongated instrument such as a metallic or wooden rod on the back. Beatings with a bicycle chain, leave pathognomonic imprints of the chain structure on the skin.
In the head of the interrogated prisoner a haze begins to form. His spirit is wearied to death, his legs are unsteady, and he has one sole desire. To sleep, to sleep just a little, not to get up, to lie, to rest, to forget... Anyone who has experienced this desire knows that not even hunger or thirst are comparable with it... I came across prisoners who signed what they were ordered to sign, only to get what the interrogator had promised them. He did not promise them liberty... [only] uninterrupted sleep!

(Begin, 1977): certainly a controversial figure, yet his evaluation of the effects of lack of sleep remains one of the most vivid and accurate to date.

opposed to physical ones) of torture in general—torture “in general” meaning the use of either physical or psychological methods, or both. There is sometimes a tendency to merge these two separate concepts into one, which leads to confusion, between methods (or “input”, as it were) and effects (or “output”). This confusion has led some authorities to deny the very existence of “psychological torture” as a separate entity (Reyes, 2008).

Sleep deprivation would warrant a chapter by itself, as it is considered by those who have been submitted to it (Begin, 1957) as perhaps the worse form of torture, along with Solitary confinement—both often administered simultaneously. It is a form of torture without the use of physical violence, and not needing any special equipment nor installation.

Prisoners interviewed often asked how I justified inquiring about their torture stories, “prying” so to say into their painful past, and to what end I wanted to know “what had happened”, which for them brought back “bad memories” they wanted to forget, or at least lock away until they had been released from prison.

My requests for information I can compare to asking prisoners to open their individual “Pandora’s Box of Horrors” so to say. Making them recall what they called bad memories, could and would indeed bring back all the thoughts and nightmares they had put away in a box under the bed, not to be opened. Some serious empathy, and as caring an approach as possible, were thus absolutely necessary before convincing them to talk about their torture experience.

With the proper approach, however, most prisoners understood that although what the ICRC was trying to do (put a stop to torture) was realistically a very long shot for dictatorships well seated in power, most of them accepted to speak up, hoping that recording their overall stories might somehow influence and improve the situation for future political prisoners.

One thing was paramount: in no way should our interviews be perceived as a “second interrogation”. The second point we had to explain very clearly was that the ICRC had no influence on their imprisonment sentences, and could not help them get out of prison, except for exceptional cases, needing transfer out for specific treatment.
As the physician of the visiting team, I had an additional advantage, as many prisoners who suffered from sequelae, physical or mental, from their experience were glad to be examined, and receive whatever medical counselling I could give them, as they didn’t trust the prison doctors.

A description of the “psychological methods” used by the Uruguayan military will be helpful. Contrary to Chile and Argentina, in Uruguay the “politics” were rarely executed. Militants of the suburban MLN - Tupamaro movement had been arrested, tortured and imprisoned, most of them incarcerated in a huge prison, ironically colloquially called “Libertad”, which was only for political prisoners. In one “less formal moment”, during a midday meal during the visit to this prison, the Uruguayans mentioned that a visiting Argentinian delegation to the prison had recently told them: the “...you [Uruguayans] must be mad to keep all these terrorists in prison... We [the Argentinians] would have killed them all!”.

In Uruguay, hundreds of Communists and other leftist militants had been arrested as well, and were imprisoned in the same prison as the Tupamaros. There, the psychological management of all the prisoners was designed and monitored by a team of psychiatrists and psychologists, and purposely tailored to the individual.

Knowing the Tupamaros and Communists loathed each other, the prison psychiatrist purposely matched up one Tupamaro and one Communist in the same, small, dual occupancy cell, its surface measuring some 3 x 2.5 meters.

We learned, after many interviews over several visits, that the “Libertad” prison was in fact an experimental laboratory for trying out many forms of psychological torture.

The Communist-Tupamaro pair was thus in what amounted to duo-solitary confinement for days, even weeks, on end. Tensions and sometimes explosions of violence between the two inmates were carefully monitored by the guards and military nurses, through the cell’s “peep holes” in the doors. If the two inmates eventually managed to come to terms and somehow “get along” together, the psychiatrist would change the pair, putting each one again with a different “incompatible” cell mate.

But the psychological pressure of confinement worked even in less conflictual cases. I remember one case where two prisoners in a doubled-up cell had managed to tolerate one another, yet one of them told me in private, and I paraphrase from memory: “Doctor, I love my wife dearly, yet I would not dream of spending 24 hours with her in the same room! Even though we both care for each other, that would be impossible. Here I have to live 24/7 with my cell mate, who snores, who tells bad jokes, who has

bad breath and smelly feet – apart from being a Communist – and I just can’t take it anymore!”

The nine leaders of the Tupamaro movement were not in Libertad prison. They were imprisoned in particularly harsh conditions in military outposts, in squalid cells or worse, for months or years on end, then transferred to equally miserable army barracks in another part of the country – and in total were held in total solitary confinement for eleven to twelve years. They were known as “hostages”, and no one was allowed to interview them5. I only got to visit and interview in private these nine Tupamaro leaders some six months before the end of the dictatorship, when all prisoners were released. One of the nine, told me that “we were all tortured, on again, off again, but the other forms of torture, such as beatings or electric shocks, were mere child’s play compared to solitary confinement... That was really the most difficult part of imprisonment”.

Another of “the nine” told me how he had to actively struggle so as not to lose his mind in the prolonged solitary confinement. He wrote poems and stories inside his mind, memorised them, and kept going back to them, expanding and modifying his thoughts as he felt necessary. One of his many creations were the “Conversations with [my] Slipper” (Conversaciones con la Alpargata), in which he relates (here I paraphrase) how

5 The true story of three of the nine Tupamaro leaders in extremely long solitary confinement has been made into an excellent film (“Compañeros”) by Alvaro Brechner, one of the best I have seen on solitary confinement, which totally conveys the mental suffering inflicted by this form of torture.
he has decided never to speak to his slipper again, it is wrong to do so, as he knows it is an inert object, not worth speaking to... merely a thing... What about you? answers the slipper back to him... This prisoner, already a writer before imprisonment, became a leading author and playwright after surviving his long ordeal, and became Director of Culture in Montevideo.

Many of the other politicals were kept in single cell imprisonment in the prison, with no contact with any other inmates. I interviewed more than fifty such prisoners individually. The first time I sat down and could speak to them, many had great difficulties in getting their thoughts together and expressing themselves, as for years they hardly ever spoke to anyone – talking to the guards was strictly forbidden – even if they did always manage to exchange written messages with other inmates by lowering them down on a string to the cell underneath theirs through the window. All prisoners in Libertad prison had been deprived of regular family visits, so it was essential that our visiting team take the time necessary to speak with all of them. The interviews easily lasted up to an hour per person during the first visit; less during the following ones. This “one hour” period may seem “normal” to those who interview ex-prisoners in post-custodial settings, but it exceptionally long for visits to political prisoners in most cases.

It was during my first visits to prisoners in South America that I was confronted with a phenomenon which was already being carefully documented in the burgeoning “Centers for Victims of Torture” in Chile (FASIC), Denmark (IRCT) and the USA (Harvard). I found that prisoners had difficulties recalling exact dates, or time frames, or remembering names and faces. This was the case whether the torture had been brutally physical or hands-off psychological – and anyway, both types of torture usually went together. The experimental Uruguayan case was exceptional at the time.

The prisoners I interviewed often had long stories to tell – but most often everything came out in a muddled order. Those dates, people, places, names, they did remember were mixed up most of the time. It thus took some time to understand and assess each case, but in the end, they convinced me that they were telling the truth, as best they could remember it, piece by piece. I found that the “inconsistencies” and episodes of “forgetfulness” were however yet another way for the authorities to “brush away” our final reporting on torture. They threw it back at us – “not only did we have no physical “marks” (sic) to show, but what the prisoners recounted was “fuzzy”, “imprecise”, and “full of discrepancies”. This was, to them, “proof” that the prisoners’ stories were lies or inventions.

I was to expand my personal knowledge on Torture and its Consequences during the years to follow, and spend a year “tele-working” with an international team led by Vincent Iacopino, the first draft of what would become the Istanbul Protocol, which would include a solid rebuttal of both of these false argumentations.

An important lesson from a prisoner in an Ethiopian prison
On my first missions to visit prisoners in Africa, I learned that the main problems to be addressed were not torture nor even abuse, but rather unsatisfactory basic living conditions, such as the need for sufficient and adequate nutrition, water and sanitation and access to proper health care. These requirements were not being met in the majority of prisons I would eventually work in, and not only in Africa. Most often the major problem, which influenced all the others, was that of
severe overcrowding. This was an issue practically everywhere! The magnitude of the overcrowding, and its effects would of course differ from context to context.

This is a complex issue, and I shall not expand on it here in any detail. Suffice to say that overcrowding is not only a “lack of space” per person, but also a functional lack of necessary facilities, services and fundamental needs for bloated prisoner populations. The causes are multifarious as well, and not merely a question of insufficient financing, but also inadequate functioning of the whole judicial system and its processes. Overcrowding also has to be weighed against local customs, economic realities, and even climate issues. Extreme overcrowding, in some African, Asian and South American prisons, has been considered a form of torture. I shall not take up this discussion here, as it goes beyond what I want to focus on.

A reference document issued by the Human Rights Council to the UN General Assembly in 2015 deals in great detail on this issue of overcrowding. Even if it can be argued, in some cases, that an “intentional” motive for overcrowding may not be the case, the effects of overcrowding can certainly be characterised as a form of Cruel Inhuman and Degrading treatment.

It was in Addis Ababa and Harrar that I visited Somali inmates, who were technically POWs, as they had been taken during the then
protracted war between Ethiopia and Somalia. The POWs were imprisoned in the same prison as common-law inmates, which was a violation of the stipulations for POWs by the IIIrd Geneva Convention (hereafter GE III), but we were told the authorities had no other place to put them. I did however speak to a non-POW prisoner, who requested to see me, who told me a long story of allegations of torture. The events he described had taken place some years ago, and were not in any way related to the conflict between Ethiopians and Somalis.

This Ethiopian prisoner told me he was a “political opponent”. He started by telling me that if I had visited him some years previously, he would have refused to speak to me outright, to me, a foreign visitor.

He had then been in a cell with four other prisoners. One day, two foreign visitors had come to interview them and had asked all of them whether they had been ill-treated or tortured. The four other prisoners told the visitors openly they had indeed been severely abused, without any guard within earshot. “My” prisoner had also been tortured, but he told me he had not said anything at all.

A day or so later, all four cell-mates who had spoken were taken from the cell. He himself, who had said nothing, was left alone. From the brief and violent exchanges between guards and the other four, he had immediately realised that one of the four had obviously been “planted” there by the prison authorities, and had reported what the others had told the visitors. The three who “talked” had never been seen again.

This vivid example illustrates why talks with prisoners in groups are to be seriously weighed and considered before going ahead with them. Interviews “in private” mean specifically that – with no one else present. This is to protect prisoners from any harm, even from fellow prisoners. Such a group visit in this case had unintentionally caused mortal harm.

Visits to prisoners of war: the Iran – Iraq war

The war between Iran and Iraq lasted eight years, from 1980 till 1988. This was what one would call a “Conventional War”, in the sense that it involved two States, more or less balanced in war capacity and size, with land, air and even maritime forces. There was also a “war front”, with trenches, infantry and tank attacks, and on the Iraqi side the use of illegal toxic war gases against infantry attacks and against civilians. It was, in a way, the bringing back of the worst of the First World War, forty years after the Second one began. Thousands of POWs were taken on both sides.

I was involved with POWs on both sides of the conflict. The International Humanitarian Law regulating treatment of POWs is stipulated in GE III, but these rules were unfortunately not being strictly followed to say the least. There was imbalance in the number of POWs. Iran held some 30 000 Iraqi POWs, whereas Iraq only held around 10 000 Iranians.

It should be recognised that the ICRC did have access to POWs in camps on both sides, but this was not without serious caveats, mainly on the Iranian side. Violations of some requisites of GEIII became so flagrant, with the use of maltreatment, coercion and even torture by the Iranian side, that the ICRC as the institution entrusted in overseeing the application of the Geneva Conventions, drew up a special Memorandum in 1983, which was circulated to all the States parties to GE III, describing in detail these violations.

6 1925 Geneva Protocol for the Prohibition of the Use in War of Asphyxiating, Poisonous or Other Gases, and of Bacteriological Methods of Warfare.
I first visited the Iranian POW camp at Gorgan, a city close to the Caspian Sea, that held hundreds of Iraqi POWs. Gorgan camp already had a history of serious problems with the ICRC, which had protested strongly about the Iranian authorities actively encouraging Shiite Iraqi POWs to betray their country and join their religious Iranian “Shiite brothers” in the war “against Saddam Hussein”. They had succeeded in enlisting a considerable number of these Iraqi POWs and created an “Arab Legion” from their group, which was meant to be sent to the frontline to combat the Iraqis. This Iranian “converting” of Iraqi POWs to commit what amounted to outright treason, and hence a capital offense against their country of origin, was most definitely against GE III stipulations.

The previous visit to Gorgan camp had had to be interrupted, as there had been a riot between POWs loyal to their government and Shiite Iraqis who had converted to the Iranian cause. The riot became a revolt and grew out of all proportion. The Iranian camp guards ended up using their firearms, resulting in six dead Iraqi POWS and more than fifty others wounded.

This serious incident ended up with Iraq accusing Iran of “murdering Prisoners of War” at the United Nations in New York. On the ground the results were more down-to-earth. The Iranians accused the ICRC of having been the cause of the riot in the first place. Hence suspension of visits for many months before the one I was to participate in.

I give this background information to describe the context of these visits, so as to better understand the lessons learned.

But I am getting ahead of myself. The Gorgan camp was extremely vast. I did not get to see the full extent of it by doing a general tour of the premises, as this was a very “touchy” visit, and the camp layout was well-known to the ICRC. The interviews in private to any POWs who requested to talk to us, were to take place in a large tent set up by the Iranians in the middle of the camp, where tables and chairs had been installed.

Two significant incidents to mention here. First of all, the whole ICRC visiting team, upon entering the camp, was led to a clearing that had been arranged for a welcome ceremony, which had been “spontaneously” prepared to greet us, supposedly by the POWs. On the pathways we had to take, between barbed wire fences delineating different spaces, we found that US and Israeli flags had been drawn in colored chalk, clearly quite recently. The width of the path was such that one had to tread on both flags on the way to the “ceremony”, which of course was an intentional provocation, meant to “test us”, the ICRC team. Stepping on the chalk drawings did not particularly fluster us and we just walked on, but it was meant to see how we foreigners reacted, and see if we balked at treading on the symbolic flags. When we arrived at the clearing, we found some twenty or thirty POWs lined up in military fashion, in uniforms, who snapped to “attention” and followed the orders of one of them who was in command. These POWs were clearly all Shiite Iraqis who were collaborating with the Iranian authorities.

“Takbîr!” the POW-in-command shouted. This term is a commonly used phrase in the Muslim faith, and is heard in the call to prayer, the faithful then reciting the well-known

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7 There had been, I do not remember exactly when, an incident in a POW camp in Iran, when a newly-arrived young delegate decided to jump over the US flag so as not to tread on it. This caused a scandal of sorts; the delegate was expelled from the camp, and the visit suspended, and there was thus “much ado about nothing much”, caused by the pro-Iranian Iraqis, who had the full support of the camp authorities in this.
**shahada**, usually translated into English as “there is no God but Allah, and Muhammed is his prophet” (loosely phonetically transcribed: “La illaha il_Lalla Muhammed Rasool_Allah”)

The welcoming party chanted the first phrase of the shahada as described. The second half, however, instead of referring to Muhammed being his prophet, had been changed into what I transcribe loosely as: “Saddam Hadu_llah”, mean “Saddam is the enemy of God”. Clearly these POWs had taken the full step of allegiance to the Iranian cause – a full-fledged betrayal of their country, as well as chanting what surely had to be a blasphematory version of the **shahada**

We then proceeded towards the large tent for interviews, when suddenly my ICRC interpreter, hearing an announcement broadcast full blast over loudspeakers, translated the message for me. The camp authorities were ordering all POWs to “stay away from the Red Cross visitors”. They were not to seek to speak to any of us. There would be overseers (meaning “kapos” – overseers – POWs working for the Iranians) who would filter and stop any POW they did not approve of, approaching the Red Cross.

The stage was thus set for the visit. I myself as physician was not required for any specific medical interviews that day, as the POWs who did turn up for interviews with the delegates were those who had nothing to say. I thus decided to go visit the camp infirmary, hoping I might get to speak to some “normal POWs”.

My idea turned out to be fruitful, as there were no filters there. I was accompanied there personally by our liaison officer, an Iranian who must have been around 55 – 60 years old, who spoke impeccable English with traces of an American accent. He was from Kerman. I was told that under Reza Shah Pahlavi, he had worked for the Intelligence service (Savak).

He had subsequently switched his allegiance to Imam Khomeini, and had been since the beginning of the war the main liaison officer for visits to POWs in Iran, accompanying ICRC visitors to practically all the POW visits. I discovered that he knew and understood the articles of **GE III** far better than most ICRC delegates. At the final talks with the camp commanders, he knew exactly how to tackle any point of disagreement, and could quote the specific article of the Convention that might sustain his arguments, and do his best to make the ICRC look non-professional!

Despite our liaison officer trying to peek into the few interviews I did manage to have with Iraqi POWs in the infirmary, I got him to respect what he most certainly knew was the right of all POWs to speak to us in private. One POW I remember particularly well spoke to me in very moving terms. He approached me, trembling with fear, at a moment when the liaison officer was not present. He told me he was a captain of the Iraqi army. As the Iranians had systematically refused us any access to Iraqi officers – they were being held in a camp the whereabouts of which we did not even know – at first, I was not sure my POW could really be the captain he said he was. From his relatively good English, and obvious education and demeanor, he soon convinced me he was. Had he managed to conceal his rank? I did not pry.

What is important is that he confirmed the heavy-handed pressure, to put it lightly, the Iranians were putting on Iraqi POWs to betray their country, to switch sides, and ultimately

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8 During my visit to Gorgan, I inquired whether the members of previous ICRC teams had ever been able to speak in private to these “Iraqi traitor POWs” (sic), to inquire whether they had been perhaps forcibly converted to betray their country. I was told that as far as they knew, it was simply impossible to speak with any of them, as they refused any form of interview with the ICRC.
join the so-called “Arab Legion”. There were constant punishments for offenses, imagined or provoked, some physical, some humiliating. The worst was the treatment by the “converted” Shiite POWs on the other POWs, loyal to their country. He told me the Iranians despised the Iraqis as “inferior Arabs”, including the Shiite converts who themselves “hated” all loyal Iraqis... When speaking about this, he was very frightened, and his words came out in phrases, not sentences, which I had to put together as best I could. We spoke half in whispers in the small lab of the infirmary, where I pretended to be verifying the lab equipment with him, but he glanced constantly all around fearing my liaison officer or someone else would see him talking to me. His last words struck me, and here I paraphrase from memory: “Please doctor, the Iranians beat us and make our lives miserable; they constantly punish us – but I do not want to betray my country. What can I do? Can you help us?”

I was at a loss. He was so frightened that I did not ask him to further expand on what he had said. He himself put an end to our “interview” at that point, apparently having heard a noise in the back room of the infirmary, not wanting to take any more chances of getting caught.

I had a few other interviews that day, some in broken English, and others once my ICRC interpreter had caught up with me. The complaints I received all concerned tensions in the camp created by the Iranians giving free rein to the Shiite Iraqi kapos to do as they pleased harassing and coercing the “loyalists”. This interview with the captain summed everything up.

In a nutshell, when working in such contexts where it is obvious that any visit by an outsider will be “prepared”, and where prisoners will be warned not to say anything about torture or similar treatment, it will be paramount to find a difficult balance between obtaining information and putting prisoners in danger. “False Flag” visitors are also used by the authorities in coercive contexts, making the establishment of real trust even more difficult.

There was unfortunately not much the ICRC could do about this serious problem of the Iranians putting pressure on POWs to switch allegiances. Needless to say, those who did manage to complain about these problems mostly refused that their stories be mentioned other than in a general context, as they were terrified of reprisals. This major issue was of course fully described in the official reports by the ICRC.

On the Iraqi side of the conflict, I did not do field visits to the camps, but I did accompany the field ICRC physicians a few times to prepare their medical evaluations for the so-called called the “Mixed Medical Commission” (MMC). GE III gives clear guidelines on the categories of wounded or ill POWs that are eligible for immediate repatriation on medical grounds, and other cases judged to be “serious” are assessed by the MMCs, which comprise physicians theoretically from both camps. In practice, the “opposite” camp can be and is often represented by an ICRC physician.

One MMC case of an Iranian POW in Iraq I shall never forget. One of our local ICRC doctors, a seasoned colleague of mine, described the case of this POW to me. The soldier had been suffering from severe depression for several years, caused by shellshock, a form of post-traumatic stress disorder which can occur after prolonged bombardments. Since he had been captured, he was apathetic...
to all and everything around him, totally im-
pervious to his condition. His case seemed
clearly severe enough to merit repatriation,
but his case had been somewhat controversial.
Since his arrival in the camp, this POW had
been totally “absent in his head”, as my inter-
preter translated what one of his fellow POWs
said. He did not speak nor answer questions,
did not seek to communicate in any way with
anyone, always looked straight ahead or down
at his feet, and sat in silence all the time. His
fellow POWs in his Cell Block helped him go
out for an accompanied walk for some fresh air
every now and then. Physically he was in rel-
atively good health, his fellow POWs helping
him take nourishment, attending to his sanita-
tary and other needs.

He had been examined several times by
different Iraqi doctors, who confirmed he was
“shell-shocked”, but did not agree on the se-
verity of his case. One had even wondered
whether he might be a simulator, and had
twice refused repatriation. Further exams had
revealed nothing one way or the other. My col-
league was certain that he was not faking his
post-traumatic trauma,

simulating, as sooner or later the camp over-
seers would have discovered his ruse. My col-
league had known this POW personally for
two or more years, and he convinced me that
the wink – which had been directly intended
for him – was absolutely intentional, and con-
veyed both the POW’s thanks and the satisfac-
tion of having “had” the Iraqis. We never found
out how he was received at the other end on
arrival, but my colleague and I both agreed
that he well deserved being repatriated for his
courage, persistence and cunning during his
years of captivity.

Visits to detainees in the Israeli –
Palestinian conflict

The context of the conflict between Israel and
the Palestinians is a more than complex one
which I shall not even begin to describe, as
again that is not the purpose here. During my
years with the ICRC, I visited prisoners on all
sides – Israel, West Bank and Gaza – on many
occasions, and gave seminars for prison and
camp doctors in all three as well.

My first visit to Palestinians in Israeli
custody was in the very large camp of Ketziot,
in the desert close to the Egyptian border. This
was before the first Intifada, which began at the
end of 1987. This prison camp in the Negev
desert was very close to the Egyptian border.
The Palestinians were held in huge tents for
20 – 30 people, in different sectors separated
from other by walls of gravel and sand, and
there was another walled sector with sub-divi-
sions, all covered by steel netting. The netting
was there to prevent escapes. The Palestinians
in these more closed sections constantly wrote
messages on pieces of paper they would then
crumple up and throw up through the netting
over to a different sub-section. This they called
“sending faxes”. Many of the faxes got stuck
in the mesh of the netting...
This was my first contact with Palestinian detainees and prisoners. Some were just youngsters who had thrown stones at Israeli soldiers. Sentenced prisoners were held in real prisons, such as the one in the city of Ashkelon in Israel proper, which I would visit many months later. At that time, some detainees were held in a temporary detention center in the city of Hebron/Al-Khalil, which was at the time in the Israeli-occupied West Bank. There were regular ICRC visits to the different places of detention and the prisons for sentenced inmates, managed by the Israeli prison service.

I visited Palestinians in the so-called Russian Compound in Jerusalem twice. It was more properly known as the “Moscobiye Detention Center” (MDC) and had a Hebrew name as well which I do not recall. Of all the many medical meanderings that come to mind, I would like to mention a few significant ones. The lessons learned may be of interest.

One aspect of the Israeli interrogation system, implemented in their prisons for “suspected terrorists”, particularly struck me. It was a well-worn scheme used to get information from Palestinian detainees. The Israelis conceived what became to be known as the “cell with the Birds”, these so-called Birds being a small group of genuine Palestinian detainees, kept in a special cell together. These Palestinians had, for whatever reason, agreed or been “convinced” to collaborate undercover for the Israelis. All the information I have on them came to me in bits and pieces from Palestinian prisoners I interviewed long after their interrogation and sentencing. I also got information from my colleagues in the field. No-one from the ICRC – as far as I know – ever got access to speak to actual Birds.

The principle was quite simple. Any newly arrested Palestinian whom the Israelis suspected knew more than what he was saying, could be sent for a short period of time, to be put into the cell with the Birds, who had been instructed to claim to be true-blue, patriotic, Palestinian militants. The Palestinian newcomer who came into the cell, was told by the Birds that they had to test him, “as they did all newcomers”, to make sure he was not a collaborator working for the Israelis. This introductory talk was tailored of course to the newcomer’s perceived or suspected status and age, but the Birds made it immediately clear there was to be “no nonsense”. If the newcomer did not convince them he was a genuine militant, or at least a loyal Palestinian, he would suffer the consequences. These could be beatings or worse, credible serious threats of violence to the newcomer’s family outside.

The Birds thus “ordered” the newcomer to tell them his real name (in case he had given a pseudonym), tell them who he was exactly, where he came from, who is family members were, and what allegiance he and his family had. He should also tell them all and anything he had “done” outside for the Palestinian cause, so they could check if he was indeed genuine and telling the truth, and of course he had to tell them anything else “he knew”, so as to help establish his status. This included the names of any superiors or significant contacts he might have had outside.

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10 Some places of detention, which were also for interrogation, such as the so-called Russian compound, were run by the Shin Bet or Israeli Security Agency (ISA). Other temporary detention centers, mainly for “small fry” detainees, such as young stone-throwers, were run by the military

11 The Russian compound got its name from the Russian pilgrims who sought refuge in it during the second half of the 19th century. It comprised a number of different buildings, among which the Detention Center.
The newly arrested Palestinian was thus confronted with a no-win, “catch 22”, situation. If he refused to say anything, he could be/would be implicating his “guilt”, and thereby his untrustworthiness. Merely saying “he knew nothing” was of course unacceptable. The Birds had experience passing for “legitimate” Palestinian militants, which thus justified their use of rough man-handling and threats to “obtain the truth”. Most newcomers who knew anything at all would usually spill whatever beans they had, and say whatever they thought would get them off the hook. If they indeed had nothing to conceal, and knew nothing more of interest (to the Israelis) this would soon become quite obvious, and the newcomer would end up being released, at least back into the general population of detainees.

Any detainee implicating himself by revealing information that was of interest, would be then taken marked for further interrogation, one of the Birds having transmitted the information to the Israelis. The detainee would then be taken out of the bird cage, and sent back for interrogation tailored to their individual situation.

This form of “outsourced coercion” as one might call it had heavy psychological consequences – and sometimes physical as well – on many detainees, and can arguably be called a form of “outsourced psychological torture”, the responsibility resting on the creators of the system.

During the years I visited in the Middle East, the Israelis had abandoned the use of heavy-handed forms of coercion, which were deemed “sloppy” and could leave “evidence”. They had devised instead, in addition to the Birds ploy, a panoply of methods which they described as “Moderate Physical Pressure”, a term coined and recommended by a Commission presided by Judge Moshe Landau, in 1987, to justify a panoply of forms of physical coercion. These practices were ultimately banned by the Israeli Supreme Court in 1999.

Coming back to the Bird system, the ruse should seem, to seasoned militants, quite obvious and transparent – all the more so with the high turnover of Palestinian detainees and prisoners throughout the system, who obviously must have amply reported its use once released from custody. How then, one could arguably wonder was it that the system kept on being used for so long? It must have worked for identifying lower or medium echelon militants, because it has been working on and off ever since! A crude, unsophisticated form of the Bird system was even in place in one Palestinian prison I visited many years later, once the Palestinian Authority had come into being. I confronted the director of this prison, this may have been in Nablus, with this query, asking him how they, the Palestinians, could be implementing the same kind of trickery they had sorely complained about, and rightfully so. They had suffered the consequences the ploy used by the Israelis. My question was all the more pertinent as I had myself visited some years ago the director I was speaking to, in Israeli detention! He merely shrugged his shoulders, and gave me a rubber-stamp answer.

This type of ruse should be known by anyone working with prisoners. It is most important to be as fully briefed as possible on all the circumstances around the overall system of arrest, interrogation and imprisonment, before interviewing prisoners about their trajectory. This will allow a thorough understanding of the ploys and counter tricks in play; and it will also give credibility to the interviewers with the interviewees, as it will be obvious they have “done their homework” and are familiar with the situation.
One of these methods I was able to actually attest, due to an error of shunting of an ICRC physician colleague of mine, during a visit to the Russian compound. The ICRC was never allowed to visit detainees held there in their actual cells, let alone inspect the corridors of the Moskobyeh center itself. All interviews and medical exams\(^\text{12}\) had to be performed in a specific cell at ground floor level, well apart from any of the living quarters or other premises. The detainees were brought to that cell by a guard, and the interviews could be held in private.

One time I accompanied our field physician, who was based in Tel Aviv as the doctor of the local ICRC team, to the Russian compound to do a few interviews, as I wanted to get an update on the situation. My colleague then had to go out for some reason or other, which I have forgotten. When he tried to come back to the interview cell, he wanted to come back via the main corridor. For some reason, maybe because we ICRC visitors were, as they say in French, practically “part of the furniture” by then, he was not accompanied just that time, and somehow took a wrong turn somewhere. He found himself rather “lost”, and asked a young soldier where he could find his ICRC “doctor colleague”, or something to that effect. The soldier spoke no English, and clearly misunderstood what he had asked, but then with his hand, indicated the way up a nearby staircase. My colleague knew this was wrong, but decided to play dumb and follow this “instruction” to proceed to the floor upstairs, where neither he nor anyone else from the ICRC had ever been. He was certainly not expecting what he was to find.

At the top he reached a dark corridor, with cells on either side. The main attraction was however in the corridor itself. There was a small chair in front of each cell, with a detainee sitting on it – if it can be called “sitting”, with one’s hands handcuffed behind one’s back, thus forcing the upper part of the body to lean forward towards one’s lap. Each detainee had a loose hood over his head. There were thus some ten or twelve of them, sitting down, leaning over in this uncomfortable position. So, this was the infamous “chair-sitting” form of “positional torture” we had heard so much about! The detainees were silent, some uttered a few grunts but nobody was saying anything. My colleague suddenly saw there was someone at the far end of the dark corridor, in what may have been a white coat, who

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\(^{12}\) Any medical “check-up” was theoretically prohibited – I normally would have had to request to have the Israeli doctor to be present, and the exam had to take place in his office. A total waste of time. I performed perfunctory exams as needed, at the request of some of the detainees, for minor complaints and for mainly for reassurance.
was slowly coming towards him, every now and then lifting a hood to see the face of the detainee underneath.

The man in the white coat suddenly saw my colleague and bellowed out something, probably in Hebrew. Whatever it was he said, he made it clear to my colleague that he was not supposed to be up there, and he immediately retreated back down the stairs, and was not followed by whoever the white-coat man (possibly a doctor) was. I vaguely remember hearing my colleague exchanging words with whomever it was he met back downstairs who led him back to “our cell”. By then all had simmered down. I don’t recall the incident having had any consequences either for my colleague or for ICRC work, but the supervision was probably enhanced from then on.

Chair-sitting was one of the Moderate methods. It had replaced the now abandoned Wall-standing as a method of coercion through what is known as forced positioning. The fact that the chairs were, when they were first introduced at least, the size for children, was of course to render their use as uncomfortable as possible.

Forced positioning has been rightfully considered to be a form of torture, and not only because the position itself causes severe discomfort to whomever is submitted to it. The procedure is usually modulated to the person. A beefy militant will not have the same “chair schedule” as a lanky young teenage newcomer. The forced sitting position may last for many hours – or even days. Used in many countries, this form of torture often implies not having access to toilets, with the ensuing consequences, both physically disgusting and psychologically demeaning and humiliating. Food and especially water are withheld as well, again for periods of time tailored to the person. All is part of the overall procedure of obviously intentional torture modulated to the victim.

Hooding or other forms of blindfolding is often used during “forced positioning”. In other contexts than the Middle East, a panoply of different “niceties” can be put inside each individual’s hood. In Asia, strong chili powder is often used. Feces, urine and vomit inside are also widely present inside the hood during torture sessions. (IFEG, 2011)

One form of forced positional torture is the so-called “Palestinian suspension”. Although the term is widely used, it is an ordeal as old, at least, as the Inquisition, during which it was modulated in degrees, hence the term “third degree”, and officially known as “Strappado”.

I have always argued that when documenting what prisoners have suffered at the hands of their tormentors, the description of methods meeting the UN 1984 definition of torture is not enough. Use of the term “torture” should not depend only on the methods used, or simply their being “intentional” and “for a purpose”, but more important, on the effects the said methods have on the actual person. To moderately or not torture a well-trained, muscular militant of whatever allegiance, who fully knows what to expect from his captors, will not produce the same effects as applying the same treatment on a civilian bystander, who doesn’t expect it, with little or no physical nor mental resistance to pain, and who is certainly not trained to withstand any coercion.

Are militants “trained” to resist torture? Some certainly are. In my discussions with IRA inmates at HMP (Her Majesty’s Prison) Maze, outside of Belfast in Northern Ireland, I was told, and could confirm this later, that all of their militants had received orders from their superiors on what to do if they were arrested. They were to resist any and all torture methods that the British applied to them, for at least 24 hours. That was the time the IRA re-
quired them to remain silent – after that they could say whatever they had to.

Those twenty-four hours gave the IRA hierarchy sufficient time to take all measures necessary to render any information the militant then revealed totally useless. A full discussion on whether – and how – torture actually “works” is a topic I have discussed many times, but it would go beyond the scope of this paper. What I have been able to confirm in discussion with more experienced colleagues than myself is that the same instructions/orders had been given in other contexts, such as the Algerian FLN facing French torturers. In fact, with of course notable exceptional cases, practically no one can resist more than 24 hours of torture by determined torturers.

One last word on lessons from Israeli detention. During the many years the ICRC visited detainees in Israel, and now Palestinian, prisons, new field workers would often ask “to what avail” the ICRC continued visiting and reporting what it documented, seeing as “nothing ever changed”. Moderate physical pressure, as well as less moderate psychological methods, were still being used; the Birds system was ever-present; etc. Their frustration was such, that many ICRC staff openly wondered whether it would not be better to discontinue the visits totally, apart from the “maintaining-family-links” aspect, as the interviews to document torture, intended to help prevent torture were visibly having no effect at all. They were merely giving the detaining authorities a “voucher of good conduct” so to say, which they could use to loudly declare that they allowed ICRC visits to their detainees, which was true, whereas neighboring countries such as Syria, Iraq, Egypt, Turkey, Iran... did not, which was also true.

I was asked this question during one of my visits to Israel. I found it to be a legitimate question, which I determined to answer. I was there to visit detainees in the (at the time) Israeli-held detention center at Hebron/Al-Khalil, in the “Occupied Territories” as they were called. The ICRC had visited detainees there for some years, and the allegations of often brutal abuse had not changed nor diminished. I was convinced our visits did have a useful impact, although perhaps not in the way initially intended – to put a stop to maltreatment and torture. I decided to inquire from those directly concerned – the Palestinians themselves – whether and how they perceived any utility of our visiting and interviewing them.

One of the Palestinians I interviewed in Hebron was a man roughly my age at the time, in his mid-forties, who turned out to be a physician as well. He himself, he said, had no specific complaints, not even the “normal beatings” described by many young Palestinian stone-throwers.

I told him I would like his honest opinion on the utility or non-utility of ICRC visits, and I explained why I wanted to hear his views – now all the more so, as he was a physician. He himself, seeing that the situation seemingly never changed, those arrested month after month being submitted to the same maltreatment as those before them, did he think it was worthwhile for us to continue our visits?

He pulled his thoughts together for a moment, then started by telling me he had noticed the ICRC presence in the West bank for years, but as this was his first time in prison, he had never understood exactly what they were for, nor what their purpose could be. Now that he had seen the ICRC teams interview the (mostly) young detainees in Hebron, where he had been for some months, he had an answer to my question. I paraphrase his answer from memory from here onwards. “Your visits to all these young Palestinian boys”, he said, “are very important for them, even if they don’t
understand them to be so. I have seen how lost most of them are when they arrive; they are afraid! For many, it is the first time they have been arrested, the first time they have seen the inside of a jail. They come in here having been beaten up during the arrest, especially during the transportation in lorries to the detention center, by the military. Here they have no visits, nor news from their families during the first weeks, and they are shouted at, threatened and therefore frightened. The fact that you people from abroad come and talk to them politely, call them by their names, sit down with them, inquire how they are, and ask them about their families – it is like someone who is drowning and who all of a sudden can grasp a tree branch and hold on to it to avoid sinking into the water!”

He unequivocally then said, “Yes, by all means, do continue visiting. We all know nothing is going to change, we know the Israelis better than you do! But your intervention, just at the right moment, is valuable to them – this I can tell you doctor to doctor!13”

I have conveyed this assessment by the Palestinian doctor in Hebron to several generations of ICRC physicians visiting prisoners in the Middle East, and elsewhere as well, to reassure them of this useful aspect of their work.

An anecdote from the First Gulf War
During the First Gulf War several U.S. pilots and airmen, as well as some U.K. SAS men had been captured by the Iraqis early on during the hostilities. The media called them “Saddam’s hostages”, as he refused to let them be visited by ICRC or anyone else. He did however put them on display in the media, for his own propaganda purposes. From the images shown on international television channels worldwide, it seemed evident that the “hostages” had been coerced into saying they had been “well treated”. Their physical aspect, however, was anything but “good”. Some of them seemed to have been severely beaten up. One stocky young American airman had a bloated face, and was swollen around both eyes. It also must have struck everyone watching the propaganda clips how false their recited words rang. One of the UK SAS men seemed deeply depressed, and what little he spoke came out in drawled, thick, language and he hardly looked at the camera at all. If Saddam had intended to give the world a good impression of how “well” he treated his POWs, it was a total fiasco.

I was part of the team given the task, at the end of the hostilities, to go fetch those “hostage” POWs in Baghdad, to receive them from the Iraqi authorities, and examine them summarily to determine whether they could travel or not. With a senior non-medical colleague, we were to take them by car all the way from Baghdad airport to Amman, where they would be handed over to their respective authorities and would receive any medical or psychological treatment they might need.

I had been particularly worried about the two hostages I have mentioned above, as their physical and particularly their psychological state had struck me when I had seen the propaganda airings. When I met them in person, they seemed totally healthy, well-groomed, in excellent moods both of them and quite jovial in fact. During the all-day drive through the desert, we had ample time to gradually become familiar with one another, and I was able to inquire how “they had been treated” during their detention – and hinted that they hadn’t looked well at all on the broadcast.

13 Another similar testimony, from an internee at Guantanamo Bay to one of our interpreters: “You are our only windows, you alone make it possible for us to breathe...”
I told the SAS man, “frankly, you looked awful...” The Brit smiled to himself, looked at me straight in the eyes, and said: “I did my best to look awful.” He was very loquacious and later wrote me a thank you letter for having been there to receive him and his fellow SAS mate, and to have talked and listened to them freely.

When I commented to the American airman how his appearance must have worried his entourage, he was not surprised in the least. He then actually showed me how he had beaten his face repeatedly with his clenched fists before the filming, causing the bruising and swelling, “so that everyone would think I had been tortured”.

This is “food for thought” for when working with victims of torture. Situations can be complex, and these survivors had taken it upon themselves to thwart the propaganda efforts of their captors in their own somewhat cunning way. This is a case of the exact opposite of “what you see is what you get...” treatment.

A visit to prisoners in a particularly harsh Uzbek prison – and its suspension
The Republic of Uzbekistan had only recently recovered its independence from the suddenly defunct USSR when I went there to visit prisoners in their most notorious prison by reputation, called Jaslik.

This prison in the Autonomous Republic of Karakalpakstan, was further west than the dying Aral Sea. Jaslik prison had a sinister reputation. Various Human Rights publications had repeatedly denounced cases of brutal torture employed during interrogations and in the prison itself, including sexual assault, electric shocks, long periods of solitary isolation and more. Jaslik was a prison that apparently held and concentrated the “heaviest” political cases, deemed by the authorities to be “the worst of the worst”.

This was a “first visit” for the ICRC, and our team had been briefed at Headquarters to expect a harsh prison regime and contentions of torture. We were also warned that the prison authorities might not necessarily be most helpful with us. I was thus a bit surprised when, upon arrival in Tashkent, we were met by a Deputy-Minister (D-M) of the all-powerful Interior Ministry, who took a very friendly approach towards us. He welcomed us warmly, and accompanied us for our preliminary meetings at Ministry level in Tashkent. We were told that all requisite conditions for visiting and speaking to prisoners in private had been accepted by the authorities. Our D-M further informed us that he himself would be accompanying us all the way to Jaslik, “to ensure everything went smoothly”, or words to that effect and was accompanied by a senior physician from the Penitentiary hospital in Tashkent, to “clarify any medical questions I might have”.

Jaslik prison was truly “in the middle of nowhere”, some 1400 km from Tashkent by road. As our ICRC driver/interpreter could not be sent alone in the vehicle for the very long drive from Tashkent to Karakalpakstan, I accompanied him, during which time he gave me a full background briefing on the prisoner situation in Uzbekistan. It was quite grim, and

Author’s drawing
I was soon to see for myself that what he told me was no overstatement.

Arrangements had been made to speak with the prison Director, in a small building 300 yards from the prison.

During this initial talk, we were able to ask all the questions we had prepared, our team leader on general issues and I on health and medical ones. However, it was either the Deputy-Minister or his accompanying senior prison doctor who answered, and not the local prison Director. Tact and experience dictated that we not “protest” this interference by Tashkent as yet, and at any rate, our accompanying duo had pre-empted any such objection, telling us that the local Director did not have the latest information and figures, as he was “new” to his posting.

We were told the prison had some forty or fifty cells on two floors, each cell holding up to twelve prisoners, with bunk beds. We would first do a cell-by-cell “tour of the premises”, explaining to the prisoners who we were and the purpose of our visit, and in the afternoon, speak in private to those who might want to speak to us. I would myself also interview the local prison doctor.

We left the Director’s office for the short downhill walk to the white prison building, so as to begin as agreed with the general tour of the premises. We were accompanied by our own expat interpreters as part of our team. It had furthermore been clearly explained to our attendant duo from Tashkent that they, of course, would not accompany us into the actual cells. Local prison guards would accompany us to guide us around and open and close whatever doors needed to be so.

What followed next surprised us all, to say the least. Walking down the path towards the white building, we approached an open space halfway down which served as a football field, with some benches for the support-
come back to each cell *after* the tour, and I underlined that the talks would be *in private*.

One of the inmates who had been up front then spoke up, in a civil tone but very sure of himself, his demeanor bordering on arrogance. He thanked us for being there, but told us right off that he and his fellow inmates had nothing to complain about. Everything was provided for by the authorities. The food was good, and no one had anything to complain about. I asked him who he was, and he said something to the effect of being their “cell leader”. Obviously, he was a detainee appointed by, or at least trusted by, the authorities. No prisoner said a word either to confirm or infirm what “the cell leader” had said to us.

During his discourse I looked around at the other inmates. Most detainees had blank stares, without any emotion, most of them were looking down at their feet. One detainee at the back was however looking directly at me with a tormented expression with what I interpreted as furious eyes. Not rage against us visitors, but what seemed like an internal rage that I suspected he might possibly want to convey to us.

After his speech, I asked the cell leader, without looking at anyone in particular, if there were any other detainees who wanted to talk to us. Two or three hands rose, but no raised hand by the one with the enraged look. I mentally took note of the latter’s face, to summon him up for a talk after we had interviewed those who had requested to talk to us.

In the next cell we entered, we found their cell leader giving a lecture to the other prisoners, all seated in front of him, listening to him almost “religiously”. This time nobody stood up when we entered. Apart from the lecture there was no noise, no comment, no asides whatsoever. A totally peculiar attitude for prisoners. The silence at the football match came to mind. Had this docile, obedient audience lapping up the words of their cell leader also been staged for our benefit? By then, we all knew the answer...

The lecture broke off after a few sentences. I then went through the same routine, through our interpreter. Icy silence. No reaction. The cell leader gave us a homily similar to the one heard in the first cell. Everything was fine; no complaints; the authorities give them everything, etc. Obviously all well prepared in advance. This time I didn’t ask if anyone wanted to talk to us. Each step of the visit seemed to confirm that the situation was being presented in a way that left no space for any contradictions to the official version. I certainly didn’t want any headstrong prisoner to blurt out a statement against the authorities, and thus put himself in serious danger of suffering reprisals or worse.

Prisoners sometimes think that, as the ICRC is allowed to visit them, we give them some sort of protection from the prison hierarchy and guards from then onwards. This is certainly *not* the case. Care should always be taken to not have prisoners put themselves “on the spot” and risk punishment after we visitors leave. Any remarks should be conveyed in private only.

This confirms an old internal saying among ICRC *old hands*: “Granted, our visits may not be useful, but at least we shouldn’t cause any problems!”. A colloquial version of “primum non nocere” (first of all, cause no harm).

More cells; same scenario. Then we came upon a group of inmates who were watching a television program in total silence. Their leader again gave us the official “party line speech”. Not one inmate looked up from the television program to see who we visitors were. A totally unnatural reaction in usual prison situations.

I then went to speak to our team leader across the corridor, and explained the situation to her. She also feared might be counter-
productive, as the prisoners were obviously frightened, not even daring to look up at us visitors. We decided on the spot to finish the cell tour so as not to give any space for any unfortunate incident. We would later in the day conduct a few interviews in private, with those inmates who had requested to speak with us, and would then play the rest by ear.

I then went to see the prison doctor in his office, while the rest of the team visited the workshops. The Ministry prison doctor insisted on accompanying me to the medical room, where the local prison doctor was waiting for us. Through my interpreter I asked the local doctor the questions I had prepared. Like many doctors in the former Soviet Union, he wore a tall, inflated white hat similar to a vintage baker’s hat, all puffed up and almost as tall as a bearskin. He looked somewhat uncomfortable, and I would quickly see why.

I started asking about his medical staff and consultation schedule. It was the Tashkent doctor who answered the questions. Again, it was the Tashkent doctor who answered. He would occasionally consult the local doctor on some minor point, but otherwise it was he doing all the answering.

Quickly fed up with this supervising, and censoring, of my talk with the local doctor, I found a pretext to ask the doctor from Tashkent to go see the D-M. I wanted him to let me continue the interview with the local prison doctor on my own, through my interpreter. As he did not want to move, claiming that he had been allotted, where I was waiting with my interpreter. He seemed a bit worried, but not really afraid. He then merely repeated that everything was fine, and that he actually wanted to reiterate what the cell leader had told us. He had no questions, no other remarks. There was no opening for any questions, as obviously he had been told what to say – and not to say. The second prisoner, and the a third one, gave me similar prepared talks. Three thus totally sterile. I then went back to the first cell, with my interpreter, and asked to see a further two prisoners, whom I chose “as randomly as I could pretend”. One of them was of course the prisoner whom I had spotted, who had looked at me with rage in his eyes.

The first one had nothing to say, and was visibly scared that I had chosen him, so I quickly let him go back to his cell. The one I had really selected then entered. His attitude had changed, and I immediately saw he
also was frightened. He did give me his name, said he was from Tashkent, and in broken sentences, constantly looking towards the (closed) cell door, said that the conditions were not as we were being shown, but said he couldn’t say any more. I asked him whether any inmates had been transferred out of the prison before our visit, he hesitated, then responded with a very tense and hardly audible “da”, and added that “many” had been taken away. I then asked him where he had been held before Jaslik, and he told me “SIZO Tashkent”\textsuperscript{14}. How was SIZO in Tashkent compared to here, I asked him. Here he turned livid, looked down, and his whole body started to shake slightly. “I cannot tell you...” he said. Then he broke down, and said he had to go back to his cell, insisting he had to leave us. He begged me to say, when “they asked me” what we had talked about, that he had talked about his old grandmother, who was very ill. He insisted on this, and of course I let him return to his cell.

Two or three further interviews only confirmed what I had already concluded. The visit itself had to be interrupted. I spoke again with our team leader, and we decided that we obviously were putting any detainees we tried to talk to in danger. Those who came to see us voluntarily had nothing to say, or repeated that “all was well”. Those we tried to call up on our initiative were afraid, some terrified. I had even put the local prison doctor in danger! My colleague had learned that the prisoners had been warned, meaning “ordered”, \textit{not} to speak to any of us, clearly implying that they all knew what to expect if they did. We therefore decided, on the spot, to suspend the visit and head back to Tashkent. There was no other choice. This had to be taken up at the highest Ministry level, and Geneva had to be informed.

Our D-M played dumb with us, raising his eyebrows and inquiring why we did not want to continue the work we had begun. Initially, we had planned to stay two full days, maybe even three. We told him we had to report back to our office in Tashkent, which would then report to the Ministry.

When taking leave of the local prison Director, and in the presence of the D-M, we told him we counted on him to ensure no detainees would be punished for having talked to us, and that we would be back to see them again. They did not comment, other than to say we would always be welcome.

I left Jaslik, fearing the worst. Some eighteen or so months later, I learned that prisoners had indeed been held for many months in the basement cells, where punishments, beatings, and various forms of abuse and torture, had taken place. These prisoners had been transferred out shortly before our visit, as they obviously might have told us about their treatment, having nothing to lose.

We also learned that it was the Deputy-Minister himself, who had done his own tour of the cells, going systematically into each one of them well before we did, so we would not catch up with him. In each one, it was he who warned the prisoners \textit{not} to complain to us foreign visitors. One family member told our office in Tashkent that the Deputy-Minister had said to them: “the Red Cross will leave the prison – you will be staying behind!”

As we had feared, all the prisoners who had spoken to us in private had been called up for questioning after our visit. Some had been beaten up, one apparently severely, according to their families.

I have given this example of Jaslik prison, even though the visit was a fiasco, because it

\textsuperscript{14} A SIZO is a jail or a remand prison, Jaslik was for sentenced prisoners, and therefore was a “Colony”.

illuminates the difficulties and dangers of seeing and interviewing prisoners when they are still in custody, in contexts where torture and repression are on-going. Our ICRC Head of delegation in Tashkent complained officially to the higher Uzbek authorities the visit having been visibly “staged”. Geneva Headquarters reported the same through official channels. This of course could not “undo” what had been done.

ICRC visits would eventually resume, though not easily. Eventually, there would be visits to Jaslik, until its closure a few years later.

The question of possible “reprisals after visits” is always in our mind when visiting prisoners. This is the reason one of the sine qua non conditions demanded from the detaining authorities is to be able to repeat the visit and again interview any and all prisoners who might have been submitted to reprisals. A first visit to a prison only ends when the second, follow-up, visit begins.

A colleague once commented to me that “You cannot make an omelet without breaking some eggs”, implying that some prisoners may indeed be put in danger by a visit, but if it is for the better good, so be it. This is not ethically acceptable on humanitarian and ethical grounds.

At Jaslik, prisoners were removed from the prison, so as to subtract them from reporting any maltreatment or torture. A few other examples of prisoners thus “subtracted” from the visiting teams deserve to be mentioned.

**Two examples of prisoners transferred out to subtract them from ICRC visits: Pul-i-Charki prison near Kabul and a Police Station in Sri Lanka**

In 1987, I was part of an ICRC team sent out to visit prisoners in Afghanistan, our visits there having been suspended in 1980. Briefly a few words on the context. Afghanistan has seen almost constant warfare since the late 1970’s – early 1980’s, following three successive “coups”, the last one immediately leading to the Soviet invasion at the end of 1979.

Afghan society and history are complex, with a great many ethnic groups, with a clear dichotomy between the rural populations and the cities. Suffice to recall here that the Soviet invasion, arguably a proxy conflict for the Cold War, led to ten years of bloody conflict, with the Soviet departure ten years later only ensuing further violence and another bloody civil war.

The visit to Pul-i-Charkhi prison I want to mention here took place during the latter years of the Soviet occupation. The prisoners visited were on the one hand, Communist afghans from failed governments of the late ‘70s, and Mujaheddin who took up arms against the Soviets and the puppet government presided first by Babrak Karmal, and then by Mohammad Najibullah.

Pul-i-Charkhi prison was an enormous complex of six large buildings. I will focus here on one of these buildings, the largest one, known as Block III, shaped like an eight-spoke wheel, four stories high, and could contain “more or less comfortably” we were told, some ten thousand prisoners (many more uncomfortably...) The aim of the visit was to check the prisoners’ living conditions and of course interview them and document any cases of maltreatment or torture. According to reliable reports from different NGOs and trustworthy media, torture and extra-judicial executions were widely employed at the time.

We learned in Afghanistan that subtraction of prisoners could easily be done inside a large prison, even during the actual visit. It is impossible to see everything that happens in a colossal wheel-shaped building like Block III in Pul-i-Charkhi prison.
When our teams started the tour, we proceeded floor by floor, wing by wing, and of course cell by cell. This would seem easy to do, as a wheel is, after all, a symmetrical structure. It would seem not too hard to systematically visit one “spoke” of the wheel on the first floor, then proceed to the intermediary building leading to the next “spoke”, and pursue with the next “spoke”, then go up one floor and repeat the procedure three times, in a neat, organised way.

We quickly found out that any such orderly step-by-step tour of Pul-i-Charkhi’s Block III would be impossible, despite the apparently symmetrical structure. This was because there were countless different places within the structure where brick walls had been put up, blocking passages between two huge cells on the same floor, or the same “spoke”, impeding any passage from one section to another, or from one floor to the floor above or below. These impediments were present at all levels, and in a haphazard way, with dozens of unexpected dead-ends. All these blockages had been constructed for alleged “safety reasons”, and even the guards were often a bit lost on how to get from one specific place to another one geographically very close, as there were no direct passages, and thus it was necessary to do a long and confusing back-track of a detour, sometimes going back up or down the stairs.

In a nutshell, the structure was a labyrinth almost impossible to follow logically, and one could easily “miss” a whole floor somewhere while going through the building, and not even notice. The point I want to make here relates to the visit in 1987, which turned out to be a visit only to the premises (!), as the authorities blocked the next steps, and specifically forbade our interviewing any of the prisoners. Thus, the subtraction of the prisoners I shall now mention, which took place in 1987, we only learned about the following year, when the Kabul authorities finally allowed a real visit to take place, and we were able to speak to the prisoners.
In 1988, we learned from many interviews, that during our tour of the prison the year before, prisoners from a whole “spoke” of the Block III wheel, perhaps some eighty or so prisoners, had been transferred out of their cells, taken down the stairs and out of the building, and then simply walked all around the circular prison, well ahead of our team. We were advancing in the same direction, but had to go up and down and across different floors, and hence proceeded more slowly. The extracted prisoners were then simply marched back upstairs to their own floor into their empty cells when they reached their “Spoke”. Cells we had gone through very quickly, as they were empty when we got to them, and had been written down merely as being “empty”.

We had thus been tricked, and a large number of prisoners had been subtracted from us, and we hadn’t had a clue that we had been duped! Such was the perimeter of the “wheel” that it would have been impossible to see this maneuver, even if we had been looking out the windows. Although it may be difficult, sometimes impossible, to thwart such maneuvers, it is essential to be alert about them, to get the true picture.

During any visit of a large prison, it is hence essential to closely examine empty cells as well as occupied ones. In empty cells there may be tell-tale signs, such as fresh crumbs of bread on the floor, or traces of other foods that may be signs that the cells were very recently occupied. Fragments of old newspapers, left behind on the floor, or often glued to the wall, should be checked for dates. A recent date will refute allegations by the authorities that the cell has been “empty for months”.

Different scenario, same bad faith, in a small Police Station in Sri Lanka some years later. While our small visiting team of three was having its initial talk with the Head of Station, one member of the team all of a sudden had to go out to fetch a document in the car outside. To his (and the rest of the team’s) surprise, he saw how some detainees were being shepherded down a ladder from a cell on the second floor, as obviously the Head of Station did not want them to talk to us visitors!

In other Police Stations, in Sri Lanka and in other countries as well, detainees we specifically go to visit on a given day, are sometimes put into a car, and driven around and around the town, blindfolded, so they will not be present in their cells during our visit. This is again a procedure to subtract prisoners from telling their stories to outside visitors such as the ICRC.

A few words on Guantánamo Bay
I shall not here go into a flagrant example of subtraction of internees from ICRC visits, which involved the great number of abducted or detained individuals outsourced to interrogation and torture centers in different countries by the CIA. These interned persons with no legal status were the ones sent to what was to become known as the “Dark Sites”, and the ICRC was of course not informed they existed. (Mayer 2005, 2009)

This is not the place to describe the torture methods used at these Dark Sites, which we only learned about much later, when the ICRC finally got access to the ones who had been sent to Guantánamo Bay. The US denied the very existence of these sites for a long time, even when many internees having been through them were transferred to the base, that the ICRC had been visiting since 2002.

Guantánamo Bay would warrant a long essay of itself. I visited internees there, mainly in Camp Delta but in other blocks as well, in 2003 and 2004 I was asked to give two training seminars there for the US Navy reservist physicians, explaining the how-and-why and
purpose of ICRC visits, but more to the point, about Torture and its absolute prohibition.

It was in 2003, that a senior Army officer confirmed to me that (and here I quote) “This is essentially an Interrogation Center; we tend to give the Interrogators everything they need...”. The objective of interrogations there at the time was to obtain, by force, if necessary, “actionable” (in Army jargon) intelligence. At that time, the notorious general who ran the camp at Guantánamo Bay, justified medical participation (by psychiatrists and psychologists) in tailoring forcible interrogations to the individual internee. He also justified the violation of medical confidentiality by the physicians if necessary for “security” needs. Final point, in 2003, Guantanamo Bay had a great many dogs all around the camp. These left the island when the general was sent to Abu Ghraib. When one sees the later photos of Abu-Ghraib, with internees terrorised by dogs accompanying the interrogators, it is easy to deduce what the dogs had been used for in Guantanamo.

In 2003, I fully documented in my medical reports the fact that internees’ medical files were openly accessible to interrogators, information which was of course included in the overall confidential ICRC Report. The reason interrogators wanted access to the files was to know when an internee was at his “most vulnerable” state, or to know what medical weakness he may have had, so as to put the pressure on him. Hence this access to the files by the interrogators constituted a gross violation of medical ethics. To do them justice, I was informed of this practice by two different US. military nurses, who strongly objected to it. None of the reservist Navy doctors ever said a word about it to me.

Under the afore mentioned general in command, so-called “Behavioral Science Consultation Teams” of psychologists and psychiatrists, commonly known as “Biscuits”, whose duty was to streamline the interrogators’ access to medical knowledge were put into place. One of the BSCTs duties was to serve the same purpose as previously, when interrogators had access to the medical files – devising and implementing individual interrogation schemes. With the BSCTs, there was no longer any need for non-medical interrogators to have access to the medical files, and furthermore informing the interrogators with what they wanted to know was streamlined by the psychologists of the BSCTs, who understood the files’ medical terms.

The overall purpose of what was at the time an “essentially “Interrogation Center” was to extract information by breaking down the internees. This whole experience has been discussed widely elsewhere, including what has been called the “reverse-engineering” of SERE tactics. In 2004, in the overall ICRC Report, I denounced this function of the BSCT system. On the ground, I also denounced it to the new commanding general, who had tried to tell me the interrogation system “was now ethical”, compared to the situation in 2003. It most certainly wasn’t.

Documenting torture – pitfalls to avoid; a subterfuge that may work...
What to do when prisoners give a credible and plausible description of treatment that clearly qualifies as torture, and may even have visible sequelae that would uphold their testimony – but insist that nothing be mentioned about torture in the visitor’s Report, because they are afraid the authorities will know they have “complained”, and they are afraid of reprisals?

As I have already underlined, victims of torture in prisons are still vulnerable and not yet survivors, and thus it is understandable that in some cases they may refuse to have
their stories reported, even in general terms, to the detaining authorities.

What to do, then, if most of the prisoners refuse their stories be reported?

I have been confronted with this type of situation several times. It can sometimes be the case when visiting a Police station, where the number of detainees is small, and it is easy for the Police to identify which detainee(s) “has talked”, even if one takes the precaution of interviewing all detainees present. In such cases, it is preferable not to mention any allegations of torture at the local level, unless there is a case so severe that some sort of protection need to be implemented on the spot, such as transfer out to a medical facility, where it may be possible to avoid reprisals. More often, the use of torture will be reported later, to the Higher Authorities, mentioning a place, but not identifying any specific person.

What about a larger context? In South America for example, visiting teams in Argentina decided to interview all 2000 prisoners in a very large prison, so as not to put any one person or group of persons on the spot just for having talked to the ICRC! Such a visit, even with a team of seven, took several weeks.

But what if every single prisoner refuses that ill-treatment or torture be mentioned, or even indirectly referred to in a Report? This was the case in a relatively large prisoner camp I visited in Sri Lanka, during the JVP (Janatha Vimukthi Peramuna) Marxist insurrection 1987 – 1989. The country was in turmoil because of the insurgency and prisoners were justifiably afraid of reprisals if they complained about having been tortured by the Police.

The Camp held several hundred prisoners. The visit focused not only on documenting torture, but on evaluating the conditions of detention and re-establishing links between the inmates and their families. As many of the prisoners’ family members had approached the ICRC and reported cases of serious abuse and torture, the main thrust of my medical visit ended up being mainly documenting the vast number of torture cases.

I interviewed dozens of detainees. Most of them willingly told me what they had been through. As is usually the case, brutal violence began at the moment of arrest, and continued without interruption during the interrogation phase. A few detainees did however say, they had suffered only “normal beatings”.

An aside here. This notion of a beating being “normal” astonishes some human rights workers, but it is a notion that one comes across quite often. Indeed, in a great many countries people who are arrested fully expect some “rough treatment” as part of the deal, so to say, and as long as it doesn’t go any further, they do not complain about their “normal beating”. The tolerance of any beating is of course not acceptable, and this should be explained to all prisoners. What may indeed be felt as a “normal beating” to one person, may well be experienced as torture by another. The bottom line is that beatings in general are not acceptable, and come at the very least under the category of “Cruel, Inhuman and Degrading treatment or punishment”.

In this case, however, the majority of detainees I interviewed had been severely beaten during arrest and interrogation, on the back and arms, with what is called a sjambok. This is a semi-rigid whip, made of heavy leather, traditionally from hippopotamus or rhinoceros hide. A sjambok leaves a distinctive scar on the back, with the mark of the tip of the whip making this type of beating easy to identify. This is another pathognomonic sign: until proven otherwise, the tell-tale sign can only have been produced by the instrument or method corresponding to it. A sjambok leaves such a scar. As the detainees had been recently arrested and beaten, the scars
they had on their backs (and on their arms, when they tried to protect themselves from the whip), were still quite evident.

I took down all their stories, and made drawings in my notes describing what I had seen. I then informed each detainee that all information they had given me would remain strictly confidential. It was here I was confronted with the dilemma. Every single detainee pleaded with me not to mention his case, not anonymously, not even in general terms. They did not want me to mention anything about the sjamboek beatings, as they “knew” that if they “complained”, word would get back to the Camp Governor, who would have the guards beat them.

What to do? A whole prison camp where the majority of the prisoners have suffered severe beatings with a cattle whip... Clearly, I could not merely write a report about the cleanliness of the sanitary installations and the quality of the rice!

I perfectly understood the reasoning behind the prisoners’ demands. As I had been asking open questions about how they had been treated, and had only discovered their torn backs when they told me about the beatings, they logically knew that any reporting of the torture would be attributed to their having “complained”.

With this in mind, a simple way to go around this reasoning occurred to me. I would show the Camp Governor “that no one had complained to me about any beatings whatsoever.”

The next day, I informed the Governor that I wanted to carry out a “health inspection” of all the prisoners. I asked him to please have them all in ranks in the courtyard, and invited him to kindly accompany me for this inspection, to which he gladly consented.

All the prisoners assembled in the yard in “sarongs” and T-shirts. I then explained to all of them that I was going to check their general state of health, and asked them to remove their T-shirts, which they did in unison. The Governor and I then passed through the ranks. Lo and behold, I was “surprised” to see that a good half of the camp population had scars of different sizes and shapes, on their backs and their arms... I asked the Governor what those scars could be, and he told me we would discuss that later. But the point was made. We went up and down the ranks, me taking notes I didn’t really need at that point, but getting the message through – I was “discovering” all of this, no one had complained to me about anything!

In short, such a subterfuge, invented on the spot, might prove useful when confronted with similar dilemmas. Each situation being different, any such ploy will have to be adapted accordingly. This was a case of physical evidence for once being present, which is most often not the case.

Documenting maltreatment and torture is difficult for any prisoner. As has been said, it opens “old wounds on body and soul”. The importance of establishing good rapport and a relation of confidence, and not rush into “documenting torture” has been hopefully sufficiently stressed. One should always begin with open questions, and then as gently as required, but without letting the story go in every which direction, slowly lead the interview to where it goes best and most sparingly for the prisoner. One should then proceed with tact and caution—never forcing anyone to give details which may be too traumatic for them. These may, or may not, be provided during a subsequent interview.

15 Unlike the Council of Europe’s visiting mechanism, the CPT (Committee for the Prevention of Torture), the ICRC has no mandate allowing it to take photographic evidence of anything during visits to prisoners.
Taking notes during interviews about torture is a particular challenge. I shudder when I remember the way one of our doctors used to conduct interviews. This I observed when I accompanied him to one of my first visits to prisoners. As indeed, the coercive methods used in the country were more or less “standardised”, so to say, the recounts received during interviews of what had happened during arrest and interrogation in the majority of cases were often similar. In this case, the interviews were done through an interpreter. The said doctor worked in the following way. He would have a first interview, ask a few basic questions, and then ignore the prisoner, and write down his notes from the interview. While he did this, he called in the next prisoner, and told his interpreter to give him the initial introduction directly, and begin asking “the usual questions” he said. He, the doctor, just barely introduced himself, and then looked away from the prisoner, and concentrated on filling in his notebook. He would then take the interpreter’s notes, and fine tune the rest of the interview from there on, as needed, mainly asking closed, “Yes or No” questions. Then the procedure would continue on the same lines. When I confronted him on his lack of empathy, not even looking at the prisoner most of the time, he merely told me that “the prisoners don’t look at me anyway, they look at the interpreter!”

No rapport, no empathy whatsoever, merely asking a standard list of questions – and effectively getting “only answers”. An appalling way of interviewing victims of torture!

Some prisoners will be more at ease speaking about torture. This is often the case with seasoned militants for example. This does not mean they have not been deeply affected by it. Torture always merges both physical and psychological components, but sometimes torture victims tend to separate what they see as two different forms of coercion. An African detainee once told me during a long interview we had, that it was easier for him “to talk about the scars on his body, that about the scars on his soul!” The worst scars in the mind and soul do indeed last longer than most physical ones.

Returning to documentation, one has to balance the taking down of important facts, dates or even names during the prisoner’s discourse on the one hand, and giving the impression of conducting what may seem like a second interrogation because of the note-taking on the other hand. One should always look at the prisoner one is speaking and listening to, even if s/he does not look back. Doing this of course will hinder note taking. I have found that what works best when the interview is long and complex, is to frankly and honestly ask prisoners every now and then for a very short pause, just to “jot down a few notes”. This prisoners usually find quite acceptable. Taking down notes furiously while the prisoners speak, and obviously not looking at them, is certainly not.

It is also appropriate, to take a couple of minutes between interviews to sort out the main points of what has been said and seen during the last one. Even when the prisoner looks at the interpreter, one should look at the prisoner and observe body language, facial expressions and occasional mimicking of a situation or position. Any sequelae observed or action mentioned by the prisoner can be taken up during the interview. Two examples to illustrate this:

- A prisoner who had been suspended many times from his hands tied behind his back, could no longer take up his water bowl and raise it to his lips. This he mimed to me, and showed me at what angle exactly his arms were blocked. This is a significant physical sequel worth mentioning.
Another prisoner, a woman militant, when describing how she has been “treated badly” during the interrogation, said to me fleetingly, looking away, and with her hands falling back into her lap: “¿sabés? Te hacen de todo...” [You know... they do all sorts of things...]. The way she said it told me she had been probably sexually man-handled, or even worse, but possibly not raped (?). She left it there, and did not want to tell me anything further on this topic, which I of course respected.

I once described, during a Ministerial interview in Sri Lanka, the way military interrogators introduced barbed wire into the rectum of young detainees – and then pulled it out roughly, in order to obtain confessions. I did not need to justify my use of the word torture; my recounting to the Authorities was met by icy silence. As for the methods employed at for example Abu Ghraib or Guantánamo Bay, the description of the suffering caused should have been more than sufficient for calling torture by its name. US authorities when discussing the ICRC findings in Guantanamo or in the Middle East would sometimes get into disdainful discussions over what they called use of “The T word”, strongly rejecting it being used by the ICRC, despite it being most often absolutely appropriate to the cases at hand.

The bottom line: in contexts where torture is widely employed, the purpose in reporting the use of torture is not to simply verify whether the UN definition of torture applies to what is inflicted on the prisoners, but to be able to demonstrate that what they have been through could not be qualified as anything but torture, or at the very least as a form of Cruel, Inhuman and Degrading treatment.

Obstacles and pitfalls of interpretation

When taking histories from former prisoners in Centers for torture survivors, care is always taken to have interpreters adapted as best as possible to each person. Preferably of the same nationality and region, preferably not from their own families. All interpreters have to be briefed on how to work with torture survivors, and informed on what possibly ghastly, always upsetting, and sometimes unspeakable horrors they may hear. Some may need psychological support when doing such work. They should be taught any specific vocabulary necessary for comprehension – on methods and sequelae for example – and for comprehending and translating the torture story back and forth.

When I began visiting with the ICRC in the eighties, I was lucky to begin in Spanish speaking countries, my mother tongue. At the time, all ICRC staff working in Spanish Latin America had to be fluent in the language, and interpreters were never used. This was however not the case in the majority of worldwide contexts, as the ICRC did not have a panoply of staff speaking non-European languages, and local interpreters were not employed for this type of interpretation. This was so local staff would not be harassed or debriefed by the authorities, to learn what had been said to the ICRC. The ICRC had often worked in situations of international war where it had been easy to find interpreters among the hundreds of POWs themselves, speaking English or French respectively, particularly among the officers.

Working through fellow POWs in the mentioned situations had been the solution, those interpreting being obviously protected as POWs themselves. In the Iran-Iraq war, this turned out to be a bit more complicated. I have already mentioned the many difficulties in the Iranian POW camps, between Sunni and Shiite POWs. In the Iraqi camps, with the Iranian POWs, the situation was again different. The Iranian POWs in Iraqi captivity may well all have been Shiite, but they came from...
very different backgrounds. Some of them were ex-military officers of Shah Pahlavi’s armed forces, and would have refused having to translate for a Revolutionary Guard POW. Ex-officers of the Shah would not be acceptable either to translate for the Basij, or children “Soldiers of God”. (Mendelson 2011)

For the Iran-Iraq war, precisely because of these differences, all ICRC interpreters were expats. However, this being said, a Swiss interpreter of Afghan origin for example, with an obvious “Dari” (the afghan form of Farsi) accent, would not have been acceptable to many Iranian POWs. As expat interpreters of Iranian ancestry were not acceptable to many Pashtun prisoners visited in Afghanistan later. But there can be other difficulties regarding interpretation in different situations.

During the already mentioned visit to Pul-i-Charkhi prison in 1987, ICRC Headquarters had not provided the visiting team with expat interpreters. The reasoning of the Delegate General had been that among the several thousand prisoners at Pul-i-Charkhi there would inevitably be enough prisoners who spoke either French, English or German, who could help us with interpretation from Farsi or Pashto. In principle, he was not totally wrong; there were indeed prisoners who could have and would have helped us with the translation. However, during the tour we immediately discovered that the prison guards, accompanying us to open and close gates during the tour of the premises, started taking down the names or numbers of any prisoner who told us they spoke English or French. We immediately stopped asking the prisoners during the rest of the tour whether any of them could be our interpreters.

However, we also found that in the majority of cells, from the way the Mujahidin prisoners looked blankly at us, there was no one in the cell who spoke any European language. We were in a quagmire – how would we proceed with the most important phase of the visit, the interviews in private with the prisoners, if we could not speak with them?

This dilemma was solved for us by the authorities themselves in 1987! After having gone through all the cells, and seen the different buildings of the huge prison – the whole tour took around four whole days – we were told by the authorities that “your visit is over. You saw all the prisoners, didn’t you? The visit is finished”. With retrospective great relief, we were off the hook. Geneva Headquarters had not given us the means, that year, to carry out any interviews, as we had no interpreters with us, and could not rely on any of the prisoners to help us, as we would have put them in danger. Furthermore, there was the additional fact that in a majority of the cells, there were no prisoners who spoke any European language.

As of 1988, however, we were able to carry out interviews in private, bringing in our own expat interpreters. It was then we could confirm the many reports that had been published on the use of torture. We received hundreds of allegations of torture and even the names of perpetrators – the most famous one being Mohammed Najibullah himself, when he was the Head of Security. We were told by one prisoner that Najibullah tortured prisoners himself – while “laughing”, the prisoner had added...

In many other situations, where torture is not the issue, it may be possible to use prisoners to translate for their cellmates. In Africa this is very common, and does not create problems, unless there are tribal rivalries or specific conflicts among different groups of prisoners. Local non-prisoner interpreters are also recruited for “non-sensitive” tasks, such as sanitation projects or hospital projects in the prisons.

There are caveats however. The following example shows how this reluctance to use the services of local interpreters is not just ICRC paranoia. In the ICRC Tuberculosis (TB)
program in the prisons of Georgia in the 1990’s, the interpreters there were all local Georgian staff. I once asked one of the TB interpreters to accompany me to the local Remand prison (SIZO), which I wanted to see again. We did a tour of the four floors, not interviewing any prisoners specifically, as that was not my purpose. At the end of the day, however, my interpreter came up to me and asked me to “please, doctor never again” ask him to accompany me even merely walking through that prison.

I was surprised and a bit shocked – what had happened? He hadn’t translated anything at all from or to the prisoners. Yes, he explained (I paraphrase from memory), “but this is Tbilisi, this is Georgia. I come from a small town just outside of Tbilisi. Here everybody knows everybody else. Six detainees, in different cells, came from my village, and they all knew me very well, practically since childhood, and they saw me with you. While you were doing your work, one of them approached me and demanded that I smuggle in a knife for him; another wanted me to bring him money; a third insisted that I take out a package for him (which may have contained drugs); yet another that I deliver a letter to someone outside; and so on.... Please doctor, never ask me to come here again. For me it is risky. They all threatened to get back at me and my family, if I did not comply with their demands!”

Point taken. From then on, I worked only with expat interpreters.

One final example which could have caused serious problems, even harm, to the very prisoners I wanted to interview:

It was when visiting prisoners in Azerbaijan, who were technically “POWs”, since they were Armenians captured on the then frozen frontline – even though they were not soldiers and most often merely civilians who had strayed across the frontline “borders”. I asked to see several prisoners, visibly well-to-do Armenian prisoners. My interpreter was an ICRC expat who spoke fluent Russian, as most Armenians speak that language. Two of the Armenians I interviewed were well educated, and spoke English, and for them there was no need for interpretation. The senior one was particularly smooth and slick, outwardly very friendly, and told me I could count on him if I needed any help with interpretation.

I didn’t understand exactly what he was up to, but would soon find out. A new group of “POWs” had recently arrived, young males only 18 or 19 of age. I asked to see them individually.

I called in the first one, a young man, quite thin, very shabbily dressed, almost in tatters, but what struck me most was that he seemed very nervous. His head sunk into his shoulders and he mostly looked down at the floor. My interpreter asked him for his name, which he mumbled without looking at her. I then asked him an open question, “How long have you been here?”, so as to put him at ease. This was translated into Russian by my interpreter. No reaction at first. We asked again, and this time he looked up with a totally blank stare. He was still nervous, but we then saw in his eyes that he seemed not to understand Russian. We tried again with simple questions, to no avail.

It was then that, all of a sudden, the slick Armenian popped his head through the door, deus ex machina almost, and asked us if he could be of any help. He added that the young newcomers came from a remote village, and didn’t speak any Russian, only Armenian.

For a split second I thought this might be helpful – but I then looked again at the young prisoner, and saw he had gone pale, and started to tremble ever so slightly. He didn’t look at the elder prisoner who had spoken at all, but he seemed to have recognised his voice. He seemed clearly distressed, but didn’t say a
word. The elder man said something to him, in Armenian, but he still didn’t look up at him.

I decided on the spot to thank the older man for his offer of “help”, but told him we would somehow manage; not to worry. He shrugged his shoulders and left without further comment.

We managed to get a member of our staff who spoke Armenian to come to the prison, and through her, we learned what the situation was. It took a while of gently explaining over and over that they should not be afraid, that we would not tell anyone what they would tell us. We finally managed to learn, obliquely, and in bits and pieces, that the “slick” prisoner and his friends beat them (the newcomers) up, made them work as their servants, and... “did bad things” to them. This was a typical case of sexual abuse occurring between cellmates.

We arranged for the young prisoners to be fully separated from the other Armenian prisoners, “because of their age”, not giving the camp commander any details.

Here our inconvenience of interpretation could have led to an unfortunate, even tragic, situation. I am convinced the young Armenian would of course had said nothing through the slick interpreter, but it would have put him in a very stressful situation, with possibly dire consequences. The ICRC usually now has its own expat interpreters – even for languages less widely spoken.

**Medical documentation of course – but not the only medical task!**

Actual medical documentation of torture is of course the subject of the Istanbul Protocol, recently revised and upgraded, for which it is the certified UN gold standard reference, which is why I have only discussed actual documentation tangentially in this piece, preferring to convey informal personal notes on the collateral aspects of obtaining such documentation through visits to prisoners, and point out that visits in custodial settings have their own specificities and pitfalls to avoid.

Such medical visits do however have a few other medical purposes, which may be just as important to the prisoners, or even more so, than providing narratives for what may seem to them as an abstract outside endeavor to put a stop to torture. Prisoners in custody may have more pressing needs and questions, that require the medical knowledge that a visiting physician can provide.

Doctors will most often begin an interview by inquiring about the prisoner’s present situation, including both physical and psychological aspects of health. If the topic of torture arises, the dialogue chosen will differ according to how recent and how traumatic any such experience has been. It is here that prisoners may refer to some specific sequel of a beating, such as a hearing problem after boxing of the ears, or more general musculo-skeletal problems. The questions they ask are often ones they dare not ask the prison doctor, whom is often seen, often rightly, as an accomplice to the repressive system. When some reasonable trust has been established with the visiting physician, they may ask elementary questions such as “Doctor is it broken?”; or “Will I be able to work again?” or “Will I be able to sit down again and do my weaving?”. The answers to these questions will depend on what methods – and how recently – any disability has been inflicted.

The least physicians can do is to answer any questions to the best of their ability, based on often summary clinical examinations performed in less-than-optimal conditions.

When any form of sexual torture has been part of the ordeal, dialogue with these prisoners will be much more complicated, and most of the time will not come spontaneously. The physician may not get any information at
all during the first contact, which is why it is most important to be able to see these prisoners again, later during the visit or as soon as possible otherwise. Sometimes, when rapport has been established, certain questions may emerge, though often with difficulty. “Will I be able to have a child after what they did to me?” “The soldiers told me that I could never sleep with a woman again.”

In the Indian sub-continent for example, young male prisoners interviewed had often been through brutal physical torture (crushing of the thighs with heavy “rollers”; or ripping apart of the adductor muscles in the thighs by over hyper abduction, a torture method called “cheera”). I often found the younger ones were more terrified by the threats the soldiers had implied to their manhood, than about other physical sequelae. The perpetrators of course knew this, and these threats were part and parcel of the whole system put in place. (Reyes, 2008)

Regarding sexual torture, there is a difference between “sexual” torture and “gender-based” torture. The latter term relates to physical and psychological abuse adapted to the gender of the victim, whereas “sexual” torture deliberately incorporates what the term implies.

In women, sexual torture is exactly what the term means, and is certainly not only limited to rape. It comprises all stages of abuse, and includes a deliberate sexually targeted component (Pérez-Sales & Zraly, 2018; 2016; Sáez, 2016; Sifris, 2014). This usually starts with verbal abuse, beginning with lewd comments implying further sexual abuse to come, often accompanied by invasive, offensive, touching and fondling. A woman in custody in any context doesn’t, and can’t, know where it is all going, and when, or whether, it is going to stop. Torture perpetrators know and use this psychological component, even before anything actually “happens”, and use it to break down the victim. All this has to be considered by the interviewing physician in the evaluation. Generally speaking, women physicians should interview women prisoners, and if this is not possible, another woman should be present to help the prisoner feel more at ease. Often it will simply not be possible for physicians of the opposite sex to interview prisoners.

While this is the rule which clearly should be followed, one should be alert to exceptions being possible. In my own experience, in Sri Lanka, I was called upon by several women detainees, who wanted to speak to me about the sexual abuse they had suffered, because I was a physician, this factor trumping the fact that I was male. The medical counselling they wanted was more important to them than the gender of the doctor providing it.

In males, physical abuse and targeting of the sexual organs can indeed also be “sexual” in nature. Anal male rape with police batons or broomsticks is a typical and unfortunately not uncommon example. However, genderized torture in males more often consists of beatings and, electric shocks for example, targeted to the genital area to cause extreme pain, not necessarily having any sexual connotation per se.

A question prisoners often ask a visiting physician is whether there is “anything I can do in the meantime?” This even more so in contexts where medical care is sorely insufficient. Here useful counselling about what exercises or specific movements can be performed in the cell or in the yard, or with the help of a fellow inmate, may be helpful while the prisoner has no access to professional care outside. The visiting physician should of course preempt any such questions, and offer whatever advice is deemed useful. One has to remember that as whatever documentation obtained from visiting prisoners, and presented in a Report, will not be of any direct practical value to those who have provided the information, the very least visiting
physicians can do is to provide such counselling as described in the examples above.

Not providing adequate medical attention can also be a form of torture, if it is denied deliberately as part and parcel of the interrogation procedures or of the coercive environment. (UNHCR, 1999)

A word on the management of hunger strikes
Hunger strikes are not the issue here, and yet one aspect relating to their ethical management has to be mentioned, as it relates to torture. In the initial landmark WMA Declaration of Tokyo of 1975 – a document which prohibits all and any use of torture – there was a curious allusion to hunger strikes in what was then its Article 5, which stipulated without any further explanation, that:

Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgment concerning the consequences of such voluntary refusal of nourishment, he or she shall not be fed artificially.

Use of the term "artificial feeding" instead of "force feeding" blurs the intent of the Statement here. In a hunger strike situation, there is an ethical conflict situation. The term that should have been used instead of "artificial" feeding, so as to avoid any ambiguity, should have been "forcible feeding". Artificial feeding merely describes nourishment given other than orally. Clearly a physician who is presented with a prisoner whom he doesn’t know as a patient, who is said to be hunger striking, who has lapsed into a state of muddled reasoning, or has lost any significant consciousness, must provide that patient treatment, via artificial feeding. In this particular situation, the physician may not have any knowledge of what the said prisoner’s wishes actually were. (Reyes, 1998)

Suffice to say here that the World Medical Association issued the Declaration of Malta of 1991 on Hunger strikes, revised and updated in 2006, to expressly forbid forcible-feeding after its practice was renewed by the US at Guantánamo Bay at the beginning of the 21st century.

This new version, 2006 WMA Malta Declaration 2006, states unequivocally, in its article 13:

13. Forcible feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment. Equally unacceptable is the forced feeding of some detainees in order to intimidate or coerce other hunger strikers to stop fasting.

The reason forcible feeding is stated to be a form of inhuman and degrading treatment, and not torture, is because no one had imagined that such aggressively violent, forcible feeding would be applied to many dozens of detainees in Guantánamo Bay, not just once, but repeatedly for weeks, months and even years! If this had been envisaged, only the word torture would have been adequate to describe such treatment. The reason I go into some detail on this subject, which I started by saying was peripheral to the subject of torture at hand, is that I have been confronted with protest fasting, a more correct term than the colloquial term “Hunger strikes” in many countries. I have had heated arguments with members of the legal profession, who often defend the State forcibly feeding fasting prisoners, supposedly to “save lives”.

The overwhelming majority of Hunger strikes end well before there is any risk of
dying from acute malnutrition. The immense majority of “hunger strikes” do not lead to “Northern Ireland-like” situations. Most often, “loose” forms of protest fasting, with some nourishment being taken on the side or on the sly, this should not be considered as “cheating” by the visiting physician, but rather as a way for the protestors to indicate that what they really want is to find a solution to their protest. This is where a visitor from “outside” often can provide help.

The detaining authorities may decide to forcibly feed fasting protestors to “save face”, because they want to be able to say they are taking medical “life-saving” measures.

During protest fasting, physicians should know that they have ample time, about a month – if the “strikers” are initially in reasonable health – before health problems arise, and most such protests are abandoned or loosely discontinued by then. At any rate, physicians should take advantage of the time they have to speak in private to the protestors, and help them find a solution to “negotiate a way out”, which is what they desire, even if they claim otherwise.

One form of medical treatment that physicians should explain and suggest to any “end-stage” Hunger strikers, is the parenteral administration of vitamins, mainly Thiamine – a treatment which has proven to avoid serious sequelae in long-time hunger strikers.

The bottom line to retain is that: forcible feeding, is never acceptable. (Reyes et al., 2013)

Reporting torture – some approaches to (absolutely) avoid
Based on years of experience reading reports on torture from the field, and trying to improve written some of the narratives recounting cases of prisoners having been submitted to torture, used to illustrate and buttress the official interventions presented to the relevant authorities, I would just like to briefly mention three basic approaches to be avoided at the field level of recording and then composing such reports.

(1) The reporting of torture methods used is, in itself quite legitimate. Nonetheless, merely listing a panoply of techniques or devices, dumped in a pile, so to say, totally unconnected to the individual persons who have suffered physical and psychological anguish and pain from them, is first of all slighting and offensive to the victims, and second such listings are ineffective in their final purpose.

The examples I give below are taken from real draft ICRC field reports in past years, and are hopefully no longer repeated:

...the alleged severe ill-treatment includes threats to be killed with a pistol, suffocation by putting the head under water, or into a plastic bag, suspension by the hands or wrists, and beating with sticks, fists or boots...

This is what I call Package-deal Torture. A listing of “techniques” will not impress the authority it is supposed to influence in the endeavor to have such practices stopped. In moments of confidence, some detaining authority contacts have told me just that – when presented with such an inventory, they just skim diagonally down the list, only looking for some possible “error” which they will then pounce on and ignore the rest, or just think “it’s again more of the same”, and not register any of it.

A possibly more effective approach would be to indeed mention what has been done to the victim, immediately followed up with a full description of the effects such torture has had on the individuals, each description tailored to the person.
Needless to say, mixing up in the same package (as above) “submarine” torture, beatings and a sham execution, all of which have completely different effects on different people, is not an effective way of conveying the message intended.

(2) For many years before the drawing up of the Istanbul protocol, reporting of torture was thought to be strengthened, by whatever “medical evidence” was obtained that could possibly “prop up” the allegations. The reverse of the coin of course was that perpetrators would then throw out any allegations that were not accompanied by any medical “evidence”.

As there very often there is little or nothing “to show”, well-meaning visitors to prisoners, and this included the ICRC in the 1980’s, chose to tag onto their reports, a few phrases stating that “some signs or scars” found by the doctor on some of the victims interviewed, were compatible, or not incompatible, with the allegations submitted. Needless to say, such feeble “medical tags” were anything but convincing.

An illustration again taken from another draft field report (my comments in italics):

“traces [what exactly is meant by “traces”?]
compatible with the allegations of torture were assessed in almost all the cases...
The methods used were:
slaps [what “traces” does a slap leave one wonders…]
punches
kicks [surely some description could be given here?]
suspension [something more could surely be said about the probable sequelae…]
beatings (with a hose)
beatings (with a stick)
beatings (with the feet)
anal rape “[this form of sexual torture is “tacked on” here at the end of the list without explanation; fortunately with no word about any “traces”…]."

This is not only another example of the “Package Deal”, but more to the point here, an attempt to render the reporting more credible, by stating there was some physical evidence in “almost all cases”.

This is what I call WYSIWYG torture (what you see is what you get). I needn’t repeat here what has been summed up previously when discussing “Absence of Evidence is not Evidence of Absence”.

A final approach to avoid when reporting documented torture, which unfortunately still tends to persist, is the use of what I call hollow statistics. The inadequate use of percentages, when the group of individuals involved is less (sometimes quite a bit less) than a hundred, is not serious, and certainly not convincing.

But worse yet is the throwing around of these “statistics” and expecting them to impress those for whom the report is intended. My last example, from another draft field report:

“Suspensions in custody:
Suspensions are up 17.2 % from last year, but beatings are down by 24.1%”

I have had long discussions in the past with experts and colleagues, even from the IRCT, who defended the gathering of statistics, even if not wholly convincing. I however beg to insist that the use of weak statistics leads to preposterous assertions as above!

I have called this approach the “Dow Jones approach” to documentation of torture, to be avoided. Most certainly legitimate studies of torture cases, compiling histories and examinations, and when possible additional documentation such as X-Rays, photographs or other exams can and should be done. If the number of cases is sufficient, then a real sta-
A statistical approach will be useful. In the cases I have mentioned, the small number of cases did not justify the use of statistics.

**In conclusion**

This informal essay by no means had any intent to be “academic”. Its purpose is what the title says – to put together “flashes” of experience and lessons learned visiting victims of torture, who were interviewed while still in custody. Victims still, not yet survivors, and thus in very different circumstances than the usual torture survivors, no longer in the hands of the perpetrators.

The difficulties inherent to such visits are many, and the examples given are just some of the most graphic and hopefully instructive ones. Some examples may be too basic for seasoned readers of the Torture Journal, but are meant for the new generation of future experts in this field of work. Actual documentation of Torture itself has only been dealt with tangentially here, as it is recorded in great detail by a multitude of professionals in the field in the Istanbul Protocol, recently updated and expanded.

The three concepts I hope I have been able to transmit as fundamental take-aways would thus be, and my apologies for the clichés:

- Absence of Evidence is never Evidence of Absence; and muddled memories are a normal self-protecting mechanism after the torture experience.
- Always consider the possibility of “reprisals after visits” when visiting prisoners. This is the reason one of the *sine qua non* condition demanded from the detaining authorities, to be able to *repeat* the visit and again interview any and all prisoners who might have been submitted to reprisals. A first visit to a prison only ends when the second, follow-up visit, begins – and one can make sure there were no reprisals. And if there were, duly document and report them.
- Documenting torture on needs to describe the methods, but much more important is to describe the effects of the whole procedure, tailored to the individual, which will hopefully be more effective in persuading those who initiate the implementation of torture, to envisage and implement putting a stop to such practices. Intention and Purpose are not sufficient criteria, and are often skewed to justify the unjustifiable.

To illustrate this, I will end with a quote from the Vietnam War. I still shudder when I remember this excuse proffered by a military officer reporting back to his hierarchy after having bombed, napalmed and strafed a village of civilians, saying “We had to destroy the village in order to save it!” [from Communism, was the direct implication]. The use of Torture is NEVER justified and is totally forbidden by international humanitarian law. May this modest contribution based on some thirty years listening to individual stories of pain, anguish, suffering and distress, some of the worst cases which I have not recounted out of respect for the victims, be useful for a younger generation of physicians who want to pursue this task.

**Acknowledgements**

Thanks to Pau Pérez-Sales, Editor-in-Chief, who has read and discussed each of the six versions of this work. It is not easy to delve into the past and it is always good to do so in company.

**References**


Reflections on healing and recovery from the legacies of trauma and violence

June P. Lopez

Abstract
The author describes her experience working in the Philippines and the logic behind a survivors’ group in her native land to reflect on life experiences and what both torture and the healing process meant from a lifelong perspective.

Introduction
On the occasion of the 30th anniversary of Torture Journal, I will discuss lessons learned in the course of my engagement in psychosocial rehabilitation projects in the war-torn communities of East Timor and Southern Philippines. Several conclusions stand out and resonate with me as a healer, a caregiver and an advocate:

The early years of the torture rehabilitation movement in the Philippines and the immediate post-conflict era in East Timor saw this tendency to see torture sequelae as physical and mental health problems that must be treated. The Philippine Action Against Torture (PACT), established by the Medical Action Group, set up a clinic for torture survivors, provided medical and physiotherapeutic interventions for individual torture survivors, investigated allegations of Torture and visited detention places to render medical and psychiatric assistance to detainees. In East Timor, international NGOs competed for scarce funds to establish similar clinics in the country’s capital, Dili. The staff of these clinics were even given short term training in Australia to familiarize them with the treatment programs used in rehabilitation centres. Australian psychiatrists were funded to see torture survivors in these Dili clinics once a month. These days, funders also look at torture rehabilitation as projects intended to identify victims and their needs as individuals, not communities. Thus, proposals required counting the prevalence of clinical symptoms and much less a social investigation of the more vast impact of the violence on the community. This led to frustrating struggles to secure funding for community-based programs. We evolved in our firm conviction that while individual healing was necessary, it could not occur without social and community healing. The 1980s definition of Torture became a hindrance as well. Community torture became a more common systematic form of Torture after the Convention Against Torture (CAT) was ratified. The CAT was primarily based on the Greek and Latin American experience of State torture which targeted individuals to terrorize the population. The community-wide extent of the psychosocial impact of Torture had not received as much attention as the need to assist individual survivors back into their everyday lives. Thus, recognition for the importance of community-based interventions was far from sufficient. Such lack of recognition was the reason for our
failure to receive funding assistance for a research project to study the impact of massive abduction of male community members by the Indonesian militia, dropping off their dead bodies back onto their village that was come to be called the “Widows Village”. The reason that was given to us was that the incidents did not fit the CAT definition of Torture.

Fortunately, our persistence with such a notion produced results. The IRCT managed to run a project for five years in Suai, a Timorese district. Suai is about 2 hours away from the capital, Dili. It suffered mass murder by the Indonesian militia, where more than 500 members of the community were killed on one occasion while attending church. We were able to document the torture experience of the community and provide community interventions such as group psychosocial processing of survivors or the creation of modules for the training of mothers and teachers on the management of trauma in children. One prominent feature of the research project was the continuing debriefing of our young interviewers, who were not only survivors of the same trauma but were also bound to be retraumatized by the research process. We were able to apply this same framework and methodology in the war-torn community of PIkit, Mindanao in the Southern Philippines, with the support of DANIDA and the Danish Embassy in Manila.

Under the most brutal results of war, displacement, massacres and torture, the need to address the traumatic human sequelae remains in the hearts and minds of surviving individuals and their communities. Individuals confronted with brutality and degradation can have incredible strength and resiliency. Thus, they must be actively engaged in the “rehabilitation” process not only as beneficiaries of services but as knowledgeable, dedicated but unfortunately, disempowered members of their community. As humanitarian aid embarks on the challenge of psychosocial rehabilitation, it is essential to realize that there is more to it than altruistic concern. As we saw in East Timor, the scramble for funds, territories of operation, even occupation of the remaining scarce undamaged buildings for offices demonstrated that humanitarian aid is also an industry which in many instances brings into play economic and political variables that can impede and even obstruct, the provision of effective rehabilitation services. Decisions regarding priorities and fund disbursement are coloured by these variables leading to prioritization of, for instance, computers or motorcycles for the organisation over psychosocial services. Then, there is the temporary nature of humanitarian aid regarding the long-term consequences of psychosocial trauma. We must anticipate donor fatigue, new catastrophes, the disappearance of CNN, changing national and global politics. The priority of building an indigenous infrastructure to empower the people to meet their needs is of most critical importance.

I would also like to highlight the different means and varying degrees to which post-conflict countries could embark on the process of “remembering”. Alfred McCoy’s profound analysis of the Philippine experience looked at the extent to which impunity was practised by those who assumed power after a dictatorship such as the Marcos Dictatorship. Torture and

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its terror, designed to inculcate mass compliance through fear, left a lasting legacy for the post-Marcos Philippines—a politicized military and a traumatized polity. Since there was no investigation of past human rights abuses, torture and salvaging have continued inside the PNP. The Philippine experience teaches us that torture has a transactional dynamic—just as the torture victim is made powerless, so the torturer is empowered. More than any other nation, the Philippines provides an example of extreme impunity."

“Remembering and truth-telling”, according to McCoy, “is a discourse in power. It is not a one shot or a series of hearings to get the people’s narratives. Hence, it is a process that requires empowerment. He posits that “there is a dialectical relationship between the legacy of violence and its traumatic consequences and the degree to which “forgetting” becomes the social and cultural norm in dealing with its traumatic consequences. The “dialogic value of memory” must not only be in the context of history-making but must also be in the context of healing”.

The importance of remembering and truth-telling is what I experienced in Cambodia. Acceptance and karma were dominating elements in the belief system of the predominantly Buddhist population, which did not see the value of remembrance and truth-telling. Other elements are the need to reestablish a sense of safety and connection, the first stages to trauma healing according to Judith Herman. Neither have been substantially felt by the survivors. IRCT training professionals on psychotherapy, which was obviously a western concept, failed to encourage survivors to talk about their stories. The concept of “cultural sensitivity” was too often given only lip service because it was politically correct.

McCoy’s observations lead me to wonder what might be the determining factors that influence these tendencies. Louis Bickford cites the relative strength of the human rights movement as a factor. Suppose we look at the Latin American experience and compare this to the Philippine experience. In that case, we might conclude that the process of “remembering” in Latin America was substantially more organised, tenacious and aggressive than what we observed in Asian countries like the Philippines and Cambodia.

These observations are consistent with the conclusion that the task of remembering and retelling one’s story requires empowerment/re-empowerment of both survivors and witnesses. Therefore, the entire process is both a means and an end unto itself. A social context that affirms and protects the victims and provides victims and witnesses opportunities for joining a joint alliance against perpetrators is undoubtedly an imperative. Hence, it is not difficult to see that there is indeed a dialectical relationship between the legacy of violence, its continuing traumatic effects and the extent to which survivors are empowered to remember and retell their stories. We can also see that this process must be documentary in nature. It must occur in healing and recovery and must be conducted most ethically and therapeutically.

However, we still need to ask ourselves this question. How true to this goal of empowering at all cost has the rehabilitation movement been? To what extent has the current “professionalization” as opposed to the activism of the 80s and “ politicization” of anti-torture work not moved efforts away from the “medical model” or worse that impunity and lack of justice become worse hindrances to healing?
Healing the wounds - personal reflections on the evolution of therapeutic methods for survivors of torture

Inger Agger

Abstract
With the arrival in Denmark of torture survivors from Latin America in the nineteen seventies and eighties, therapists faced the challenge of how best to accompany the survivors in their healing processes. The New Left and Feminism were important political movements which influenced the therapeutic approaches discussed at that time. In the author's meeting with Latin American colleagues a dialogue about therapeutic methods was further developed with emphasis on the connection between “Human Rights and Mental Health”. The civil war in the Balkans in the nineties brought new challenges: the development of psychosocial community interventions as well as an intensification of the debate between the “medical” and psychosocial approaches to trauma healing. Co-operation during the last decade with NGOs in e.g., India, Cambodia, and Honduras brought new and more holistic perspectives on therapy represented by a brief version of Testimonial Therapy that sought to integrate cultural and spiritual traditions as well as “third wave” cognitive methods.

From European feminism to Latin America reality
For me, a reflection on the past should take its point of departure in 1984, when I started working at the RCT as a clinical psychologist with Latin American political refugees who had arrived in Denmark and had been exposed to torture and persecution in their homelands. At that time, I was active in the New Left Movement, which assembled activists who campaigned for social issues such as women’s rights and political rights. I wanted to use my psychology degree politically, primarily through a feminist perspective. I was a member of a Consciousness-Raising Group (CR-G). CR groups were a central and revolutionary part of the Women’s Liberation Movement and I wrote my master’s thesis on the healing dimensions of CR groups with the purpose of analysing how they supported women in understanding the relationship between the “private and the political spheres”. One of the main subjects in these groups concerned female sexual oppression and how a patriarchal society dominated women’s sexuality. In the CR-groups, women gave testimony about their private lives, seeking to see their personal experiences from a political perspective.

When I met the Latin American refugees and torture victims, I found resonance and political discourse that was familiar. They talked about their “life project”, how it had been disrupted and how they longed to return to their homelands and continue the struggle for human rights and freedom. Many of them were activists. That was why they had
been imprisoned and tortured. During the Eighties, I also met with Elizabeth Lira and other Latin American colleagues at conferences who brought their books and articles to Denmark. They connected, following Martín-Baró, “mental health and human rights” with political oppression and torture. The healing processes we created in the dialectical connection between the private and the political spheres. The victims suffering from a repressive political system. Furthermore, refugee women from the Middle East and Latin American women also gave testimonies about how patriarchal oppression of women was abused worldwide during sexual torture (Agger, 1989; 1994).

Colleagues in the South were sending us, in Europe, a clear message: paternalistic and medicalising attitudes were not acceptable when torture and violence are rooted in politics. Evidence of this was the heated debate among professionals working with survivors of torture and state violence in the Nineties. On one side of the battle were the “medicalising” people who viewed the distress of torture survivors as an “illness” (Post-Traumatic Stress Disorder), which in principle should be cured as other types of medical conditions. On the other side were the professionals from the psychosocial community, which I belonged to. Part of this debate was reflected in the pages of Torture Journal, among other places. We accused the medical side of neo-colonialist approaches and were critical of the widespread use of the PTSD diagnosis. Many of us did not feel that the symptoms of PTSD could adequately describe the stressful experiences of torture and war. As Chilean colleagues emphasized: giving medical diagnoses to survivors of state terrorism can be viewed as double victimisation: “blaming the victims” by stigmatising them as “mentally ill” (Agger & Jensen, 1996).

**Psychosocial and community work: the debate in the Balkans**

From 1993 to 1997, during the war in the former Yugoslavia, as the European Union (EU) Coordinator of Psychosocial Programs for war-affected people, we searched for practical and valuable methods to accompany the suffering population. National and international mental health professionals were feeling overwhelmed and helpless as the first war in Europe since the Second World War developed and the refugee crisis intensified. Likewise, did the battle between the “medical” and “psychosocial” professionals. How should one approach trauma and healing in this new war context? The war necessitated other interventions on a mass scale than what was common under peaceful circumstances.

Eventually, it was recognised that little healing could be done during the war. The best approach was to focus on survival or prevention of the deterioration of the survivors’ psychological and social status through community mental health. Eventually, we arrived at the following definition of psychosocial emergency assistance: The aim of psychosocial emergency assistance under war conditions is to promote mental health and human rights by strategies that support the already existing protective social and psychological factors and diminish the stressor factors at different levels of intervention (Agger et al., 1995)\(^1\). That definition was an official EU position and, thus, a commitment beyond the biomedical approach.

The war rapes and sexual torture of both men and women in ex-Yugoslavia ignited further discussions and reflections. Were there

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\(^1\) The research also concluded that psychosocial work needs to be accountable, despite the large difficulties it might entail to do assessments of efficacy of projects implemented in war-torn communities.
national or international interests in constructing a rape victim identity of ex-Yugoslav women or a trauma victim identity of the ex-Yugoslav people? It would seem like the war rape and trauma survivors were exploited for various political purposes.

In an evaluation carried out by the EU in Bosnia and Croatia in 1995 during the last months of the war, we distributed questionnaires to 2,291 participants and 165 national staff members of psychosocial projects funded by the European community (Agger & Mimica, 1996). The results indicated that the participants were most often exposed to life-threatening events (85%), loss of home and property (85%), hunger and thirst (60%), torture or extremely bad treatment (30%), and illness (30%). 80% reported that participation in the project was of considerable help to them. Our study illustrated that war trauma is much more than exposure to a single stressful event. It is a long and enduring state of severe stress and uncertainty about the future (Agger & Mimica, 1996). Maybe the true war trauma symptoms should have been identified as nationalism, lack of tolerance for differences, and withdrawal into ethnic groups – symptoms of the terror and mistrust that the horror of civil war had caused in the population. However, the psychosocial projects, viewed as crisis intervention, seemed to have attained their goal: to keep people going even under complicated circumstances.

**Integrating new ideas towards a holistic approach to therapy**

Over the last years, interesting new developments have been the “third wave” cognitive methods, which are inspired by Asian religious practices and combine elements of meditation and mindfulness with cognitive-behavioural therapy (CBT). In an action research project from 2008-2010, we developed a particular brief version of Testimonial Therapy (TT) that sought to integrate Asian cultural and spiritual traditions (Agger et al., 2012, Jørgensen et al., 2015). This new version included a public ceremony at the end of the testimony process. This ceremony came to play an essential role because it connected the survivor to his or her community through public acknowledgement and mobilisation based on the narrative about the human rights violations suffered by the survivor.

Sadly, Testimonial Therapy has in some instances been used to justify the expansion of Narrative Exposure Therapy (NET) – a therapy allegedly based on TT with little emphasis on the political context of the traumatic experience. The emphasis of NET is rather on narrating in as much detail as possible the survivors’ painful experiences without reference to the ideological and cultural meaning or frame within which the torture was perpetrated. The lack of a meaningful frame might hinder the process of integrating the traumatic experience and in some cases lead to re-traumatisation by repeating the painful experience without facilitating an understand-

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2 In a cooperation between the RCT and Asian NGO partners, in particular with People’s Vigilance Committee for Human Rights (PVCHR), led by Dr. Lenin Raghuvanshi, Varanasi, India. I was in the role of an external consultant.

3 Testimonial Therapy is an individual “human rights” psychotherapy for survivors of torture and other types of violence that has the narration of the survivors’ traumatic experiences and a public ceremony as its central components. The trauma stories are recorded, jointly edited by the therapist and survivor, compiled into a document, and read out in a public ceremony. The document may be used by the survivor to raise public and international awareness about human rights violations (Agger et al., 2012; Puvimanasinghe & Price, 2016).
ing of “why this horror happened to me”. NET can basically be viewed as one more exposure technique with another label, and not much different from the medical model which the RCT advocated in the Eighties (Mundt, Wünsche, Heinz & Pross, 2014).

“Third wave” cognitive methods, which have emerged recently, focus on holistic processes of well-being in contrast to symptom alleviation, and they often incorporate “Eastern” methods of meditation and spirituality, e.g., Compassion Focused Therapy (CFT), and Culturally-Adapted Cognitive Behavioural Therapy (CA-CBT). My research in Buddhist Cambodia from 2010 to 2012 indicated that Third Wave methods are becoming more readily transposable to work not only with Buddhist torture survivors but also with victims of persecution in other cultural or religious contexts. As “Western” practitioners of psychotherapy we have much to learn from Eastern traditions, e.g., Cambodian notions of the importance of “cooling the body” and “thinking too much” correspond well with Western notions of core “emotion regulation and distress tolerance skills” and how to “restore self-regulation” (Agger, 2015).

**Integrating Indigenous practice**

In Honduras in 2017, during training with thirteen Indigenous leaders of the Lenca people who were also survivors of state violence, we explored and integrated Indigenous cultural practices of the Lenca into a local design of a psychological trauma healing process which included Testimonial Therapy. The leadership of MILPAH emphasized their determination to preserve the culture and religion of the Lenca, and during the training the participants designed a Cosmic Circle Ceremony which consisted of a circle on the earth made with plants, flowers, water, incense, and four colored candles. Standing within this altar, which they had built themselves, the survivors read their testimonies aloud and the Circle, thus, became an essential healing element of the modified Testimonial Therapy ceremony. The Cosmic Circle incorporated elements of nature: earth, air, fire, water, by which the participants could invoke their ancestors, and the guardians of the rivers and the forest. The ceremony also allowed the survivors to invite their relatives and neighbours of the community whereby their struggle for human rights could be reaffirmed and legitimised.

As an effect of the COVID pandemic, the Cambodian mental health NGO Transcultural Psychosocial Organization (TPO) has recently explored the possibilities of including online testimonial therapy in its toolbox. An online ceremony might include up to one hundred people who could witness the ceremony at a time when only a few people are allowed to attend a ceremony at the local pagoda.

**Final remarks**

When I look back at the reflections on the evolution of therapeutic methods described here, there seems to be a direction going

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4 The Honduran Psychologist Arely Alvarado and I cooperated in the framework of the Danish NGO “Nunca Más – International Network for Human Rights and Psychosocial Response” and in collaboration with “MILPAH” (Movimiento Independiente Indigena Lenca de la Paz-Honduras), an indigenous Honduran human rights group.

5 Especially through the Cambodian Psychologist Phaneth Sok. Testimonial Therapy carried out by TPO was adopted by the UN-supported Khmer Rouge Tribunal in 2014 as one of the reparations made available to survivors (Lesley, 2021; Esala & Taing, 2017). The tribunal was established in 2006 to bring to trial senior leaders and those most responsible for crimes committed during the Khmer Rouge regime from 1975-1979.
from a rather radical one-sided view in the early Eighties towards a broader spectrum of approaches that includes diverse aspects of human existence in the political, social, physical, spiritual and cultural spheres. A long journey shared with people and communities in many different contexts and positions.

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ECHO.
Reflections on 30 years of anti-torture experiences

Vincent Iacopino

On the 30th anniversary of the Torture Journal, I offer my sincere congratulations to the Journal editors, staff and contributors for their success in providing a space for analytical and practical thinking on one of the most challenging and enduring problems of humanity – torture. In thinking about those years, I would like to share some reflections that I hope will be useful to future generations in securing a world without torture.

In 1991, after my training in internal medicine, I started a post-doctoral fellowship with Robert Wood Johnson Clinical Scholars Program at Stanford University. In conducting a qualitative research project on human suffering, I approached a treatment center for survivors of torture in San Francisco, Survivors International, seeking a collaboration. We not only provided medical and psychological care, but also social and economic support in the form of job placement and food assistance. We conducted asylum evaluations to assess physical and psychological evidence of allegations of torture, which had a profound effect on adjudicators’ decisions. Asylum approval rates increased from approximately 5% or 10% to more than 90%. In the early 1990’s, the U.S. contribution to the U.N. Voluntary Fund for Victims of Torture increased tenfold from $500,000 annually to $5 million; and the Office of Refugee Resettlement was provided a budget of $20 million to establish and support treatment centers for survivors of torture in the United States.

Of course, one thing led to another. In 1992, I attended a Physicians for Human Rights (PHR) conference on medicine and human rights. Given my newly acquired skill of documenting clinical evidence of torture, I was asked to participate in several PHR human rights investigations. The first one was documenting the excessive use of force and disappearances of pro-democracy demonstrators in Thailand, and then, investigating and documenting torture, political killings, disappearances, rape, and attacks on health professionals and facilities in Kashmir and Punjab, India.

Through my 27 years of work with Physicians for Human Rights, I came to understand the power of medicine and science to prevent human rights violations and hold perpetrators accountable through effective investigation and documentation practices. At PHR, we have documented the health consequences of a wide range of human rights violations including genocide, war crimes, crimes against humanity, torture and ill treatment, the use of chemical weapons on civilian populations, war-related sexual violence, landmine injuries, excessive use of force in crowd control settings, child labor practices, HIV/AIDS policies, attacks on health professionals and facilities and many more. In 1996, PHR was co-recipients of the Nobel Peace Prize for as
a co-founder of the International Campaign to Ban Landmines.

While the documentation of human rights violations can have a profound effect on prevention and remedial reform, it was apparent from my point of view from working in the field that the realisation of any one right, such as freedom from torture, depended on the protection and promotion of other rights, for example, in the case of torture, the rights to due process, freedom of speech, peaceful assembly, education, work, and the right to vote. I came to understand what human rights advocates already knew, that human rights are universal, interdependent, and indivisible. As social claims articulated in the aftermath of the horrors of World War II and the Holocaust, human rights represented a unified vision of a just and peaceful world, free from fear and want. However, as a health professional seeing the extraordinary health consequences of violations of civil and political rights and unrealised human needs, human rights represented more than a moral vision of the world and legal duties of States; they also represented the necessary conditions for health as defined by the World Health Organization, “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

Unfortunately, simply envisioning a world free from torture through the protection and promotion of human rights does not make it so. In 1853, before the Civil War in the United States, a slavery abolitionist and Unitarian minister, Theodore Parker, wrote that “The arc of the moral universe is long, but it bends toward justice.” Yet, the truth is, the moral universe is what we envision it to be; and it does not bend toward justice without human intention and agency. To the contrary, one may argue that the “moral universe” is bending toward injustice and self-destruction of humanity and our planet. How, then, do we bend the arc of a moral universe? If I have learned anything of value for future generations who seek to end torture and live in a more just world, I would offer these suggestions.

We must continue to envision the world we want to live in and codify into law, constraints and obligations on State and non-State actors to achieve that vision; and we must empower ourselves to hold States accountable. As Dr. Martin Luther King Jr. said, “Power, properly understood, is the ability to achieve purpose. It is the strength required to bring about social, political or economic changes. In this sense, power is not only desirable but necessary in order to implement the demands of love and justice.” In my own journey, I have learned the importance of codifying norms as a framework to empower civil society and to hold States accountable in their obligations to investigate, prosecute and punish perpetrators of torture and ill-treatment. Some twenty years ago, together with colleagues in civil society around the world and representatives of the U.N. anti-torture bodies, we developed U.N. standards for the effective investigation and documentation of torture and ill-treatment known as the Istanbul Protocol, standards now recognised throughout the world. Recently, these standards have been strengthened through a large-scale effort by 180 clinical, legal and human rights experts from 51 countries to include guidance for states on how to provide the necessary conditions for effective implementation of Istanbul Protocol standards. Such implementation guidance seeks to establish and maintain a sea change across legal, judicial, health and law enforcement sectors and involves awareness raising, capacity building, legal, judicial & administrative reform as well as active engagement with civil society.

Such efforts to establish norms are critical in achieving State accountability for human rights violations, but they are insufficient in
preventing such crimes in the first place. One evening in Istanbul in 1998 just after completing our final meeting on the development of the Istanbul Protocol, Sir Nigel Rodley, then U.N. Special Rapporteur on Torture, and I sat down for a dinner celebration with our Istanbul Protocol colleagues. At some point, we began discussing what it would take to end torture. Nigel argued, “Ending impunity through legal prosecutions is the only way.” I countered that, “There is no way that torture and its many cousins will end in the absence of a culture of human rights.” We argued and smiled as we each knew the other was also right.

I agree with David Weissbrodt, distinguished professor of law at the University of Minnesota Law School, who famously said, “Human rights is the first universal ideology.” The evolution of human rights during the past 70 years is largely the result of civil society compelling States to ensure the respect for the inherent dignity of all people and human rights as the foundation for freedom, justice and peace in the world. For States to affirmatively protect, promote and fulfill their human rights obligations, the international culture of human rights must flourish and public constituencies for human rights must be represented in governance. Human rights awareness and education is essential in developing the consciousness and commitment to action in order to realize the vision of human rights.

In seeking an end to torture and, by necessity, protecting and promoting all human rights, we must make human rights count in our everyday interactions, in “…small places, close to home…” as Eleanor Roosevelt said on the tenth anniversary of the Universal Declaration of Human Rights, “…so close and so small that they cannot be seen on any maps of the world” --meaning that respect for human dignity is more than a matter of holding states accountable; it is a way of being in the world.
Reflections on an international engagement in the fight against torture

Henrik Døcker

Abstract
The author describes some of the early beginning of the RCT and Torture Journal.

Keywords: torture journal, history of torture.

Being born just before the Second World War I, grew up and matured at a time when internationalism developed enormously. In addition to that, the international human rights movement was also beginning and growing at the time, and as a journalist, I began to work with Danish NGOs (Amnesty International, the Danish UN Federation and European Movement Denmark). Later, as a journalist, I worked for many years as a correspondent for Ritzau, the national Danish news agency.

Among other events, I proudly attended and reported from the foundation of the International Center for Treatment of Torture Victims in 1982, in my home city – Copenhagen. At the time of inauguration, the centre was in the premises of a big Danish hospital, the Rigshospitalet.

Living close to the building, I often remember many encounters with Dr. Inge Genefke, the idealistic young neurologist who had initiated, what for long should be known as the RCT – today with a new name: Dignity. Dr. Genefke proposed me to join the team to have a journalist who would edit what would be a new international magazine informing about the work of alleviating the sufferings of torture victims. The editorial board consisted of doctors related to a field that was new in the medical world.

We met regularly and agreed on the distribution of tasks and how to develop the magazine. As the need for treatment grew all over the world the Copenhagen based centre became an important focal point in widespread and international dispersion of knowledge of torture victim treatment. Quite a few Danish doctors learned the treatment, consequently RCT developed the research part of the centre tremendously, reducing the number of individual torture victims being treated here.

Dr. Genefke encountered initially some problems with medical colleagues that didn’t have the same strong idealism driven by a wish to alleviate the plight of torture victims – they basically feared political implications. She herself had founded a medical group within Amnesty International already in 1974 and couldn’t escape a feeling of moral obligation to act.

In international law torture, was not forbidden until a clause in the European Convention on Human Rights of 1950 mentioned it. The UN Declaration on Human Rights of 1948 mentioned the notion torture but with no binding effect on the states supporting it.

The beginning of the Torture Journal was just some years shortly after the UK versus Ireland case -1978- where the Court found the infa-
amous “five techniques” to be ill-treatment, but not torture. The Convention against torture would come a lot later, in 1984. To say in a few words: those were times in which most of the topics we were covering were in their early definition and thus, the RCT was a place of constant debate.

In this framework, a medical professor, Bent Sørensen (1924-2017), long-time chairman of the RCT, was elected member of both the European and the UN anti-torture committees. As the Optional Protocol was approved, for the first time, members of the European committee had a right to inspect prisons of their own choice. The RCT organised education for police officers in various countries and developed international conferences for the growing number of doctors with demanded knowledge of rehabilitation work for torture victims and spaces for exchanging lessons learned.

I can perfectly remember how Bent Sørensen took the lead of the board of the organisation in a moment of a decisive crisis at the RCT. Various professional groups disagreed with the medical staff on how to run the centre. There was a general lack of management skills. Sørensen, respected medical expert and chief physician for the department of burn wounds at a Copenhagen hospital, became a rock-solid support for Inge Genefke. Eventually, her husband.

Bent also became a kind of “roving ambassador” for the anti-torture cause. He travelled around the world training doctors, instructing prison wardens and doing advocacy work in national and international institutions. I remember his interest, for instance, in the size of prison cells, referring to the judgment in Kalashnikov vs. Russia passed by the European Court of Human Rights in 2001, in which confinement of 15 people in a prison cell of 17 square meters was considered degrading treatment in violation of art 3 of the European Human Rights Convention. He tried to use the sentence to advocate for clear rules related to prison conditions.

Being financed by Danish public purse, the Danish government realised that a full separation of the national and international branches was necessary. This was a turmoil that, on the one hand, gripped the organisation, but on the other, was a real wake up call. It must be admitted that not all foreign partners to the Centre followed good governance concerning rules for accounts, which also meant, further crisis with donors that reflected in internal crisis within the RCT, sometimes with painful consequences in terms of people leaving the organisation. But this is a different story.

Some activists combatting the use of torture, spoke in the 1990s about abolishing torture before 2000. This is to illustrate how idealistic we were at that time.

In my opinion, torture and the fight against it could not be approached without taking the protection of the notion of all human rights into consideration. Torture cannot be considered as an isolated element, but part of the overall human rights policy of a country. We know now that we are far beyond that idealist endeavour and the new generation has different but also complex challenges to face. Not to forget the legal side: The European Human Rights Convention, to just put an example, has no provisions on the punishment of torturers, but only rules on satisfactory compensation to the victims which are paid by governments in the individual states according to judgments from the European Human Rights Court. Since 2002, the International Criminal Court (ICC) in The Hague has sentenced a limited amount of people, mostly from African countries. None of the big perpetrators from the Global North has been brought before this court. Only a minor group of governments in the world accept universal or extra-legal juris-
diction for torture crimes. We have, in overall, a framework of impunity.\footnote{More interest should be given to a judgment from January 2022, in which a German High Court in Koblenz sentenced a Syrian torturer Asman Raslan, former colonel and intelligence officer, to life imprisonment for crimes against humanity as co-responsible for the torture of 4,000 prisoners in a prison in the Syrian capital Damascus.}

But also democratic Denmark has been forced to account for violation of international obligations concerning torture. During a military operation in Southern Iraq in 2004 Danish soldiers assisted British military posted there on Iraqi invitation. Some inhabitants in the Basra area were captured suspected of rebellion and later transferred to an Iraqi police station where they were seriously maltreated. Many years later a group of 23 Iraqi men initiated a lawsuit against Denmark and got compensation by the Danish High Court: Denmark was co-responsible as it was more or less common knowledge, that Iraqi authorities were not lenient when people had been detained, although the Supreme Court has recently rejected the demand for compensation.

Nobody is free from torture. The work of the anti-torture organisations must always not be ceased.
Inside the belly of the beast. Reflections on the history of IRCT

Christian Pross

Abstract
This paper is looking back and taking stock of the history of IRCT from the perspective of a founder of a treatment center, former member of the IRCT council and Executive Committee (ExCom) and contributor to the Torture Journal. It is the story of enthusiasm, ambition, dedication, devotion, hope and dreams that the worldwide battle against torture could be won in the near future. And it is also the story of a rocky road with failures, disillusionment, disappointment, team conflicts and burnout which commonly but insufficiently are described as “vicarious traumatization”.

Key words: Vicarious trauma, burnout, care for caregivers, structure of organisations, clinical supervision

My first encounter with RCT and the international torture rehabilitation network in its embryonic stage was in Fall 1989. A total newcomer in the field, I received a warm welcome from a small cosmopolitan circle of enlightened, charismatic and inspiring colleagues. It was like being adopted into a family. Coming from a feudal culture in German medicine still tainted by its Nazi past, I was used to a relationship between young doctors and their senior superiors like that between servant and master. So my reception as an equal by these older colleagues was like a shining light for me. One anecdote may illustrate this: A Danish colleague, at the time President of the Danish Medical Association, jokingly told me about the very formal encounters with his rigid and conceited German partners in the pretentious headquarters of the German Medical Association (GMA), which he sarcastically named “Palazzo Sewering,” a reference to the past president of the GMA, former SS-doctor Hans Joachim Sewering. I agreed with my Danish colleague wholeheartedly; it was as if he had taken his remark right out of my mouth. And it so happened that my contribution to the first “International Symposium on Torture and the Medical Profession” in Tromsø, Norway in June 1990 was a paper on “Breaking through the postwar coverup of Nazi doctors in Germany,” (Pross, 1991) which earlier had been my main field of research and practice.

Encouraged by my adoption into the “family,” we, a small task force of Berlin doctors, were able to establish a Center for the Treatment of Torture Victims (BZFO) in January 1992. It was an exciting time. We were full of enthusiasm, ambition, devotion, and hope, echoing the optimistic, encouraging message from the “family” that our network would win the worldwide battle against torture in the near future (?). The second International Symposium in Istanbul in December 1992 was filled with this same spirit. It was the
typical honeymoon that so many of the early centers enjoyed. We did not allow our optimism to be dampened by messages and warnings about serious conflicts, ruptures and splits in other pioneer organisations. We were confident that this would not happen to us because we had from the very beginning implemented such preventive safeguards as clinical supervision, an open-minded culture of dialogue, a flat hierarchy, an egalitarian team structure and opportunities for advanced training in trauma therapy. So it came as a shock when our honeymoon suddenly ended in a sharp, deeply antagonistic conflict that almost destroyed our center. I learned in subsequent years, when serving as IRCT council and ExCom member, that such conflicts occurred in many organisations in the field of torture rehabilitation and human rights, and that they followed a certain stereotypical pattern.

The issue of vicarious trauma, the need for care for caregivers at the time was still rather unknown territory. Clinical supervision was regarded as “navel gazing”. The self-image of many pioneers was that of the heroic rescuer and warrior in the front line of the fight against evil, rewarding self-sacrifice and devaluing self-care. This attitude ignored the unconscious dynamics of transference, projection, parallel processes, and reenactment; and the contagiousness and virulence of extreme trauma. So it was a painful and shocking experience when caregivers suddenly woke up in a pile of broken glass, as if a rug had been pulled out from under them and they had been catapulted into a torture chamber, right inside the belly of the beast. Colleagues who had been comrades and buddies suddenly started attacking and antagonizing each other, suspecting conspiracies against them, and no longer speaking to each other.

My interest in reflecting about this subject led me to take notes and keep a diary. An ongoing dialogue with colleagues from other centers and various networks helped me to formulate hypotheses about the nature of these patterns. I had been myself so deeply involved in these struggles, however, that in order to analyse them I needed to step aside, surrender all my executive positions in BZFO and IRCT, in order to adopt a more objective, birds-eye perspective. It was a painful decision to separate from the “family” in 2003 and enter the world of academia, which has its own vicissitudes and pitfalls. After examining the history, structure, politics and team dynamics of more than a dozen organisations worldwide I presented my first findings to a workshop on vicarious traumatization at the International Symposium on Torture in Berlin in December 2006.

We were about five speakers, with some 20-30 people attending the workshop. My memory may be tinted by nostalgia, but never before or after did I experience such an intense, open-minded and emotional dialogue, such a high level of self-reflection, such a frank search for truth and solutions regarding this issue. It was a magic moment; everybody in the room had themselves experienced vicarious trauma, and the participants came from the most diverse backgrounds: a US Army psychologist and Vietnam veteran, an Eastern European psychiatrist and Gulag

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1 Significantly one pioneer organization chose as its name “Oasis”. Oasis Copenhagen was founded in 1987. It originated from a split in RCT, when a whole dissident section of the team was kicked out by RCT’s founders after the dissidents confronted them with their authoritarian management style and dogmatic therapeutic approach. It was one of the earliest examples of how unresolved vicarious trauma can disrupt an organization. The story was published like a “roman a clef” by one of the key players who had been laid off (Bustos, 1990)
survivor, an African human rights activist struggling with post-colonial dictatorship, a Western European psychologist working in a shelter for women who were survivors of family violence, and a Latin American psychologist and survivor of the military junta. I remember a Palestinian psychologist speaking about the effects of Israeli supersonic bombs on his clients and fellow caregivers, and the emphatic, compassionate response to him by a European Jewish psychiatrist and Holocaust child survivor. This was particularly surprising because the latter was an outspoken advocate of the Israeli West Bank Wall. There is unfortunately no audio recording nor transcript of the workshop. Yet I am certain that the participants internalised and benefited from its precious healing messages.

I first published that same year in Torture Journal some of my hypotheses and preliminary findings, including two standardised, illustrative case histories of burned-out caregivers, in which I summarised my observations about myself and others (Pross, 2006). In the next issue of Torture a colleague who believed he recognised himself in one case history wrote an outraged letter to the editor accusing me of mobbing (bullying in workplace) (Graessner, 2006). This brought home to me that by writing on such a delicate issue I was touching a sore spot, and made me wonder if I could ever publish my research. However, the positive feedback from further presentations in professional circles and conferences encouraged me to press ahead (Pross, 2009).

Looking back, I think that many of the pioneers in those early years struggled hard with best intentions to create a safe, clean and sound haven in their own organisations, a kind of oasis as a counter-model, a healthy counter-world against the gloomy, dirty, destructive monstrous world that their clients had been exposed to inside the belly of the beast. The pioneers’ family culture, friendly, informal buddy-like work climate, empathy and solidarity would somehow naturally protect them and their clients.

So I have the highest respect for RCT and IRCT’s founders, namely their key figure Inge Genefke. Inge was kind of a role model and stands for many other pioneers from all over the globe representing the prototype of the charismatic leader, the visionary pioneer with entrepreneurial skills and a missionary sense, which enabled them to create and defend the organisation against reluctant bureaucracies and the prevailing attitude of social denial and indifference. Inge deserves enormous credit for building RCT and IRCT from scratch and making it one of the most important, efficient and widespread anti-torture networks of the world. It was her energy, her stamina, her courage, dedication and persuasiveness which enabled her to achieve that. She was a brilliant promoter and advocate with the capacity to set an audience of stubborn sceptical donors, politicians and VIPs on fire. Like a lioness she fearlessly confronted perpetrators - dictators, military leaders, police chiefs, prison directors - some of whom may have been scared stiff by a powerful woman of her caliber. She supported and protected many colleagues – especially in countries under dictatorship where torture was happening. She helped them establish torture rehabilitation centers by raising funds, advocating and lobbying for them. For many she was a friend, like a mother and they feel a deep gratitude to her up to this day.

Others however experienced another side of Inge. The enormous success and rapid growth of RCT/IRCT fostered a sense of grandiosity and infallibility in her. She was deeply suspicious of and felt threatened by people, who had a different approach than her in therapy, advocacy and organisation build-
ing. She had a tendency for splitting people in friends and enemies and it was difficult for her to handle dissent – a character trait that may point to some traumatic experience in her own life. This led to permanent conflicts within the organisation and a brain drain of qualified staff. It is a lonely at the top and an experienced wise organisational consultant and coach for leaders may have helped Inge to cope with the overwhelming work load and responsibility that had outgrown her. She had a hard time giving up her “baby” RCT/IRCT and handing it over to a second generation.

One of my key experiences in this context was an IRCT council meeting sometime in the mid-1990s. It started with business as usual in the familiar harmonic family-like atmosphere when suddenly the president, a renowned, respected elder statesman and person of integrity announced that he would resign. It must be emphasized that he was the only independent person in the superstructure of RCT/IRCT at the time, the only person with no stake in the company and no conflict of interest. His announcement ignited a chaotic scene with the complete decomposition of the nuclear “family”. The adopted newcomers including me felt like children watching their divorcing parents lacerating themselves in a War of the Roses. None of us understood what was going on. After a period of hectic running around in the corridors, whispering campaigns, floating rumours, and meetings behind closed doors it leaked out that the reason for the president’s resignation was an evaluation of RCT/IRCT, a report by an independent expert commission, called the COWI report – hired by the main public donor. The report identified major deficiencies in the organisation such as the amalgamation of board and management, concentration of power in the hands of the top managers, and lack of a participatory horizontal structure – all typical for enterprises led by first-generation founding fathers. The report therefore recommended the transition from a “first generation” to a “second generation” leadership. A faction within the nuclear family of founding fathers/mothers had kept the COWI-report confidential, wanted to hide it from the council members, prevent the president from making it public and refused to implement the report’s recommendations.²

In the aftermath of this historic meeting some of the “children” (including me) were elected to the ExCom (it was the first “election” instead of cooptation into RCT/IRCT’s superstructure). We were expected to assume responsibility as a sort of “second generation” board and implement the recommended reforms. We did our best, hired a new young general secretary, introduced regular evaluatory meetings with staff, hired an external team supervisor and organisational consultant, etc. But we failed all along the line because the founder faction used informal channels (they no longer held any formal positions in the superstructure) to undermine all our and the new GS’ reform efforts.

These years were a rough period of blood, sweat and tears, an ongoing drama of Shakespearean proportions lasting almost a decade. The IRCT headquarters and council were haunted by endless infighting, turf battles, people working themselves down to the point of complete burnout, a permanent high rate of sick leave, drop-outs, and turnover of staff and leadership resulting in a decline in performance to the point of near collapse.

Challenging the beast requires a certain degree of steel, the strength and stamina of a Heracles, a powerful superhuman fearless

² One structural re-arrangement following the report was separating RCT and IRCT in two self-governed organisations.
giant. More faint-hearted, gentle individuals may never have achieved what the pioneers of the early years did. Yet these characteristics may not suit the role of the Good Samaritan\(^3\), the therapist, the healer, the good-parenting, tolerant type of leader, who nurtures his staff and fosters a supportive, creative and humane team culture. Heracles and Good Samaritan are rarely to be found in one person. There was a short period in RCT/IRCT when in a division of labor between those two types Heracles acted as external leader and a Samaritan acted as internal leader. But this also failed, because Heracles could not accept dual leadership and by constant interfering and undermining made life impossible for the Samaritan to a point when he/she gave up and resigned.

**Lessons to be learned:**

1. **Qualification of caregivers**
   Empathy and solidarity with victims of torture is a vital assumption for this work. Many centres for torture survivors have been built by survivors themselves. It is only natural and human that those who suffered will be most motivated to help their fellow victims. Their personal experience is a strong motive and driving force for this work. They have a particular sensitivity and deep understanding for their clients, who frequently and justly complain about the ignorance and lack of empathy of “normal” people. On the other hand, survivor-caregivers risk getting enmeshed and over-identified with clients, losing professional objectivity and transmitting their own trauma to the clients and colleagues. This risk is only mitigated if they have worked through their personal history in some kind of self-awareness process while in therapeutic training and are able to keep a professional distance from the trauma of their clients. The strongest and most important asset and working tool of a caregiver/therapist is his personality, because he or she serves as a role model to the client, and because the therapeutic relationship is first and foremost a human relationship. So beyond one’s professional skills and experience it is important to look at a candidate’s character: is he or she warm-hearted, sensitive, empathetic, solid, and balanced? Does he or she have resources in his personal life, a normal life outside work, a sense of humour, capacity to rest and relax, does he or she value pleasure? Workaholics, who centre their lives around work can often impress their peers by enormous dedication, zeal and achievements in advocacy and politics, yet they usually prove not to be good caregivers, one of the reasons being that they do not take good care of themselves.

2. **Qualification of leaders**
   Natural born leaders are very rare. People working in the health and human rights field usually do not have management skills, yet this can be learned in special training. A trauma centre needs a clearly authorised leadership. There should be a clinical director in charge of client services and an administrative director in charge of finances and organisational issues. Leadership requires some elementary properties like talent for listening, modesty, level-headedness, maturity, life experi-

\(^3\) Heracles is a mythical figure from ancient Greece. A divine hero with extraordinary strength, courage and ingenuity is considered the protector of mankind. The good Samaritan is a biblical figure who stands for a merciful altruistic human being who practices charity and takes care of the wounded and sick.
ence, stability, persistence, assertiveness and wisdom. Leading a trauma centre is a special challenge because one serves as a projection screen for all the negative and destructive energy that comes along with this work and which the leader has to contain. A good leader carries his role without blurring functional hierarchy, is prepared to endure “bad-boss” projections and carry through unpopular decisions. At the same time, they must encourage creative ideas and initiatives from staff, let others grow and blossom instead of seeing them as competitors, not abuse their power, and work with transparency to staff and accountability to the board.

3. Structural requirements
Centers and networks need a professional, clear, and efficient structure, one of the key elements being a board of independent individuals who have no stake in the company and no conflict of interest (like the above-mentioned elder statesman and first president of RCT/IRCT). They need a board that hires and supervises the leaders, initiates reforms and takes action when things go wrong and get out of control. The democratic principle that the tenure of office is limited should also maintain in our field. There is a time when leaders should step back and give way to a new generation.

4. Care for Caregivers
Centers and networks need regular clinical supervision for caregivers, organisational development, management consultation and coaching for leaders. Supervisors and consultants must be independent external professionals without personal ties to staff or management. These policies are key elements of self-care because they protect caregivers, managers and leaders from drowning in work, losing their professional distance and getting too enmeshed. They provide a safe space for conflict management, peer review, critical self-reflection, transparency about formal and informal hierarchies, insight into the unconscious dynamics of this work and a climate without fear for resolution of sensitive issues such as vicarious trauma. A care for caregivers program matching the specific culture and needs of staff should also be provided.

To cut a long story short: IRCT has survived the rough and turbulent times thanks to numerous reliable, responsible, faithful, qualified and dedicated staff members, who like Sisyphus repeatedly rolled the boulder uphill. And – as far as I can see - thanks to the persistent energetic commitment of numerous qualified, experienced, down-to-earth council and Ex-Com members, independent experts and external consultants IRCT has finally transformed itself into a highly professional and democratic “third/fourth generation” organisation. There is good reason to celebrate 30 years of Torture Journal.

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4 For more elaboration on these issues see Pross, C. (2011), Manual for Good Practice and Management in Trauma Centres: Structural Aspects of Work Related Stress - Care for Caregivers, International Rehabilitation Council for Torture Victims (IRCT), Kopenhagen. This manual was the product of a task force team of independent experts and council members, summarizing the lessons to be learned from the turbulences of the founding years. https://www.christian-pross.de/manualgoodpract.pdf
An Arabic, Turkish and Spanish version is available from the same source: https://www.christian-pross.de/manualgoodpract_ar.pdf
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From untried steps to omnipresence

Peter Vesti

Abstract
The author introduces new ideas - in this case the multidisciplinary treatment of torture survivors - may be understood as the benevolent work of altruistic people. It is indeed, but it requires hard work, toughness and cut-through leadership. The formulation of ideas and some of the unexpected troubles in one of the early periods at The Rehabilitation Center for Torture Victims is portrayed from a personal angle.

Keywords: torture journal, history of torture.

I joined the RCT in 1989 as a psychiatrist, one of the people that actually attended to patients and was not involved in managerial tasks. I am now 72 and I still work on my private practice: caring for patients is what provides sense to my work and life.

I left the RCT in 1993 a lot wiser… During that time I wrote a book and some papers in the Torture Journal regarding medical complicity in torture (ref to add). This was one of the main topics of concern in an organisation closely linked to the Amnesty International medical group.

What I remember, as a young enthusiast approaching a complex world for the first time, is an institution with a high level of commitment that was fighting to innovate, create, and reflect on fields that today seem very well defined, but which at the time were still spaces to be explored, at least in Denmark. I imagine that in the victim’s countries of origin, the reality was different, and people developed theoretical frameworks pushed by the need to act upon an urgent reality.

I have in my head a thousand anecdotes that I cannot recount here, it seems to imply that you can’t recount these anecdotes because they are inappropriate), but perhaps some flashes can give an idea of the intensity of the debates, often in long meetings at the headquarters, sometimes emptying the wine cellar of any bar or our homes. The RCT was, I can say, a battle for new ideas. It was chaos, a political issue in a time of politics, now mostly lost due to professionalization.

Our opponents were primarily the general administration of the mental health systems (allocating the money or trying to avoid allocating the funds to torture survivors) and the need to introduce the topic to the agendas of health systems at the national and international levels. This is why medical ethics was important, as was being present in the World Psychiatric Association, with a Section?. It meant gaining political space in front of a medical establishment that answered: «why do we want new subspecialties of psychiatry» (is this a question?). The debates, in those enthusiastic and complex times, were also around the political position...
of the team (therapist and organisation): «Can a conservative reality (do you mean really?) show compassion? Or even «Can we really accept money from the rich Jews in the US for the treatment of Arabs (arabs or Palestinians?) (some even having been in Israeli prisons)? Any debate meant, somehow, confrontation, as emotions were always present as the ideological debate was brought to its last consequences. Insights included who was to provide the psychotherapy itself and even, strange it might seem now, the political ideas of the clients/ survivors. It was amazing to see how the Chileans fought amongst themselves even to the point of wanting to exclude from treatment those not of the extreme left. Looking back with the perspective of years past, therapy was also part of the political struggle (we always knew torture was politically motivated). This meant that a therapy centre should be a space of confidence and that part of therapy was helping the survivor to remain politically active, not only because this was thought to be part of the healing process, but because the survivors were important elements of that fight.

Dr Genefke ruthlessly fired the disgruntled, demanded discipline, and several of the staff left disheartened and formed new centres: The Oasis as well as Etika (names implying reasons or living this meaning is unclear). There were divisions and hard times, and not much space for caring as our mission was urgent and invaded everything. But not everything was negative: staff members falling in love and long nights of thinking that we were really making a change.

In all of this we were looking for a medical model for psychological therapies. Would it not be nice to demonstrate the effects of, for example, falaka with a microscope (a rheumatologist looked at this) rather than the usual ups, downs, and debates of all the diverse directions of psychotherapy (from classical Freudian catharsis to the rudimentary cognitive therapy of the time). Yes we failed, we did not find morphological signs that only appeared after (physical) torture. However, we helped to link Post-Traumatic Stress Disorder to torture and help in documenting psychological wounds. Not the ideal, not capturing the complexities of the human experience, but the possible.

Yet, treatment from the RCT was a very persuasive argument in obtaining asylum, that is, the right to stay in the country. If you provided a certificate from the RCT as to the effects of torture on your health the right to stay was practically always granted.

With everybody fighting for their understanding and privileges, the only way to secure the road forward was the visionary Dr Genefke. The main issue was sustainability, which in plain words, means money. For years, the RCT lived only on non-governmental donations, but it took quite a lot of money to run. The RCT was fragile and had an uncertain future, but Dr Genefke and Prof Sørensen were able to raise these funds elegantly.

The treatment of torture survivors was not possible for economic reasons because the therapy was enormously time consuming and required a multidisciplinary approach. Dr. Genefke was able to see that and get the funds when no attention was devoted to the topic.

Now, (2022) everything is well organised and the ‘omnipresence’ of the title means that all major psychiatric centres now have a unit for traumatized refugees. These units have a lot of administrators and supervisors, in my opinion «too many officers, too few soldiers» (interestingly enough, professionals often leave their immediate professions to administrate, supervise, etc. Not easy to stay day after day looking into what torture means and entails). The «RCT Original» was eventually lost and sort of taken over by the economic reality, and
a fee for service arrangement, paid by the taxpayers, was accepted.

The battle is over - chaos has been replaced by order, journals secure that order, and while we did get wiser, new battles will come. If we follow only the ways of politicians or even ‘well-meaning guardians of the (everchanging) truth’ development will come to a stop. We need the occasional free-roaming wild spirit and yes, ‘cheating in the interest of good’ may be needed (which does not mean that the end always justifies the means).

As a reader, perhaps you would ask me: “did you tell it all then?” And I would answer: “no, that would have been unkind!”
Making the road as we go...

Diana Kordon and Darío Lagos

Memory is not to remain in the past but to illuminate the present and rebuild hope.


Abstract

From the early beginnings of the psychological assistance team of Madres de la Plaza de Mayo, the authors reflect on the challenges working during the Argentinian dictatorship and the importance of emerging international networks of exchanged support.

The opportunity to celebrate the 30th anniversary of the Torture Journal calls for some reflection on the roles of the Rehabilitation Center for Torture Victims (RCT) and the International Rehabilitation Council for Torture Victims (IRCT) and our relationship with them. This review is undoubtedly marked by memories and emotions, which, immersed in our daily work, we do not usually write about. This exercise in thinking brings us countless moments and stories between the personal, the professional, and the stubborn need to continue betting, from the current unprecedented complexity, on the illusion of equality and inclusion of a fairer and more united future.

We do not intend to make an exhaustive analysis but rather to contribute with a few brushstrokes, collage-style, that can stimulate and contribute to a collective work of historicisation.

In Argentina, we have gone through many traumatic social situations. However, as is well known, two of them have been the most relevant: the genocide of the native peoples, silenced for years, which left a deep mark on our society and our culture; and the last military dictatorship (1976-1984). Every 24th of March, the streets and squares of the country commemorate the anniversary of the coup d’état that implemented the most ferocious dictatorship in our history and imposed a system of disappearances of up to 30,000 people, thousands murdered, and tens of thousands exiled. Torture was a systematic and widespread practice.

From the experience of one of us who collaborated in solidarity with the Mothers, we both founded, with Lucila Edelman and other colleagues, amid the military dictatorship, the Mothers of Plaza de Mayo Psychological Assistance Team (1979-1990). Later, together with Daniel Kersner, the Argentine Psychosocial Work and Research Team (1990 - present), in which Mariana Lagos, Noemí Sosa, Silvana Bekerman, Nicolás Pedregal, and Cintia Oberti have also participated since its foundation. Several members of the team (Diana Kordon, Darío Lagos, Lucila Edelman, and Mariana Lagos) were members of the IRCT Council and Executive Committee at different times.
Over the years, numerous colleagues have collaborated with our team. This includes the psychiatrists and psychologists who have accompanied witnesses in cases of crimes against humanity (Margrethe & Herman, 2021) and who aided in developing the psychological accompaniment service during the pandemic.

Today, our team is consolidated and has a vast experience that has allowed us to develop theoretical and technical conceptualisations and connect to the professional, university, and social fields. However, during the dictatorship, we had to go through a complex learning process as we went along. On the one hand, we had to manage our fears due to the risky conditions in which we lived. On the other, we were the first mental health and human rights team to be set up in our country, and we also had very little references. Despite having had contact with some international missions, the first of them from Amnesty International in 1976, we carried out our work in a framework of national and international isolation.

In this context, we still remember the impact we had when we were invited to a meeting of the medical area of Amnesty International in the USA in 1983. We met colleagues working in different fields and countries for the first time on related issues. Moreover, it was there that we received our first invitation to participate in the inaugural RCT Seminar in Copenhagen in February 1984.

We were no longer alone. We now had colleagues who worked in solidarity in countries like ours, countries that were going through fierce dictatorships, and colleagues who worked in the Global North, caring for exiles and refugees. We were beginning to feel that we were part of a whole in which everyone contributed with their own experience.

A network was being formed around the RCT. We remember meetings, missions, and seminars, first in Copenhagen and then in different countries. At the first seminar, we met Inge Genefke and the pioneers of the future IRCT.

In those years, we got to know and recognise each other in our agreements and our contrasts. It was not easy. We came from different political perspectives, experiences, ideologies, and understandings of the issue of Torture. Nevertheless, we had one fundamental element in common: our commitment to the fight against human rights violations and assistance to victims. Amid passionate discussions, we learned to live together, to build ideas and consensus.

Despite the difficulties presented by the differences in languages, backgrounds, and cultures, the meetings also made it possible to forge meaningful bonds of affection between teams and countries (Kordon et al., 1989; Lagos & Kordon, 1996).

We also shared and continued to share the idea that, for those of us who lived in dependent countries, our constant exposure to highly traumatic situations meant that we were experiencing the same problems as those we were assisting. The possibility of helping to alleviate suffering and subjectively elaborate traumas gives a stimulating meaning to our work.

These were years of reciprocal learning and shared constructions. The RCT, a Danish organisation basically made up of doctors and physiotherapists, opened its doors and listened to the teams that worked in different countries, where, in many cases, there were psychiatrists and psychologists who considered torture to be a psychosocial phenomenon and who emphasised its psychological and psychosocial aspects. This point of view allowed a fundamental step to be taken, which was to de-medicalise and depathologise torture. From a restricted perspective, centred on the effects on the body, we moved on to a concep-
tion of the phenomenon which incorporated not only the idea of physical and psychological torture but also broadened the scope in terms of who is affected, and began to conceive it as a social phenomenon that operates on the body and subjectivity.

On the other hand, many of us understood the relevant role of the physiotherapeutic rehabilitation implemented in the RCT, which actively contributed to physical reparation and the recovery of self-esteem. Moreover, much later, we came closer to the importance of self-care and care for carers as essential elements of the task.

In the exchange between the centres, with the direct knowledge of the practices we developed. According to studies carried out throughout the last century on populations such as the victims of the Armenian genocide, concentration camps of Nazism and the Holocaust, prisoners of war and the forced internment of Japanese Americans during the Second World War, survivors of the atomic bomb, the Vietnam War, prisoners in the military base in Guantanamo Bay, dictatorships in Chile, Brazil, Paraguay, Uruguay, Argentina, Central American countries, South Africa, Greece, and many others, the vicissitudes of the Palestinian people, the humanitarian crises of refugees and migrants, we were able to confirm the hypothesis we had. The traumatic situation affects both the people who suffer it directly and the social body as a whole, and that it has an impact on several generations (Lagos et al., 2009).

Thus, in those years, we were able to agree on the psychosocial nature of the mental health and human rights problem and on defining impunity as a factor of re-traumatisation (Edelman & Kordon, 1996; D. Kordon et al., 1998).

We want to give special recognition to Inge Genefke and Bent Sorensen. To Inge for her generosity, for having dedicated all her efforts to the fight against Torture, wherever it occurred, for consciously contributing to the construction of a protective umbrella for those of us who could experience situations of persecution; and to Bent, for his capacity and lucidity, and because, even though he could be comfortably installed in the armchairs of international agencies, he did not hesitate to participate as a peer in the activities of the IRCT, among them, in the Latin American seminars. To both for having dared to trust us and to support our mission unconditionally as part of their own.

The exchange of experiences between the teams was deepening. So did the incorporation of new centres for rehabilitation of torture survivors that led to the formation of the IRCT in 1985. We were part of the founding nucleus (Kordon, 1988). The core objective: to establish an international network of centres whose task was to put our profession at the service of the fight against Torture and in the rehabilitation and treatment of those directly affected and their families. A network of solidarity. We conceive solidarity as a practice carried out in common with others, in pursuit of specific objectives and which builds a «we». It is doing with others and not by or for others. In this walking and building together, we transform our behaviour and ideas.

Inge Genefke’s passion for solidarity left its mark: the international organisation should be at the service of the fight against torture in all its expressions and try not to become a bureaucratic institution closed in on itself. This struggle to put the IRCT at the service of the people and not be chained to the hegemonic mechanics of international organisations continues to be a tension that challenges us and constantly demands our efforts.
There have been many achievements in all these years. The IRCT is a sounding board and an instrument of reporting on all situations where human rights are violated. And torture is applied anywhere in the world, so a lot of work ahead. It has brought its voice on many occasions to United Nations meetings, symposia and different multilateral bodies and governments. It has organised, participated in, and supported a number of missions to critical areas where serious human rights violations occur (Rasmussen et al., 1990; Thorsig et al., 1993). The rehabilitation of those affected is its hallmark.

Exchange and training seminars and international meetings are held routinely with hundreds of centres from all over the world. Regional networks recognised common problems and frequently shared activities, allegations, research, and projects. The Istanbul Protocol, a tool that describes in detail the physical and psychological damage caused by torture, emerged as an initiative of one of the seminars held in Istanbul, and has since been used at the international, approved by the United Nations, and validated by Parliaments in many countries.

The IRCT has become a key reference point in the international field in the fight against Torture. More than 150 centres from all continents are active members.

The Torture Journal has become a privileged tool of the project. Torture contributes to putting the issue of torture and human rights in relation to mental health on the agenda and discussion, as a unifying element, while at the same time allowing for the expression of diversity in terms of practices and theories, and is available to the centres for the dissemination of their experiences and conceptualisations, both in terms of denunciation and the production of knowledge.

In our case, we actively participate in the IRCT and the Latin American Network, of which we were founders together with other centres, and which has been joined by teams from all over the region, representing a fundamental space for the development and strengthening of the centres themselves, as well as the IRCT. It is worth noting that in the 1960s and early 1970s the winds of social transformation were blowing in Latin America. However, they were violently suppressed, and most countries imposed military dictatorships. In all these countries, mental health workers felt called upon, and we have been working together until the present day, even in the production of books (EATIP et al., 2002; Kordon et al., 2005, 2010; Kordon & Edelman, 2007; Kordon et al., 1986) which in many cases were published with the support of the IRCT.

From our insertion in the IRCT, we were able to appreciate the importance of turning to international organisations. Until 1990, in our work with the Mothers, our team had neither applied for nor received any subsidy, and we carried out our work voluntarily. From 1990 onwards, with the formation of EATIP and our headquarters opening, we needed to apply for funds for our projects and others shared with different centres. In our view, money is a great help for the support and development of our teams, but it is not an exclusive condition, and, consequently, neither should it be a condition for IRCT membership. We consider it necessary to debate this issue, given that, by implication, it calls into question conceptions that stem from the hegemony of neoliberal discourses.

Finally, although it is not the subject of this piece, we do not want to fail to mention the historical phenomenon we are experiencing. An unforeseen, complex, and painful situation: the outbreak of the pandemic on a planetary scale. In addition to the real and symbolic
losses, uncertainty about the future dominates the social scene.

The pandemic has brought to light problems in the socio-economic structure of many countries, the main symptom of which is the inequality in the material and social conditions of existence, which are becoming more acute in most of the countries affected by the pandemic. The global health crisis and the subsequent economic and social crisis are not neutral but are taking place in a context of confrontation of often conflicting interests. In this context, a genuine dispute is also developing in the production of subjectivities, often polarised between individualistic conceptions and others that privilege the power of collective and solidarity-based action to confront problems.

Once again, a painful reality challenges us. The IRCT and its member centres have extensive long experience in dealing with traumatic situations which we can use to help alleviate the suffering caused by the scourge of the pandemic, thus continuing our commitment to place our profession at the service of our people.

Acknowledgements.
We would especially like to thank Pau Perez-Sales for his insistence and help on our participation in this Special issue of *Torture*, and his assistance in translation, style editing and referencing of the original text.

References


The military coup in Chile in 1973, the immediate reaction of international organisations, and the founding of the first rehabilitation program for torture victims in 1977

José Quiroga and Elizabeth Lira

Abstract
This paper documents the historical steps of the immediate reactions of the United Nations, Amnesty International, the World Council of Churches (WCC), the Inter-American Commission on Human Rights, and lawyers’ organisations in support of the victims of torture and others suffering gross violations of their human rights, as perpetrated by the Chilean military from 1973 to 1990. This article is also the history of the founding of the first rehabilitation programs for torture victims in Chile in 1977 and the other care programs for victims under local and international churches’ protection during the worst period of the military dictatorship. The actions of denunciation and defense of the victims were possible through national and international networks sustained in collaborative work from inside and outside Chile, which lasted for 17 years. The results and lessons learned projected the creation of new commissions, funds, and international networks that continue today in the international arena. The rehabilitation programs under the dictatorship began as a solidarity response to the needs of victims. The rehabilitation programs, born during the dictatorship, projected their practice and experience to create a comprehensive health program as part of the State’s reparation measures. The testimonies of the victims made it possible to understand the consequences of human rights violations on individuals and society. State policies and civil society actions have sought to contribute to the reparation of victims through rehabilitation actions directly.

This paper is part of the memory of that past by reconstructing the solidarity actions of denunciation and rehabilitation, and the details of which are often unknown.

Introduction
This paper documents the historical steps of the immediate reactions of the United Nations, Amnesty International, the World Council of Churches (WCC), the Inter-American Commission on Human Rights, and lawyers’ organisations in support of the victims of torture and others suffering gross violations of their human rights, as perpetrated by the Chilean military from 1973 to 1990. This article is also the history of the founding of the first rehabilitation programs for torture victims in Chile in 1977 and the other care programs for victims under local and international churches’ protection during the worst period of the military dictatorship.

The military coup and reaction international organisations
Chile has been one of the long-standing democracies in Latin America. Salvador Allende, a medical doctor, member of the Socialist Party of Chile, and a well-known Marxist, was defeated...
in the 1958 and 1964 elections as a presidential candidate. He was elected president of Chile in 1970. He was the first Marxist democratically elected in the world. This was a new political outcome that unique political effect generated tremendous international interest.

The duly elected democratic government of Salvador Allende was overthrown in a military coup d’état on September 11, 1973. The commanders in chief of the Army, the Navy, the Air Force, and the Director-General of the Corps of Carabineros (national police) jointly established a military government that became one of the more repressive dictatorships in the western hemisphere. A Decree-law was published on September 11, 1973, stating four components of the so-called “Government Military Junta” (Junta Militar de Gobierno).

President Nixon described Allende in his memoirs as a pro-Castro Marxist politician. He wrote that he, President Kennedy, and President Johnson authorised the CIA to help avert the communist takeover in Chile. (Nixon, 1978, p. 489-490).

A state of siege, as a state of war, was proclaimed throughout the nation. The country was mainly under the military code of justice that had extreme impacts on Chile’s previous political and social status. The National Congress, political parties, trade unions, and professional organisations dissolved. Arbitrary detention, forced disappearance, and political killings were systematically implemented from the first day against the former government members and followers.

Each branch of the army forces has its intelligence service. They were the Military Intelligence Service (SIM), Navy Intelligence Service (SIN, in Spanish), Air Force Intelligence Service (SIFA), and the Carabineros Intelligence Service (SICAR). These services were actively involved in repression between 1973 and 1974 (Comisión Nacional de Prisión Política y Tortura, 2004). The Directorate of National Intelligence (DINA) was created on June 14, 1974, and was responsible for coordinating, supervising, and producing intelligence information for the government. A General directed the DINA under the direct supervision of the Junta and later that of President Pinochet. (UN Report, 1975, p. 50).

The United Nations General Assembly, Amnesty International, and International Commission of Jurists issued statements calling for international intervention to stop executions, arbitrary arrests, torture, and deportations of civilians who supported the Allende government and refugees living in Chile that time.

Amnesty International (AI)

Amnesty International launched its first worldwide campaign to abolish torture in 1973: Amnesty International [AI] in London and the USA published the first report on the prevalence of torture worldwide and by country in 1973. The operational definition of torture used by AI in this study was: “Torture is the systematic and deliberate infliction of acute pain in any form by one person on another, or in a third person, to accomplish the purpose of the former against the will of the latter.” (Amnesty International 1975). The World Medical Association adopted a similar definition in its Declaration of Tokyo in 1975. (World Medical Association (WMA) 1975).

In October, at the UN meeting in New York, Amnesty International Secretary-General Martin Ennals was given assurances by the Chilean Foreign Minister, Admiral Ismael Huerta Diaz, that “torture is against the principles of the Chilean Government” and that all prisoners will be given a fair trial and the right to appeal their sentence. Admiral Huerta Diaz invited Amnesty International to visit Chile
and assured Mr. Ennals that such a mission would be free to carry out investigations.

An AI mission visited Chile from November 1-8, 1973. This was the first international mission after its foundation. The delegates were Professor Frank Newman, professor of law at the University of California, Judge Bruce W. Sumner, presiding judge of the Supreme Court of Orange County, California, and Roger Plant, a researcher in the Latin American Department of AI’s International Secretariat.

The mission’s terms of reference were to investigate all violations of human rights implemented by the military. Professor Frank Newman gave testimony on the findings of the AI mission to members of the Committee on Foreign Affairs of the United States House of Representatives on December 7, 1973. AI sent a cable to Chile’s Military government protesting long prison sentences and death sentences on December 11, 1973.

The mission’s report was sent in December 1973 to the Chilean Government. In a letter to General Pinochet, Martin Ennals urged that:

- extrajudicial executions, arbitrary detention, and torture be stopped,
- a list of victims of these violations be published,
- an account of the disappeared persons be made, and
- detained persons, against whom charges have not been filed, be released.


**The Inter-American Commission on Human Rights**

The Inter-American Commission on Human Rights of the Organization of American States (IACHR-CIDH) reported that the United Nations Commission on Human Rights, the International Labor Organization (ILO), the World Council of Churches, Amnesty International, and the International Organization of Jurists, among others, reacted with alarm to what was happening in Chile. Some of these organisations sent their representatives to the country in 1973.

The IACHR received complaints on September 14, 1973, from Amnesty International and the International Commission of Jurists. The IACHR sent a communication to the Chilean Minister of Foreign Affairs Admiral Ismael Huerta (September 20, 1973), giving an account of these episodes and the consent given by the Government of Chile for the visit of the Executive Secretary next days. (CIDH, 1974).

**United Nations immediate action**

As a member of the United Nations [UN], Chile must fulfill article 1, paragraph 3, and article 55 to “respect human rights and fundamental freedom for all without distinction as to race, sex, language, or religion.”

The charter gives the UN the power to study, examine, and make recommendations to fulfill these obligations by the state. It was essential to study the UN’s intense, focused, and prolonged reaction to Chile’s severe violation of human rights. (United Nations, 1995, p. 143-144).

The General Assembly adopted resolution 3059 based on Article 5 of the Universal Declaration of Human Rights on November 2, 1973, which affirms that no one should be subjected to torture or cruel, inhuman, or degrading treatment or punishment. The resolution also urges all governments to become parties to existing international instruments, which contain provisions relating to the prohibition of torture. The General Assembly decided to examine the question of torture in their next year’s session.
The General Assembly, on November 6, 1974, under resolutions 32/119 Protection of Human rights in Chile, expressed big concern about reports of gross and massive violations of human rights, particularly those related to human life and liberty. The General Assembly adopted a resolution that created an Ad Hoc Working Group to «inquire into the present situation of human rights in Chile» visit the country, and present a report based on oral and written evidence gathered from all relevant sources.

In compliance with the General assembly’s resolution, The Commission of HHRR nominated an Ad Hoc working group of five members in their capacity. The Chairman was Mr. G. A. Ali Allana from Pakistan, who appointed the four additional members. Mr. Leopoldo Benites from Ecuador, the President of the General Assembly at its twenty-ninth session; Abdoulaye Dièye, a member of the Supreme Court of Senegal; Professor Félix Ermacora, a member of the Austrian parliament, and Mrs. M. J. T. Kamara, a social worker from Sierra Leone.

Despite the Chilean government’s refusal to permit the Ad Hoc group to visit the country following its mandate, they presented a report to the thirtieth session of the agenda General Assembly as document A 10285, October 7, 1975.

The General Assembly reviewed the reports of the Ad Hoc Working Group on Human Rights in Chile and the documents submitted by the Chilean authorities in December 1976 and 1977.

The General Assembly concluded that constant and flagrant violations of basic human rights and fundamental freedoms continue to occur in Chile and expressed its profound indignation to extend the mandate of the Ad Hoc Working Group.

The Ad Hoc Working Group on Violations of Human Rights in Chile visited the country in July 1978. They reported some improvements, but violations continued with a lack of progress in investigating the fate of missing and disappeared persons, dissolution of labor organisations, confiscations of their properties, and the refusal of Chilean authorities to accept responsibility.

Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

For the first time, the General Assembly adopted a Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

This critical declaration of 12 articles was made under resolution 3452 on December 9, 1975.

The first article defined torture as “any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted by or at the instigation of a public official on a person for such purposes as obtaining from him or third person information or confession, punishing him for an act he has committed or is suspected of having committed, or intimidating him or other persons. It does not include pain or suffering arising only from inherent in or incidental to, lawful sanctions to the extent consistent with the Standard Minimum Rules for the Treatment of Prisoners.”

The second article established that “any act of torture or other cruel, inhuman, or degrading treatment or punishment is an offense to human dignity and shall be condemned as a denial of the purposes of the Charter of the United Nations and as a violation of the human rights and fundamental freedoms proclaimed in the Universal Declaration of Human Rights.”
Following articles identify the state’s responsibilities, defining the duty to take effective measures “to prevent torture and other cruel, inhuman, or degrading treatment or punishment from being practiced within its jurisdiction,” and assure “the training of law enforcement personnel and of other public officials who may be responsible for persons deprived of their liberty shall ensure that full account is taken of the prohibition against torture and other cruel, inhuman, or degrading treatment or punishment” and to “… promptly proceed to an impartial investigation even if there has been no formal complaint.” (Article 9).

United Nations established a Special Rapporteur on Human Rights in Chile
The UN General Assembly decided after a three-year mandate of the Ad-Hoc Group to replace it with a Special Rapporteur on the Situation of Human Rights in Chile. They would report directly to the Commission on Human Rights and the General Assembly (Resolution 33/175).

This was the first time that the UN General Assembly had created a country-specific Special Rapporteur on Human Rights active from 1979 to 1990. (United Nations General Assembly Resolution A/34/583/Add.1, N 1, November 21, 1979). The first Rapporteur was Abdoulaye Dièye’ (Limon &Power, 2014).

The General Assembly in Resolution 34/179 on December 17, 1979, declared: «Recalling the previous report concluded that the situation of human rights has not improved but deteriorated in many areas; concern on reports of the discovery of hundreds of unmarked graves in the cemetery of Santiago; reiterates its indignation and strongly urge the Chilean authorities to respect and promote human rights and investigate and clarify the fate of persons missing and disappearing. The Resolution also extended the mandate of the Special Rapporteur Abdoulaye Dièye.” After 1981, Rajsoomer Lallah replaced Mr. Dièye, and in 1985 Mr. Fernando Volio Jimenez (Costa Rica) was designated as Rapporteur (Sánchez, 1990, p. 65).

United Nations designated Antonio Cassese Special Rapporteur: Foreign economic aid and assistance and human rights in Chile
The Sub Commission on Prevention of Discrimination and Protection of Minorities of Human Rights Commission requested Antonio Cassese in 1976 as a special Rapporteur to prepare a study on the impact of foreign economic aid and assistance on respect for human rights in Chile.

The Rapporteur set out to investigate Chile’s general economic and social situation. He tried to determine what kind of repercussion the economic policy carried out by the present government and what impact it has had on the economic, social, and cultural rights of the population. He also wanted to know whether that policy turned out to promote the effective implementation of those human rights of the Chileans or whether it proved detrimental to the realization of human rights. To undertake this research, it was necessary to determine the main trends of the economic policy pursued by the Chilean authorities.

The Rapporteur concluded that inequality resulted from the economic policy adopted by the government to favor small, elite, large landowners, financiers, industrialists, and military whose interests ignore the needs of the majority of the population (Fernández, Bohoslavsky &Smart, 2019).

United Nations establishes a Special Rapporteur on Enforced Disappearances in Chile
In 1978, the Human Rights Commission asked Félix Ermarcora, a member of the Working Group of Human Rights in Chile, to investigate
forced disappearances in Chile. In 1979, Ernacora delivered the “Report of the Expert on the Question of the Fate of Missing and Disappeared Persons in Chile.” This was a 91-page report that also analyses the state’s responsibility under international law. (UN Human Rights Commission, 21 November 1979).

The report stated: »The Government of Chile has the duty of explaining and clarifying to the international community the fate of these disappeared persons; to punish those responsible for the disappearance; to compensate the relatives of the victims and to take measures to prevent the recurrence of such cases in the future ... the disappearance of the disappeared persons in Chile is a violation of international humanitarian law (...) the disappearance of these persons constitutes a persistent pattern of human rights violations and a serious humanitarian problem for the relatives who wish to know, as is their right, what has happened to their relatives.« (United Nations, 1979, Supplement Six, p. 115).

After an exhaustive examination of the available documentary evidence, there was no indication whether any of the disappeared detainees were alive, including pregnant women and their babies. His report created the Working Group on Enforced and Involuntary Disappearances in 1980 as the Commission’s first thematic special procedure.

Establishment of the United Nations Trust Fund for Chile
For the first time, the General Assembly decided to establish a voluntary fund, called the United Nations Trust Fund for Chile, through resolution 33/174 on December 20, 1978. This fund was a plan to give humanitarian, legal, and financial aid to persons whose human rights have been violated by detention or imprisonment in Chile, those forced to leave the country, and relatives of persons in the above category.

Under the Financial Regulations of the United Nations, this fund was administered by the Secretary-General with the advice of a Board of Trustees, composed of a chair and four members with vast experience of the situation in Chile, who was appointed to serve for a three-year term. The Director of the Division of Human Rights and, with the advice of the Board of Trustees, determined the procedures for soliciting voluntary contributions to the Fund.

On August 14, 1979, the Secretary-General announced that he had appointed the following persons to serve for a three-year term on the Board of Trustees of the United Nations Trust Fund. Mr. Ghulam Ali Allana (Pakistan) as chairman, Mr. Leopoldo Benites (Ecuador), Mr. Hans Danelius (Sweden), Mrs. Marian J.T. Kamara (Sierra Leone), and Mr. Adam Lopatka (Poland). The Board members serve in their capacity. The Controller shall ensure that the operation and control of the Fund shall be by the Financial Regulations and Rules of the United Nations. The controller shall be responsible for reporting the financial transactions of the Fund (UN Report A/34/648 1979).

The United Nations Trust Fund for Chile changed to United Nations Voluntary Fund for Torture Victims
Three years after implementing the Trust Fund for Chile, the General Assembly re-designated this Fund as The United Nations Voluntary Fund for Torture Victims (UN VFFTV). This Fund was established by the General Assembly in Resolution 36/151, on December 16, 1981, with a mandate to support torture survivors and their families in any part of the world.

The United States Voluntary Fund for Torture Victims has been administered following the Financial Regulations of the United Nations by the Secretary-General, with the advice of a Board of Trustees of the Fund composed of a chair and four members with vast
experience in the field of human rights, acting in their capacity. (General Assembly Resolution 36/151).

The Fund is managed by the Office of the United Nations High Commissioner for Human Rights, with the advice of a Board of Trustees composed of independent experts from the five world regions.

The 40th anniversary of the Fund was in 2021, and it has already approved 171 direct assistance annual grants in 79 countries across all regions of the world. This assistance has contributed to the rehabilitation of more than 47,000 victims of torture and their families each year. (UN High Commissioner HR, 2006).

**United Nations work of the Special Rapporteurs continued in Chile.**

*The United Nations is concerned about human rights violations in Chile.* Deeply worried about the persistence and, in certain respects, the deterioration of situations that affect the enjoyment and exercise of human rights and fundamental freedoms in Chile, extended the mandate of Special Rapporteur each year.

The last Special Rapporteur was Fernando Volio Jiménez that took over in 1985. Based on his report, the General Assembly condemns the persistence of torture, the repression of social protests, arbitrary detentions, and the death of opponents, among other actions. The Chilean government systematically rejected the reports, pointing out that the rapporteur did not consider the progress made and the resurgence of terrorism in the country.

On December 8, 1987, Fernando Volio made his third visit to Chile. The special rapporteur arrived in the country days before the Plebiscite and visited electoral precincts on October 5th. In March 1989, he resigned from his post for health reasons. The Chilean government informed the United Nations that it would not accept the appointment of any ad hoc rapporteur, considering it a useless and unproductive route (Vargas, 1990; United Nations, E/CN, 4/1989/3).

The General Assembly takes note of the Special rapporteur’s report and congratulates Chile for the peaceful progress towards the re-establishment of democracy. The General Assembly urged the government to ensure the independence of the judiciary and effective judicial procedures. In addition, it encouraged the government to investigate all cases of severe violations of human rights that occurred in the past.

The UN Commission on Human Rights, after the restoration of civilian democratic power after recent elections, decided that the mandate of the Special Rapporteur would not be renewed. (The General Assembly on resolution 44/166 on December 15, 1989).

**Report of a mission of inquiring to Chile and the foundation of Physician for Human Rights in the US**

Dr. Jonathan Fine was the Medical Director of North End Community Health Center in Boston, Massachusetts. He received a request to travel to Chile to investigate the situation of three physicians who were victims of torture in June 1981. Dr. James S. Koopman, Assistant Professor, Dept. Epidemiology, Uni-

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1 Giorgio Solimano, MD faculty at Columbia University, and Roberto Belmar, MD faculty at the Montefiore Hospital, members of Chile Democrático (Democratic Chile), received the information of three distinguished physicians detained in Chile. They asked Dr. Fine and Dr. Koopman, also members of the American Public Health Association, to travel to Chile in a fact-finding mission. The travel was sponsored by The American Public Health Associations (APHA), the American Association for the Advancement of Science (AAAS), the National Association of Social Workers, Physician Forum, and the Emergency Committee to Defend Chilean Health Workers.
Table 1. International organisations that visited Chile

<table>
<thead>
<tr>
<th>Organisations</th>
<th>Visit Chile</th>
<th>Action</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amnesty International (AI)</td>
<td>November 1 to 8 November 1973</td>
<td>AI Report 1974</td>
<td>The military rejected the report</td>
</tr>
<tr>
<td>UN High Commission for Refugees (UNHCR)</td>
<td>Chilean office under the refuge convention</td>
<td>Five shelters for refugees</td>
<td>Financed with emergency funds of UN</td>
</tr>
<tr>
<td>World Council of Churches (WCC)</td>
<td>A delegation remained in Chile for 4 months in 1973</td>
<td>Finance and supervised CONAR refugee program</td>
<td>More than 12,000 refugees in Chile were relocated</td>
</tr>
</tbody>
</table>

Table 2. United Nations General Assembly Resolutions on Protection of Human Rights in Chile

<table>
<thead>
<tr>
<th>Resolution Symbol</th>
<th>Publication Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ad Hoc working group</td>
<td>3219 XXIX              November 6, 1974</td>
</tr>
<tr>
<td>Protection of person of torture and CIDT</td>
<td>3452 XXX              December 9, 1975</td>
</tr>
<tr>
<td></td>
<td>31/124                 December 16, 1976</td>
</tr>
<tr>
<td></td>
<td>32/118                 December 17, 1977</td>
</tr>
<tr>
<td>UN Trust Fund for Chile</td>
<td>33/174                 December 20, 1978</td>
</tr>
<tr>
<td>Special Rapporteur</td>
<td>33/175 33/176           December 20, 1978</td>
</tr>
<tr>
<td></td>
<td>A/34/583/Add,1N1       November 21, 1979</td>
</tr>
<tr>
<td>Special Rapporteur</td>
<td>A34/179                December 17, 1979</td>
</tr>
<tr>
<td>Rapporteur on economic assistance</td>
<td>1976</td>
</tr>
<tr>
<td>Rapporteur on enforced disappearance.</td>
<td>1978</td>
</tr>
<tr>
<td>Fund for Chile change to UN Voluntary Fund for Torture Victims</td>
<td>36/151                December 16, 1981</td>
</tr>
<tr>
<td>General Assembly extended mandate of Special Rapporteur on Chile</td>
<td>36/157                December 16, 1981</td>
</tr>
<tr>
<td>General Assembly extended mandate of Special Rapporteur on Chile</td>
<td>39/46                 March 11, 1981</td>
</tr>
<tr>
<td>UN Commission on Human Rights ends the mandate of the Special Rapporteur on Chile</td>
<td>44/166                December 15, 1989</td>
</tr>
<tr>
<td>UN Commission on HR ends the mandate of the Special Rapporteur on Chile</td>
<td>Supplement No.2  1990/78</td>
</tr>
</tbody>
</table>
The three tortured physicians were Dr. Manuel Almeida, aged 57; Dr. Pedro Castillo, 54; and Dr. Patricio Arroyo, 49. They were detained because they gave medical care to victims of torture and went on hunger strikes denouncing political repression. The mission remained in Chile from June 7 to 11. They could visit physicians in the jail and verify that they had been tortured. They also had a meeting with Jose M. Eyzaguirre, the acting president of the Supreme Court. The international pressure was efficient, and the three physicians were released, and the charges dropped. (Jefferys, 1981).


This mission changed Dr. Fine’s life forever. He decided he would leave his medical practice and dedicate himself to the defense of human rights as a full-time work. He founded with his own economic resources the American Committee for Human Rights. Later, with John Constable’s commitment, Carola

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Table 3. United Nations Reports on Protection of Human Rights in Chile

<table>
<thead>
<tr>
<th>UN Section</th>
<th>Mandate</th>
<th>Report</th>
<th>Document Symbol</th>
<th>Publication Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Assembly Secretary-General</td>
<td>Protection HR</td>
<td>Report 132 pages</td>
<td>A/1028</td>
<td>October 7, 1975</td>
</tr>
</tbody>
</table>

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Eisenberg, Jack Geiger, Jane Green Schaller, and Robert Lawrence founded Physician for Human Rights in 1986. He was the first Executive Director (PHR, Lyall 2018, BMJ).

Legal, Social, Medical and Psychological Assistance for the rehabilitation of torture victims in Chile. The foundation of the first programs

The fall of the Popular Unity government elected was in 1970. There was the death of President Salvador Allende, and the installation of the military junta of government under General Augusto Pinochet, who was the commander in chief of the army, and mobilised international and national organisations that were helping the persecuted people.

In September 1973, two ecumenical initiatives started. One was in favor of foreign refugees (CONAR) and the other supported persecuted Chileans (COPACHI). It also caused the presentation of numerous complaints and denunciations alleging violations of human rights to the United Nations, the International Labor Organization, the Interamerican Commission of Human Rights, and international NGOs.

Foreign refugees: protection and social, and legal assistance.

The UNHCR (High Commissioner for Refugees) delegate in Chile, Oldrich Haselman, reached an agreement with the government on September 24 to install five shelters under the protection of the United Nations for foreign refugees, who were mainly Latin Americans. The UN Convention on Refugees framework was signed by Chile in 1951 and its 1967 Protocol, which the Allende government had ratified in 1972, allowing these agreements.

On September 20, 1973, a UNHCR office opened in Santiago. An ecumenical organisation, created by the bishop of the Lutheran Church, Helmut Frenz, with the support of the World Council of Churches, the International Committee of the Red Cross (ICRC), the Intergovernmental Committee for European Migration (ICEM), and American Friends Service Committee (AFSC Quakers) had an official authorization to aid detainees and refugees granted by Decree-Law 1308 of October 3, 1973 (Espinoza, 2012).

Helmut Frenz described CONAR’s main activities as providing material (food and lodging) and spiritual assistance to the refugees and medical services; legal aid for their departure and their relocation to other countries; resolving documentation problems; and legal advice in cases where required by the authorities (Frenz, 2006 p. 138). The WCC launched an Emergency Task Force on the Chilean situation in November 1973. (Calandra B 2010, p.25).
Demand grew from 600 refugees in September 1973 to 3,574 in March 1974. More than 40 countries received 2,608 of them, and 288 were repatriated to their countries of origin. In addition, some 1,500 fled illegally to Peru and Argentina. (CIDH, 1974). The military, after international pressure, accepted the creation of nine more refugee centers. These centers lodged 4,442 persons until 1974. (Garcés & Nicolls, 2005, Pp. 27-28).

Pro Paz Committee (1973-1975) The “Committee of Cooperation for Peace in Chile (COPACHI)” was founded in October 1973 by the Methodist, Lutheran, Catholic, Pentecostal Churches, and the Jewish community. It was the first organisation to assist Chilean victims. COPACHI provided free medical care and mental health services through a network of volunteers, medical doctors, psychiatrists, and psychologists. In 1975, 2,166 people in Santiago consulted for mental health services. The health program provided a total of 64,986 consultations, including medical specialists and mental health care (COPACHI, 1975). The Committee dissolved under the pressure of the military government. (Bastías, 2014, p. 98).

Vicariate of Solidarity (1976-1992) The Cardinal Raúl Silva Henríquez as archbishop of the Archdiocese of Santiago, established the successor organisation, the Vicariate of Solidarity, in January 1976. The Vicariate gave legal, social, medical, and spiritual assistance to the Chilean victims of repression until the democratic government was in place in 1992. The two psychologists of COPACHI, incorporated with a psychiatrist, worked, providing mainly emergency consultation during the first years.

Social Aid Foundation of Christian Churches (Fundación de Ayuda Social de las Iglesias Cristianas (FASIC) is an ecumenical institution, founded in April 1975 to continue the work of CONAR, and is supported by Methodist, Lutheran, Orthodox, Pentecostal, and Catholic Church representatives. The military junta, on April 12, 1975, published the Decree-Law (DL) 504, allowing the commutation of the prison sentence to “extrañamiento” (serving a sentence in freedom in another country without permission to return). The beneficiaries were the political prisoners sentenced by military tribunals. FASIC processed the arrangements for travel (visa, air ticket, and arrival in the refugee country) for individuals and their families. They also provided social and psychological care to the prisoner and his family until his departure. Between 1975 and 1980, 3,983 former political prisoners were released through FASIC for commutation of sentence and 3,299 family members (Orellana & Hutchinson, 1990, p 170; Harper, 2007).

As mentioned above, the denunciation of human rights violations led to the country’s condemnation by United Nations General Assembly every year. The former ambassador of the Popular Unity Government before the United States, Orlando Letelier, was assassinated in the embassy’s road in Washington in September of 1976, increasing the international pressure on the Chilean dictatorship. In this political context, the military junta dictated an Amnesty Decree-Law in April 1978, “to all persons who committed criminal acts, whether as perpetrators, accomplices, and accessories, when the State of Siege was in force, between September 11, 1973, and March 10, 1978” (DL 2191). Many former prisoners were able to decide whether to remain in the country or to continue the process of seeking refuge in other countries. The main effect was the dismissal of all ongoing legal proceedings for human rights violations. Extrajudicial executions, the disappearance of persons, and complaints of torture went unpunished.
The needs of the victims who remained in the country were wide-ranging: protection, legal defense, housing, food, and health and mental health care. The agencies created to provide these services initially functioned as an emergency response, seeking to alleviate suffering, and responding to the most urgent needs. The intensification of repression and the severe consequences on individuals generated the need to expand medical and psychological care capacity.

**Medical and psychological care to victims of torture**

FASIC developed a specialised team that collaborated with mental health teams created in other agencies in the following years. Some medical doctors who had collaborated with COPACHI had to go into exile. Some of them came up with the idea of forming a specialised program for the mental health care of the victims. Paz Rojas, neuropsychiatrist, Fanny Pollarolo, Mario Vidal, Mario Inzunza, psychiatrists, and Mariano Requena, a specialist in Public Health, contributed to formulating the project, which began at FASIC towards the end of 1977 as Programa Médico Psiquiátrico (PMS) [“Medical Psychiatric Program”] (Garcés & Nicholls, 2005, p. 68). After 1978, the first team was formed by Eliana Morales as a family therapist, and Eliana Ortiz and Norma Rojas as social workers; Elizabeth

**Table 4: Legal, social, medical and psychological assistance institutions**

<table>
<thead>
<tr>
<th>Year</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1973</td>
<td>CONAR. Support to foreign refugees Ecumenical initiatives.</td>
</tr>
<tr>
<td>1973</td>
<td>COPACHI. Support of Chileans inside the country - Ecumenical</td>
</tr>
<tr>
<td>1973-75</td>
<td>UNHCR office in Santiago</td>
</tr>
<tr>
<td>1975</td>
<td>Pro-Paz Office</td>
</tr>
<tr>
<td>1975</td>
<td>FASIC - Fundación de Ayuda Social de las Iglesias Cristianas (Social Aid</td>
</tr>
<tr>
<td></td>
<td>Foundation of Christian Churches). - Methodist, Lutheran, Orthodox, Pentecostal, and Catholic Church representatives</td>
</tr>
<tr>
<td>1976-92</td>
<td>Vicaria de la Solidaridad (Vicariate of Solidarity)</td>
</tr>
<tr>
<td>1979-</td>
<td>PIDEE - Fundación para la Infancia Dañada por Estados de Emergencia</td>
</tr>
<tr>
<td>1980-</td>
<td>(Foundation for Children Harmed by States of Emergency)</td>
</tr>
<tr>
<td>1980-</td>
<td>CODEPU – Corporación para la defensa de los Derechos del Pueblo (Corporation for the Defense of People’s Rights)</td>
</tr>
<tr>
<td>1985</td>
<td>CINTRAS – Centro de Investigación y Tratamiento del Estrés – (Stress Research and Treatment Center) – First IRCT centre in Chile.</td>
</tr>
<tr>
<td>1988</td>
<td>ILAS - Instituto Latinoamericano de Salud Mental y Derechos Humanos -</td>
</tr>
<tr>
<td></td>
<td>(Latin American Institute of Mental Health and Human Rights)</td>
</tr>
<tr>
<td>1990</td>
<td>End of dictatorship</td>
</tr>
</tbody>
</table>
Lira, Eugenia Weinstein, Rosario Domínguez, and Adriana Maggi as psychologists; Elena Gómez, Sofía Salamovich and María Angélica Monréal as psychiatrists. Fanny Pollarolo was its first director.

The program gave medical, psychological, and social care to victims of torture and their families, to relatives of forced disappearance victims, and to relatives of extrajudicial execution victims. After the first ten months of services, they cared for 382 victims. (Garcés & Nicolls, 2005, p. 69). After 1985, 4,174 persons received medical and psychological services (Weinstein, Lira & Rojas, 1987, p 17).

The clinical work initiated at FASIC made it necessary to use different formats (written and recorded) to work with the victims. The work methodologies combined medical and psychotherapeutic treatment and psychosocial follow-up of complex and overwhelming situations in conditions of vulnerability and insecurity of both victims and health teams.

Each victim had a file, which included legal and social information. This record refers to the “fact” that triggers the problem and defines the type of violation in question, operating as a situational diagnosis. The file’s organisation was according to the primary situation, such as “former political prisoners,” “relatives of disappeared detainees,” or “politically executed.”

The search for treatment methods that would allow the victims to recognize and deploy their resources to cope with almost catastrophic experiences for many of them defined the therapeutic approach. The first publication on the team’s work appeared in a Chilean Jesuit magazine called Mensaje in 1978. It denounced the practice of torture, the consequences on the victims, and the difficult task of rehabilitation in very repressive political conditions: “Detenidos políticos: sufrimiento y esperanza” (Rodriguez, 1978).

The FASIC team prepared an international seminar for professionals working with victims of human rights violations in Chile and Latin America and professionals working with Latin-American refugees in Europe. The meeting brought social workers, lawyers, psychologists, physicians, and psychiatrists, mainly from Vicariate, FASIC, and other collaborators, to Punta de Tralca, a safe Catholic church house on the beach near Santiago [“The house of Cardinal Raul Silva Henríquez”] in April 1980. The papers and interventions on this meeting, published in 1982 in two-volume books, disseminated the experience and reflections achieved by these teams discussing the problems, clinical approaches, and difficulties working with victims under dictatorship. The book is “Crisis Política y Daño Psicológico. Lecturas de Psicología y Política” [Political Crisis and Psychological Harm: Readings in Psychology and Politics].

The authors residing in Chile appeared under pseudonyms.

They began in 1978 with the documentation of testimonies to collect in textual form some particularly extreme and brutal situations of suffering from torture for their legal denunciation, which was requested by the consultants. The relationship between patient and therapist developed in a context that required sustained emotional and social support. Years later, a scientific article described the experience. (Cienfuegos & Monelli, 1983). The FASIC team published after 1984 under their names: “Psicoterapia y represión política” in México. After 1986 “Exilio 1986-1978”, [Exilio] and “Trauma, duelo y reparación” (1987) have the institutional affiliation. These writings describe the therapeutic approaches,
the fundamental concepts used, and some results under the dictatorship.

The therapeutic process was based on the reconstruction of the traumatic experience; alleviating of symptoms; emotional elaboration (working through) of the traumatic experience; linking to the existential meanings of the subject’s life; recovery of their social role; and collective links. (Weinstein, Lira & Rojas, 1987, p. 65).

The "Fundación para la Infancia Dañada por Estados de Emergencia" (PIDEE) [Foundation for Children Harmed by States of Emergency] started to provide psychological care, psycho-pedagogical support, and recreational workshops to children and young people affected by the political repression of their parents, in 1979. It reached about 12,000 children and young people.

The "Corporación de Promoción y Defensa de los Derechos del Pueblo" (CODEPU) [Denunciation, investigation, and treatment of the tortured and their family group] was founded in 1980. In 1981, a multidisciplinary team was structured for the “Denunciation, investigation and treatment of the tortured and their family group” with the name of DIT-T. Tortured and political prisoners inside prisons and their families received medical and psychological care by teams of DIT-T. They also assisted relatives of the executed, victims of forced disappearance, and returnees from exile. Its founder Paz Rojas wrote (…), “Suppose we would like to identify our work in epidemiological terms. In that case, we could say that the denunciation corresponds to a primary prevention level. It tries to create awareness and shape opinion to prevent political repression and torture. Our individual and collective therapeutic action is part of secondary prevention. Its attempt to repair the damage and, finally, our intransient commitment to help build a society in which human rights are truly respected constitutes, in our opinion, the third level of prevention.” (CODEPU, 1989, p. 1).

The "Centros de Investigación y Tratamiento del Estrés" (CINTRANS) [The Stress, Research and Treatment Centre] started in 1985 with the International Rehabilitation Center for Torture Victims in Denmark’s [IRCT] support. The CINTRANS team provided medical-psychological treatment to victims of serious human rights violations. Between 1985 and 1991, 1,344 people participated in different care programs. The professional teams offered individual, family, and group therapy. According to their statements, the therapeutic approach implemented theoretical and technical epistemological resources from the different currents of modern psychotherapy (Vidal, 1993; Madariaga, 2002).

In addition, they implemented occupational therapy workshops for patients with severe psychic damage.

The "Instituto Latinoamericano de Salud Mental y Derechos Humanos (ILAS) [Latin American Institute of Mental Health and Human Rights]. In 1988, professionals who worked before in FASIC founded ILAS. The team provided therapeutic, medical, social, and psychological care to individuals and families that were mainly diagnosed as extremely traumatized, tortured people, relatives of victims of forced disappearance, and relatives of victims of political execution. The ILAS team developed clinical and psychosocial research. Established collaboration with governmental and non-governmental organisations supported health and mental health teams in several regions (Magallanes, Araucanía, Bío Bío, Tarapacá) before the end of dictatorship. They developed seminars and collaborative activities with Latin American professionals. They published articles and books documenting their work (Lira, Becker, &Castillo,
Some ILAS professionals participated in the recommendations for public policies on reparations for victims of human rights violations that included the provision of medical and psychological care. Some of them worked with the National Commission for Truth and Reconciliation, providing emergency support and mental health services to relatives and families who testified before the Commission and collaborated over the National Commission for Truth and Reconciliation recommendations regarding the health of victims.

Programa de Reparación y Atención integral de salud para las víctimas de violaciones a los derechos humanos 1973-1990 (PRAIS) [Program of Reparations and Comprehensive Health Care for Victims of Human Rights Violations]

At the end of the dictatorship, six mental health care teams in Santiago coordinated regularly. They contributed to creating the reparation program for victims of human rights violations recognised by the State of Chile, which started in 1991. Psychologists, psychiatrists, and social workers from the human rights organisations developed a psychosocial approach for clinical, medical, and psychosocial care (Agger & Jensen, 1996). This approach recognised the importance of acknowledging the victims by society and the therapeutic value of both access to justice and symbolic and solidarity actions in their favor. These actions were part of a rehabilitation process, despite the limited resources of the therapeutic teams and the impossibility of symbolic reparations under the dictatorship (Lira, 2001).

PRAIS is a health care program aimed at rehabilitating individuals and families affected by human rights violations during the military dictatorship. A ministerial resolution established the right of free health, mental health, and care for victims recognised by the State (Domínguez et al., 1994). Law 19,980 (2004) officially defined PRAIS as a rehabilitation program for victims of human rights violations recognised by the State. The law specified that all beneficiaries have free health care at all public health services in Chile. On June 30, 2006, a ministerial resolution (“resolución exenta” Nº 437) updated PRAIS technical regulation (Nº 88) and complemented the law. It added a new category, recognizing the right to care for those working to protect human rights and providing services to victims for at least ten years under the dictatorship. (Lawyers, medical doctors, social workers, psychologists, journalists, and other workers of Human Rights organisations).

Chilean State has progressively recognised victims and their relatives (until the third generation), providing them the right to rehabilitation as part of the reparation process. The number of beneficiaries has been increasing every year. Despite the official purposes, it has been described that 16% of victims suffer from physical and psychological consequences years or decades after torture regardless of received medical and psychological care (Gómez-Varas, 2016). At the end of 2019, the number of beneficiaries reached near 800,000. After law 19,980 (2004) more medical doctors, psychiatrists, psychologists, and social workers were created under PRAIS, reaching 29, installed in regional hospitals.

From the beginning of the program, PRAIS’s clinical and therapeutic approach used the experiences of teams of social workers, psychiatrists, and psychologists, who worked under the dictatorship. The slogan of PRAIS is ‘Back to Life.’ Professionals working with victims have learned from the beginning that there is a need to connect the whole personal
experience of the victim, not only the traumatic one, with the social and political context. PRAIS also offers opportunities to process the memories of traumatic experiences through social activities. Rehabilitation in this context has implied working with victims, their families, and relatives for years to recover dignity and the capacity to give meaning to their own lives (Lira, 2016, p 216).

Final reflections
This article traces the trajectory of the pioneer actions of International Human Rights Organizations to stop political repression and human rights violations after the military coup. It shows how activities, initially directed at the situation in Chile, gave way to permanent instances and mechanisms for all countries. United Nations nominated an Ad Hoc Working Group on Human Rights for the first time in Chile. Later, the president of this working group was designated as a special rapporteur on human rights for the first time. One member of the same group was named a rapporteur on enforced disappearances in 1979. Years later, this work evolved into a convention. United Nations implemented a Trust fund for Chilean victims that becomes the UN Voluntary fund for torture victims.

This article also traces a genealogy of health actions mainly for torture victims. Health services were initiated in networks of volunteer professionals in 1973, which then created a care center in 1977 under the protection of the churches in Santiago, which was followed and expanded by other independent centers also installed in regions after 1980. This trajectory culminated when the National Commission for Truth and Reconciliation (1990-91) recommended creating “a special program and the funding and coordination will have to come from the Ministry of Health. Such a program should seek technical cooperation from non-governmental health organisations, particularly those that have provided health care to this population and have accumulated valuable experience over all these years” (National Commission on Truth and Reconciliation, 1993, p 1068. (n 23). After 1991, started the health rehabilitation program (PRAIS) implemented throughout the country under the Ministry of Health, lasting until now.

As described in this paper, from 1973 through 1990, the victims of gross human rights violations in Chile and their families were given much-needed medical care and other critical support by physicians, psychologists, lawyers, and social workers. Their work was made possible by the protection offered to them by local and international organisations from the first beginning.

Denunciation of the existence of torture, its methods, and the groups affected was initially conceived as a legal task, carried out by lawyers starting with writs of habeas corpus and complaints against those responsible for arbitrary detention and torture. Later, medical doctors and psychologists denounced the medical and psychological consequences of torture. Denunciation became possible as therapeutic work became more systematic and clinicians identified and understood the emotional impact of political repression on victims and society.

In all the human rights institutions, the healing work resulted from denunciation, investigation, and treatment. The testimony method is an example of the unification of three principles:

- The testimony denounces the human rights violations.
- It supplies new knowledge about the repressive system.
- It has a healing effect on the person who bears witness.
With the benefit of hindsight, the experiences summarized here to provide lessons learned that have transcended the situation in Chile. The needs of the victims were at the center of the investigation and denunciations, seeking to establish the truth of what happened, generating national and international actions seeking justice and reparation, and reflected in international human rights law.

The health and mental health services organised in response to the emergency anticipated forms of reparation consolidated in health and memory policies in many other places. That has allowed new knowledge and answers to the needs of victims, integrating professional disciplines ethical and political perspectives at the service of the rehabilitation of victims and their families.

Acknowledgments
We are grateful to Pau Perez-Sales, as the Editor-in-Chief of the Journal, who assisted us in preparing this historical review.

References
SECTION I: LEARNING FROM THE PAST

United Nations (1973) General Assembly Resolution 3059 (XXVIII) “Question of Torture and other cruel, inhuman or degrading treatment or


United Nations, (1975) General Assembly Resolution 3452 (XXX) Date 9 December 1975. Declaration on the protection of all persons from being subjected to torture and other cruel, inhuman or degrading treatment or punishment.


Abbreviations
AAAS American Association for the Advancement of Science
AFSC Quakers American Friends Service Committee
AI Amnesty International
APHAAmerican Public Health Association
CIA Central Intelligence Agency (USA)
CIDH Comisión Interamericana de Derechos Humanos [Inter-American Commission on
Human Rights]
CINTRAS Centro de Investigación y Tratamiento
del Stress [The Stress Research and Treatment
Center]
CODEPU Corporación para la Defensa de los
Derechos del Pueblo [Corporation for the
Defense of People’s Rights]
CONAR Comisión Nacional de Refugiados
[National Commission of Refugees]
COPACHI Comité de Cooperación para la Paz en
Chile [Committee of Cooperation for Peace in
Chile]
DINA Dirección de Inteligencia Nacional
[Directorate of National Intelligence]
DIT-T Denuncia, investigación y tratamiento del
torturado y su grupo familiar [Denunciation,
investigation, and treatment of the tortured and
their family group]
FASIC Fundación de Ayuda Social de las Iglesias
Cristianas [Social Aid Foundation of Christian
Churches]
IALCHR Inter-American Commission on Human
Rights [In Spanish CIDH]
ICEM Intergovernmental Committee for European
Migration [In Spanish CIME]
ICRC International Committee of the Red Cross
ILAS Instituto Latinoamericano de Salud y Derechos
Humanos [Latin American Institute of Mental
Health and Human Rights]
ILO International Labor Organization
IRCT International Rehabilitation Center for Torture
Victims. Denmark.
PIDEE Fundación para la Infancia Dañada por
Estados de Emergencia” [Foundation for
Children Harmed by States of Emergency]
PMS Programa Médico Psiquiátrico [Medical
Psychiatric Program]
PRAIS Programa de Reparación y Atención Integral
de Salud para las víctimas de violaciones a los
derechos humanos 1973-1990 [Program of
Reparations and Comprehensive Health Care for
Victims of Human Rights Violations 1973-1990]
SICAR Servicio de Inteligencia de Carabineros
[Carabineros Intelligence Service]
SIFA Servicio de Inteligencia de la Fuerza Aérea [Air
Force Intelligence Service]
SIM Servicio de Inteligencia Militar [Military
Intelligence Service]
SIN Servicio de Inteligencia Naval [Navy Intelligence
Service]
UNHCR United Nations High Commission for
Refugees
UN United Nations
UNVFTTV United Nations Voluntary Fund for
Torture Victims.
USA United States of America
WCG World Council of Churches
WMA World Medical Association
Towards a systematic approach for the treatment and rehabilitation of torture and trauma survivors: The experience of STARTTS in Australia.

Jorge Aroche and Mariano Coello

Abstract
This paper recovers a text written in 1994 that explored and discussed the complex interaction between the psychological and psychosocial sequelae of exposure to highly traumatic situations in the context of organized violence, and the stresses and demands of the exile and re-settlement process of refugees. The effects on the individual, the family and refugee communities were explored, and a model to address these problems from a systemic perspective, involving action at the individual, family, refugee community, mainstream community and mainstream political structures was put forward. The role of approaches such as individual counselling, group work and community development in this framework, and various issues in the practical application of this model were discussed in the context of STARTTS experience. Looking back, almost 30 years later, the paper has renewed value as it shows the founding theoretical principles and the path to what today is one of the most important anti-torture organizations in the world.

Keywords: Torture, Rehabilitation, STARTTS, History of anti-torture movement.

Introduction
Torture Journal’s 30th anniversary is just a few years after the 30th anniversary of the creation of STARTTS, celebrated in 2019. When invited to contribute to this Special Issue, it came to our mind a paper that was first written and presented in 1994 and finally never published. This paper has as much value as a historical piece as for the framework it proposes to conceptualize the challenges faced by torture and trauma survivors resettled far from home. Still current nearly 30 years since we wrote the first draft, the conceptual framework depicted in this paper has provided the blueprint for the development of STARTTS since at least 1994.

It has been an incredibly eventful three decades, during which STARTTS has been able to assist over 70,000 registered clients from almost 180 national and minority groups as it grew from a handful of people working from a three-bedroom cottage to 250 staff working from 11 offices across New South Wales (NSW). This growth happened in the context of a changing world, defined by successive humanitarian crises leading to record numbers of forcefully displaced people and refugees, and a deterioration in Australian policies affecting asylum seekers.
The conceptual framework proposed in this pioneering article guided STARTTS service provision philosophy through these tumultuous times and enabled the service to adapt, evolve and grow without compromising the key elements that make it effective and relevant to our clients and their communities.

Just as STARTTS has grown in size, scope and depth, so has the complexity of our service provision model. While the basic tenets remain the same, it has acquired new layers of complexity in theory and practice. STARTTS services now reflect our growing understanding of the neuroscience of trauma, as well as our expanded appreciation -gained from experience and the increasing evidence base in the sector- of the complementary role that different interventions and approaches can play in the effective application of a systemic perspective that is context sensitive and biopsychosocial in nature. More importantly, it reflects the learnings gained in the course of supporting the healing journeys and walking alongside our clients. A revised and updated version of the article that fully portrays this evolution is long overdue and finally underway, and hopefully might feature in Torture sooner than later.

Background
Countries such as Australia provide asylum for refugees from a large range of national, cultural, religious and language groups. Most of these refugees can expect to face a number of challenges in their country of resettlement, which will affect their lives in many different ways. Some of these challenges relate to the sequelae of their own traumatic experiences and their impact on various aspects...
of their life. Others are associated with the losses and demands associated with exile and the process of migration and settlement in a new country. In addition, refugees also face the many challenges that confront us all as we struggle with the trials of everyday life and the hazards of different developmental stages in our lives. These factors not only affect people as individuals, but also as families, as social networks, as communities, and in their interaction with the social and political systems of the host society at large.

These factors, furthermore, don’t operate in isolation, but are likely to interact in often powerful and complex ways. It is precisely the complex interface between these factors on the canvass formed by the psychological, cultural, educational and religious attributes or baggage of the individual, family or community that can be best said to define the predicaments that refugees confront in exile.

Torture and Trauma

Many articles have been published about the physical (Goldfeld, et al., 1988), psychological (Allodi, et al., 1985; RCT, 1985; Bendfeldt & Zachrison, 1985; Goldfeld, et al., 1988; CODEPU, 1989; Lira, & Weinstein, 1984; Gonsalves, 1990; Fischman, 1990; Barudy, 1989) sequelae of organised violence. While a detailed discussion of this topic is outside the scope of this paper, it is important to emphasise the range of traumatic experiences that take place in the context of organised violence, and the pervasiveness of many of the most commonly observed symptoms. These symptoms may include depression, feelings of guilt (survivor’s guilt), loss of self esteem, anxiety, sleep disorders (particularly nightmares), intrusive thoughts and flashbacks, memory and concentration problems, difficulties in social functioning, marital and family disruption (Allodi, et al., 1985; RCT, 1985; Bendfeldt & Zachrison, 1985; Goldfeld, et al., 1988; CODEPU, 1989; Lira, & Weinstein, 1984; Gonsalves, 1990; Fischman, 1990; Barudy, 1989).

The sequelae of torture and other traumas experienced in the context of organised violence not only places individuals, families and communities in a vulnerable position in the host country, at risk of secondary victimisation, but it also interferes with their ability to access and utilise their internal resources to their full potential. This places refugees at a profound disadvantage to negotiate the complex demands of the exile, migration and resettlement processes.

In addition to the sequelae associated with direct exposure to traumatic circumstances in the context of organised violence, just living in a situation characterised by organised violence and repression, what Martin-Baro (1989) described as Systematic State Terrorism (SST), can result in people developing particular sequelae at both individual and collective levels (Martin-Baro, 1989). Survival in societies which are being grossly distorted by the systematic use of organised violence tend to foster the development of conceptual frameworks and behaviour patterns that, although of immediate adaptive value in terms of survival can have long term pathological consequences for both individuals and the collective (Martin-Baro, 1989).

The psychosocial consequences of exposure to SST are characterised by the narrowing and stiffening of the frame of reference, leading to extreme reliance on stereotyping and reluctance to interact outside the boundaries of these stereotypes; social polarisation, weakening of personal autonomy and self confidence, and the devaluation of human life (Martin-Baro, 1989). These psychosocial sequelae can affect people well beyond the origi-
inal context in which they were developed, and can have long term implications for the way they construe and interact with the host society, hence affecting their chances of successful resettlement in the country of asylum.

Exile, Migration and Resettlement
Although there is some overlap between the processes these three terms describe, it is important to differentiate between these main aspects of the transitional process of refugees in exile.

Exile and Migration
Although both processes have many similarities, the experience of exile differs from migration in the way that the decision to leave the country is made, the amount of preparation possible, the amount of trauma associated with the decision to leave and the process of leaving, and the impossibility, temporary or semi-permanent, of returning to the country of origin. Therefore, although both are transitional processes with enormous disruptive potential, their emotional and psychological connotations can be very different.

In addition, for many refugees there is often a protracted period of transitional and limbo like situations between the time they leave their country of origin and their eventual arrival in the country of resettlement. These often involve highly traumatic situations in transit, at refugee camps, or in countries of first asylum where persecution and discrimination may be present. At best, and this also applies to asylum seekers in countries of resettlement, there is a period characterised by anxious waiting in a vacuum, often in situations of total dependence on government or camp officials.

Another situation much more common in exile than in migration is the loss of contact with relatives and close relations in the country of origin.

Migration, even in the absence of traumatic events and refugee like situations, can be an extremely disruptive transitional process, where significant relationships and vital links with the objective and subjective reality of the country of origin are severed at the same time. As such, the migration process is often characterised by the loss of crucial connections with vital aspects of the environment at different levels of the system, and the psychological process of coping with these losses, often akin to a mourning process.

The often-radical change in the external environment also means that the internal representations of reality, or cognitive maps, no longer fit the external reality, and hence are less effective as tools to interpret and predict the outcome of our interactions with the external environment. Huntington (1980) describes this characteristic of the migration process as “a discrepancy between our inner and outer worlds”. Sluzki (1979) uses a musical term to describe this phenomena, “dissonance”, and emphasises the disconcerting effect it has on migrants, particularly in relation to the more automated and instinctive aspects of our relationship with the external environment, such as cars driving “on the wrong side of the road”, climatic differences (e.g.; Christmas without snow for Europeans and North Americans in Australia) and culturally determined differences in body language and social cues.

This phenomenon can elicit a range of reactions in people going through the migration process, ranging from vague discomfort, through distress, to complete breakdown (Huntington, 1980) and is often associated with physical and psychosomatic disorders, as well as psychological problems, particularly depression. This miss-match between internal representations of reality and the external reality often results in the loss of external reference points, and therefore in identity problems.
Resettlement

Resettlement can be an elusive concept to define. According to the National (Australia) Population Council Refugee Review, resettlement is the “process by which an immigrant establishes economic viability and social networks following immigration in order to contribute to, and make full use of, opportunities generally available to the receiving society” (NPC, 1988). Successful resettlement, therefore, can be seen as a function of how well an individual, family or community are able to rebuild social support networks and learn to negotiate the complex set of tasks and demands associated with life in the new country, and to what extent they are able to gain a semblance of control over their own lives and the new environment.

From finding accommodation to learning the language, from learning to do the shopping to understanding the education system of the new country, from finding a job to becoming familiar with a new physical environment; most resettlement tasks involve learning new skills, absorbing and processing information about the new environment. The process of resettlement, therefore, is characterised by a steep learning curve, which most refugees must face in the context of personal resources diminished by the effects of their experiences of loss, dislocation and grief, torture and trauma, and cultural dissonance.

Refugees themselves often fail to realise the extent to which their own personal resources are overwhelmed by these demands, both emotionally and intellectually. Their response is often to blame themselves for their difficulties, and demand more of themselves. This introduces a further drain on their self-esteem, and contributes to their feeling of lack of control and confusion. Often this may be complicated further by racism, discrimination, and or structural barriers in accessing services or information.

Restructuring a life in a new country, whether there is an expectation of permanency or not, is a complex and difficult process, which places a lot of demands on inner resources at the individual, family, social group and community levels. Successful resettlement relates more to the quality of life that refugees are able to achieve in the host country than to the duration of their stay or their commitment to adopt the host country as their own. Even in countries like Australia, which encourage the permanent resettlement of resident refugees through active citizenship campaigns and provide a range of services to facilitate this process within the context of a pluralistic, multicultural society, successful resettlement does not need to be synonymous with permanency.

Normal Life Cycle

Australia, and indeed most countries, have health and welfare systems that have been developed largely to cater for the needs of people that have neither migrated, become refugees, or survived torture or other traumatic experiences in the context of organised violence. Yet they often have problems that prompt them to seek counselling or welfare services at some stage in their lives. Often, these problems are associated with difficulties negotiating different stages of the normal life cycle; be it learning to live in a marital relationship, mastering parenting skills, facing the trials of adolescence or the doldrums of retirement, bereavement, or the consequences of accidents or illness.

Refugees in exile are not exempt from the problems associated with what we could call the normal life cycle. The disruptive effects of trauma and relocation, in fact, can often render refugees more vulnerable to problems associated with the normal life cycle. Conversely, the effect of normal life cycle problems can often bring back to the surface or
complicate problem areas connected to traumatic experiences of the exile, migration and resettlement process.

**A Complex Interaction**

There is a complex interaction between the problems associated with the aftermath of traumatic experiences in the context of organised violence, the problems related to the exile, migration and resettlement processes, and the trials and difficulties that are part and parcel of the normal life cycle. One way to conceptualise the complex nature of the problems faced by refugees in exile in countries such as Australia, is as the complex interface between these factors, and their interaction with the attributes of the individual, including his/her emotional, psychological, cultural, educational and experiential baggage, as illustrated in the diagram below (figure 1). This interface is also relevant to define these factors at other levels of the system, such as the family unit or the refugee community.

An example of how these factors can interact is learning English, a task highly correlated with successful resettlement in Australia. A difficult endeavour at best, the task of learning a new language can be further complicated by some of the sequelae often found in torture and trauma survivors. Post traumatic symptomatology such as concentration and memory problems, sleep disorders, irritability, anxiety and depression would all tend to interfere with learning abilities. Other problems associated with exposure to a situation of organised violence, such as difficulties with trust, particularly in group situations and with perceived authority figures, can place additional barriers to the learning process.

In addition to interfering with communication in general, thus contributing to social isolation, failure to learn English is likely to place individuals and families at a disadvantage in terms of other tasks essential for resettlement. Tasks like finding employment or dealing with government organisations are less likely to be successfully completed without English. This is likely to have both objective consequences such as failure to achieve economic stability, and subjective ones, such as erosion of self-confidence and self-esteem. Individuals who are not successful in learning English may become more dependent on other family members, often children, who have been able to master the English language. Family structure and dynamics, and the perception of roles within the family may be severely disrupted as a result, impacting on its role as an effective source of support to its members.

Given the crucial role that a supportive family environment plays in the rehabilitation from the sequelae of traumatic experiences (Figley, 1987; Lyons, 1991) and other stresses (such as those associated with exile, migration and resettlement), any process that degrades the ability of the family to act as an effective system of social support will undermine the survivor’s process of recovery.

This complex interaction not only takes place at the level of the individual, but, as introduced by the above example, at the family level, and indeed, at other levels of the system, such as the refugee community. The difficulties many new refugee communities have in organising supportive structures within their community (which in turn are effective in advocating for resources and services that facilitate recovery and successful resettlement) for example, may be partially explained by the psychosocial consequences of organised violence described by Martin-Baro (1989).

The relationship between refugees and the suprasystem, which includes the political system, the complex network of government and non-government service providers,
the community at large and other systems, eventually determines the overall conditions for success in the processes of recovery and resettlement of refugees. Attention to this aspect of the problem interface, therefore, is crucial, both in terms of achieving a balanced understanding of the role of the suprasystem in hindering or propitiating the recovery and resettlement of refugees, and in terms of formulating and implementing effective strategies for action.

**Implications for intervention**

The above model is useful as a framework for understanding the complex problems confronting refugees in exile, but also has implications for assessment and intervention. A conceptualisation of the problem as the interface of a complex interplay of different factors suggests a wholistic approach to assessment that takes into account these factors. In terms of intervention, it follows that refugees in exile are more likely to benefit from multi-
disciplinary and multi-pronged approaches that attempt to address all the major factors compounding the problem at various levels of the system.

In practice at STARTTS, the implementation of this approach has resulted in a set of interventions that attempt to address the problem interface through a variety of strategies focusing on different levels of the system. These range from those focusing on the individual to those that target the community at large and government services and policies. The following diagram illustrates some of the strategies implemented at STARTTS from a systemic perspective.

As can be seen in the above diagram, the approaches at the individual level include clinical interventions, such as counselling, psychiatric assessment and treatment, physiotherapy, referral, assistance with employment and case-work approaches such as individual advocacy, often implemented through the involvement of, and in close liaison with other agencies. The common aim of these interventions remains that of assisting the client to make sense of and deal with, the problem interface.
discussed earlier. A multidisciplinary, integrative approach, therefore, pervades through, and case plans often include various complementary services being offered to clients on a parallel basis.

In addition, interventions at other levels of the system may be offered to the individual client where appropriate. These may comprise interventions at the family level, such as family therapy, parenting workshops, or referral of the children to the youth program; or at other levels such as the social support network, as in the case of referral to a self-help group. These interventions may be offered to clients concurrently, or be introduced as appropriate and relevant for the client. Often, specific strategies may be developed to cater for the manifested needs of clients, often in partnership with the clients themselves. An agricultural cooperative set up by Latin American refugees from a rural background with STARTTS assistance is a successful example of this type of intervention. Projects such as this require liaison and advocacy at many levels, as well as substantial support in the initial stages of the formation of the group.

On the other end of the spectrum, strategies such as lobbying for changes to government policies, participation in awareness raising campaigns targeting the general community, or training of mainstream service providers in order to increase their ability to effectively address the problems of refugees are preventative in nature, and target the potential as well as the actual client group.

As can be seen in the above examples the implementation of this approach involves the integration of both clinical and community development approaches in a complementary relationship. Traditionally clinical and community development approaches are often regarded as incompatible rather than complementary, and developed on the basis of different epistemologies. Achieving a balanced and congruent integration between them, therefore, is not always easy, and requires commitment and understanding of both approaches, and recognition of their merits and limitations as strategies for intervention at different levels of the system.

To date, STARTTS has been able to successfully integrate the two approaches in a complementary relationship, which, so far, has resulted in more effective service provision to a range of clients, has assisted to promote policy changes and a heightened awareness of refugee issues which has contributed to facilitate the settlement of exiled refugees, and has helped to prevent burnout and increase job satisfaction amongst STARTTS workers.

One of the challenges of putting this model of intervention into practice is that the higher up in the system one considers to intervene, the more insignificant that the resources available seem in contrast with the problem or task ahead. Strategic use of these resources, therefore, becomes essential, as does sharing the tasks with other appropriate groups and organisations through joint projects, input into existing task forces or coalitions advocating for appropriate policy changes, networking, and resourcing grassroots community initiatives.

The Future
At present STARTTS is going through a process of restructure, and one of the challenges that it faces in the course of this process is that of preserving the advantages of this multilevel model of intervention as the organisation grows in size and complexity. STARTTS new structure reflects this preoccupation. The two direct services team function on the basis of a formula that incorporates a clinical component of 50%, a community development component of 30%, and a 20% to be devoted to the pursuit of special
interests or projects of benefit to STARTTS, in areas such as research, policy development, or training.

In addition to the two direct services teams, there is a resource group which comprises more specialised positions, such as a youth worker, employment officer, family worker, training coordinator, community development worker, community services and clinical services coordinators. These positions coordinate program areas, ensuring quality improvement and excellence, and resourcing the rest of the staff on those particular areas.

We hope this structure embodies a formula that will enable STARTTS and its client group to continue to benefit from a systemic, integrative approach to the treatment and rehabilitation of torture and trauma survivors. So far, the signs are encouraging.

Acknowledgments

The conceptual framework that underpins this historical article grew organically at STARTTS, inspired by countless interactions with our clients and our clinical observations, and enriched by discussions with colleagues, board members and other stakeholders. As any meaningful piece of work, it was also inspired and influenced by the writings and informal communications with authors and key figures in the field. More importantly, its implementation and ongoing development has also continued to be guided by our clients and supported by our staff and partners as the organisation grew. Our enormous gratitude to them all for their contribution to this framework and the work of STARTTS.

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Editores
From sunrise to sunset: personal memories of the early years

Lilla Hárdi

What can Cordelia do? ‘Be silent and love’
W. Shakespeare, King Lear

Abstract
The author writes about her personal experiences in the field of the rehabilitation of torture survivors. The article shows the first steps of the therapists exploring individual and group therapy methods. The mobile team consisting of psychiatrists, psychologists, child therapists, non-verbal therapists and trained interpreters’ and the visits to refugee shelters. This type of work cannot be separated from the actually existing political waves in Hungary and decisions regarding the legal regulations for refugees, neither from other factors like the pandemic. This task and mission demand innovative abilities from therapists in a permanently changing setting.

Keywords: Cordelia Foundation, refugees, torture survivors, therapeutic methods

As Editor-in-chief of the Torture Journal, Pau Perez-Sales asked me to write ‘something personal’ for the 30th anniversary annual edition.

What shall I write about? I found myself pondering. Perhaps an article on the activities of the Hungarian Cordelia Foundation? About our psychotherapeutic working methods? On the challenges of the present political situation and its influence on our daily work? Or on my experiences with the Torture Journal? I had several ideas, but attending to daily duties and patients meant I had little time left to write.

I keep my promises, so I finally made a decision and chose to write about my 26 years with the Cordelia Foundation and 30 years with the IRCT, including my memories with the Torture Journal.

How did it all begin?
I was an ordinary medical doctor, psychiatrist, and psychotherapist working in the early 90s at Budapest’s most prominent mental institute -the National Institute of Psychiatry and Neurology. One morning, my boss showed up at one of our departmental physician’s meetings and asked: ‘Dear colleagues, can any of you speak English?’ I timidly raised my hand, and he declared,’ Lilla, you should immediately suspend your shift and go straight to the Academy of Sciences. There is a conference there, and I appoint you to participate’. I asked him what the conference was about. –‘I am not sure, but it has something to do with torture’- he said. Oh no, no, no! I had nothing to do with such horrific things, and I began to think about how to avoid this ‘special honour’. I was pretty unhappy and angry about it, but there was no way to avoid it. I had to comply and go to the second international conference of RCT organised in Budapest in 1991(after the first one held in Tromso)
After listening to the second presentation, I knew that that was it - I got hooked. From a psychiatric standpoint, I found the topic incredibly intriguing and interesting. Understanding the severity of the problem, I became concerned that I would want to become involved with the rehabilitation of torture survivors in the near future.

It was also at the conference where I met Inge Genefke and her colleagues for the first time. We made friends with each other throughout the conference, and I was later invited to a short training in Copenhagen.

I then went back home, and, together with a colleague from the Psychiatric Institute, we set up the foundations for the rehabilitation of torture victims. We began our activities in one of the refugee shelters hosting asylum seekers from Bosnia. We employed interpreters and began to collaborate with a human rights' defense center at the Southern border of Hungary.

We did not really know how to go about it. Our experiences as psychiatrist and psychologist were the only things we had. We had no special screening methods or therapeutic tools; we did not know anything about multiculturalism and traumatic war experiences. There was nothing outstanding in our psychotherapeutic and psychoanalytic training backgrounds, nothing on vicarious trauma, burn-out, or the working team’s psychological processes. We had to learn from our experiences and failures.

This lack of knowledge meant that we did not know how to identify potential torture survivors in the pool of 2,000 asylum seekers at the shelter where we were working.

So we went from room to room asking people: ‘Have you been tortured?’ The answer was stereotypical: ‘NO!’

Once, we saw a person laying in his bed holding his head in his hands. I asked him: ‘Have you been tortured?’ And the magic happened! The answer was ‘Yes!’

We sat down on the bed and began to ask how and by whom. The person answered: ‘By the local dentist in the village, when he extracted my tooth!’

It could not go on like this, and we decided to start using questionnaires. We were able to identify some patients, but they later reported that they felt like they were being interrogated.

We incorporated this learning experience into our practice, and Step-by-step, we elaborated methods to screen the patients.

Another significant failure was brought about by our naivety about the psychological processes of the working team. The first Foundation broke into pieces due to serious personal conflicts. I was also broken and decided to devote my energy to the Institute and my psychoanalytical practice.

However, shortly after, Inge phoned me to inform that a delegation of different centers was coming to Budapest and wanted to meet me. They knew about how the Foundation had disintegrated. Inge grasped my hand, saying: ‘We have come to help you to stand up and begin again! You cannot give up! It is a mission, and it cannot be simply given up!’ She was right, I knew. I had to stand up and begin to set up the new Foundation.

The dilemma was how to name the Foundation. How to call a foundation born out of your love and heart? Heart is ‘cor’ in Latin, but that did not make a good name for a Foundation. I also wanted to involve the name of the person I loved, and that was my first-born child, my daughter Delia. That is how Cordelia Foundation came into life in 1996.

By then, only two of us worked as therapists: Eva, the non-verbal therapist, and myself. Eva was a puppet theatre artist originally. She was a great ‘magician’. Eva became a non-verbal therapist during her working years in the Psychiatric Institute, and adapted animation therapy to suit refugees’ needs. Animation therapy was
built upon the idea of 'animate inanimate objects': working with objects that would evoke associations from memories of trauma and torture.

Once, she tied a rope around a person's hurting abdominal area. Subsequently, she eased their pain by using the person's peers' cold hands on the wounded area. This type of therapy also increased group cohesion, which is essential for people far away from their own culture.

We continued the work with Bosnian refugees. On the other hand, when new asylum seekers came from Kosovo, we realised that we had to find new methods of psychological rehabilitation that were culturally-sensitive.

The non-verbal therapist started using more direct methods with movements and gestures to drain the hostile feelings and anger brought from past painful experiences. She called it 'station group therapy,' reminding Jesus Christ's stations at Mount Golgota referring to the different mental stations that the survivors went through. We elaborated the 'symbol group therapy' for patients coming from Saddam Hussein's prisons in Iraq. In this type of therapy, symbolic objects evoked both traumatic and calming memories of the past.

'Epic group therapy' was elaborated for women from Afghanistan, evoking their painful and tragic memories from the past using cultural elements. These patients were all either recovering during the nonverbal therapeutic process, or getting to a point where they felt ready for the verbal elaboration of the trauma(s).

In 1998, new regulations were put in place for non-European asylum seekers, and we began to work with survivors from Afghanistan, Iraq, Iran, Somalia and other countries.

The therapeutic group went out every week from Budapest to different refugee shelters and detention centres all over the country. We treated more than 1,000 persons yearly. We listened to the stories of the patients and learned about people, cultures, historical changes, political situations, and individual tragedies.

We also learned about physical and psychological wounds through these stories.

We learned from the young girl from an African country whose parents were killed in front of her. She was then enslaved to serve people. She was abused and tortured. She carried a child that the perpetrators beat out of her womb.

We learned from the elderly lady from Afghanistan whose daughter was raped and kidnapped by the Taliban, and from the young Somalian boys who had to draw lots, and the 'winner' had to rape his brother to save his own life. Nevertheless, lately, both of them were shot dead, as the other group members told us.

We used individual, phase-based, and group verbal and non-verbal therapeutic methods. We employed different therapeutic modalities, from supportive psychotherapy, through trauma-focused therapeutic methods, to single-session therapy. We continued refining our screening methods for torture victims and other people surviving extreme traumas. We learned how to write a medico-legal report after the Istanbul Protocol landed on our hands in 1999.

We were trained on how to use it, and, later, we trained other civil organisations on how to care for refugees. We began to offer regular supervision to the staff at the shelters and to many other people responsible for the care and rehabilitation of asylum seekers and refugees.

We were aware of the importance of not neglecting our own psychological needs, so we had regular group supervision in the Foundation.

We set up therapeutic spaces, we referred to two refugee shelters out of the capital as 'local rehabilitation centres'.

We called our therapeutic model the 'Stay and Go model'. Either the patients came to the local centres in the shelters (‘Stay’ element), or the mobile therapeutic group went out from the
capital to the shelters offering therapies in the patients’ rooms (»Go« element). If we, the therapists, were treating the patients in their room, we entered into their space symbolising their (temporary) home. If they came to our facilities, they had to adapt to the service’s rules or social norms (e.g. they had to arrive on time). It was a learning process for them - a form of psychoeducation, a step forwards integration.

We were travelling long distances to provide support and treatment.

We trained our interpreters on how to appropriately interpret the psychological content in the messages they translated. We learned how to protect our staff from vicarious trauma to prevent problems in the group.

We were participating in the global network of IRCT, actively contributing to the elaboration of working strategies. The present author contributed as a Council member, a former Ex-Com member, and worked as an Editor-in-chief of Torture Journal for nearly two years.

We were following the history, the history of wars. We realised that we also live in history, and our situation is gradually changing with the different political contexts.

After 2015, the attitude towards civil organisations changed in Hungary. There were less and less asylum seekers allowed into the country, and we became gradually isolated from the persons in need of care and treatment, as they were kept away from the borders by the fence and the transit zones.

Progressively, the shelters closed down. Less and less people arrived. The previous employees trained by our Foundation left, and anew staff came who did not want to communicate with us. The previously open-minded general population got instilled with the negative idea of the ‘migrant’ who wants to take away the local population’s work and invade our country. The previous empathetic attitude of the population began to change and turned into a hostile attitude against the ‘aliens’. Those in charge of the support of these persons were also listed as the ‘mercenary of Mr Soros’.

The number of our patients began to decrease. Nobody or very few persons were let into the country asking for asylum, and life became very tough for them if they wanted to remain as refugees.

We had to reduce the number of staff members, and had to change the focus of our activities. We began to educate and train other professionals responsible for torture survivors and people who experienced extreme trauma.

And then came the pandemic... It meant a new challenge to the therapists and the other staff members. Let’s work online, and let’s elaborate on special working strategies! We wrote a manual and held webinars on training interpreters and intercultural mediators to act during a pandemic. It was a great inspiration to continue in a different way.

We reached out to those had not contacted us, and many previously treated patients came back due to a moderate relapse as a result of the pandemic. We worked with limited capacity, but did our best to bring the same quality online and in person.

We have always carried on and we will carry on! This is the time to share our experiences and knowledge and build new frames for a different future.

We do know that the sun always rises after every sunset!

References
30 years of solitary confinement: what has changed, and what still needs to happen

Sharon Shalev

Abstract
Solitary confinement cells are where those considered to be too dangerous to themselves or to others, too troublesome, too mentally unwell, or simply different, will be locked away, spending 22-24 hours a day alone, out of sight and out of mind.

Solitary confinement is an extreme and harmful practice on the cusp of prohibited treatment of people deprived of their liberty, with potentially grave consequences for the individuals concerned and the societies to which they eventually return.

This article reflects on some of the achievements, and remaining challenges, around the use and regulation of solitary confinement practices internationally in the last 30 years, drawing on recent developments and the author’s work in the area.

Introduction
Solitary confinement is regularly and commonly practiced in closed institutions, including prisons; psychiatric hospitals (where it is sometimes called ‘seclusion’ or ‘isolation’); police detention; jails holding pre-trial detainees and people undergoing interrogation; and immigration detention facilities.

Solitary confinement is often the precursor to torture, as well as being a form of ill treatment, and sometimes torture, in itself. Solitary confinement cells are where those undergoing coercive interrogation will be housed, and to which they will be returned once the interrogation is over. It is where, in countries still practicing the death penalty, people awaiting execution will typically be held, and where spies and ‘enemies of the state’ may spend years and decades. It is where prisoners who committed an offence in prison, or broke a prison rule, will serve the punishment of being banished from the prison society- usually as a short, but ‘hard’, punishment. It is where those considered to be too dangerous to themselves or to others, too troublesome or too mentally unwell will be housed. In all these instances solitary confinement means being locked away and apart from other human beings in a small cell where the individual will have to sleep, eat, defecate, and spend 22-24 hours alone, out of sight and out of mind.

Solitary confinement is an extreme practice on the cusp of prohibited treatment of people deprived of their liberty, with potentially extreme consequences for the individuals concerned and the societies to which they eventually return.

This article reflects on some of the achievements, and remaining challenges, around the use and regulation of solitary confinement practices internationally in the last 30 years. I have been researching and active in this field for most of the lifespan of this journal, and as...
the editors have been generous in their remit, I thought that I would use this opportunity to reflect on these developments from the perspective of my own work in the area.

**Shining a light on solitary**

My interest in solitary confinement dates back to the early 1990’s and my work as Complaints Coordinator for Israeli-Palestinian Physicians for Human Rights. In the course of our work, we encountered people who were isolated during their interrogation by the security services, often with dire health consequences. The purpose of solitary confinement in the context of coercive interrogation is set out in an FBI manual on interrogation techniques as follows:

“Isolation of the detainee not only ensures the safety of other detainees but also prevents the individual detainee from drawing strength from the support and companionship of other detainees. It also prevents collusion on cover stories between detainees. A large part of the Interrogators [sic] advantage is the natural fear of the unknown that the detainee will be experiencing. Exposure to other detainees will mitigate that fear. … if the policy of the facility permits consider having your detainee placed in an individual cell several days before you begin interrogation.”

FBI, 2010.

From the interrogator’s perspective, the supposed advantages of solitary confinement as an interrogation technique are obvious— it does not require any physical contact with the detainee— no electric shocks, beatings or other torturing of the body are required. And it does not leave broken bones and physical scars.

Putting aside though the questionable quality of information obtained through such methods and the concerns around the detainee’s access to justice (O’Mara, 2015; Ginbar, 2008; Physicians for Human Rights, 2007), the hope and expectation of adverse psychological effects as a result of being isolated from others set out in the FBI’s interrogation manual, hints at why solitary confinement is a controversial and problematic practice.

Solitary confinement ‘attacks’ the isolated individual in two ways: it places them in highly stressful conditions, and it takes away the usual coping mechanisms— access to human company, nature, and things to do. Perhaps unsurprisingly, the documented adverse health effects of solitary confinement are both psychological and physiological, and wide ranging (World Health Organisation, 2014. See also Haney, 2018). Neuroscientific research demonstrate that solitary confinement and the reduced sensory input associated with it affect not only brain function, but also brain architecture, resulting in irreversible changes (Akil, 2019; See also Coppola, 2019).

Solitary confinement may not leave physical scars, but as the title of an article written by Hernan Reyes MD, a colleague and long-time collaborator in efforts to reduce the use of solitary confinement, asserted, the worst scars are in the mind (Reyes, 2007. See also Perez-Sales, 2016). The literature on the health effects of solitary confinement as well as personal accounts by incarcerated and formerly incarcerated people (Casella, Ridgeway and Shroud, 2016), make it clear that solitary confinement has a devastating effect on the human mind, making it at least arguably— a form of psychological torture.

William Blake, a man who at the time was serving his 25th year in solitary confinement in a US supermax prison, wrote:

I’ve read of the studies done regarding the effects of long-term isolation in soli-
tary confinement on inmates, seen how researchers say it can ruin a man’s mind, and I’ve watched with my own eyes the slow descent of men into madness—sometimes not so slow. What I’ve never seen the experts write about, though, is what year after year of abject isolation can do to that immaterial part in our middle where hopes survive or die, and the spirit resides. So please allow me to speak to you of what I’ve seen and felt during some of the harder times of my twenty-five-year SHU odyssey.

I’ve experienced times so difficult and felt boredom and loneliness to such a degree that it seemed to be a physical thing inside so thick it felt like it was choking me, trying to squeeze the sanity from my mind, the spirit from my soul, and the life from my body.”

Blake, 2016:29.

Serving and former prisoners who have spent long stretches in solitary confinement have told me about times when they provoked guards, knowing that they would be wrestled down to the ground, just to be touched by another human being, or times when they cut themselves just to see the blood flow, affirming they were still alive. Others described solitary confinement like being in a pressure cooker, waiting to explode, or being in a coffin.

Research has shown that the harms of solitary confinement can also continue to affect individuals after their release from prison. People who have previously spent time in solitary confinement describe how, even many years later, they are unable to form intimate relationships and are uncomfortable in social settings, preferring instead to lead a life of solitude. Some opt for more extreme options. One study found an association between solitary confinement and elevated mortality due to non-natural causes in individuals who had previously spent time in solitary confinement (Wildeman &Andersen, 2020).

**Solitary confinement and human rights law pre-2015**

Despite a recognition of the damaging effects of solitary confinement and the obvious contradiction between these and the proclaimed wish of most prison systems1 to ‘rehabilitate’ ‘reform’ or ‘reintegrate’ those in their custody, until recently there was little reference to the practice in the international arena. The UN Standard Minimum Rules for the Treatment of Prisoners (SMR) from 1955 only address the more obviously torturous, or medieval aspects of the practice. Not mentioning solitary confinement by name, Rule 31 stipulates only that:

> Corporal punishment, punishment by placing in a dark cell, and all cruel, inhuman or degrading punishments shall be completely prohibited as punishments for disciplinary offences.

Rule 32 places the burden of supervising punishments on the prison doctor, requiring that

32. (1) Punishment by close confinement or reduction of diet shall never be inflicted unless the medical officer has examined the prisoner and certified in writing that he is fit to sustain it.

(2) The same shall apply to any other punishment that may be prejudicial to the physical or mental health of a prisoner. In no case may such punishment be contrary to or depart from the principle stated in rule 31.

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1 The discussion which follows centres around the use of solitary confinement in prisons, though, as noted, it is practiced in other closed institutions too.
(3) The medical officer shall visit daily prisoners undergoing such punishments and shall advise the director if he considers the termination or alteration of the punishment necessary on grounds of physical or mental health.

Just before the birth of this Journal, in December 1990, the United Nations Basic Principles for the Treatment of Prisoners were adopted. These principles included a call on Member States to ensure that,

Efforts addressed to the abolition of solitary confinement as a punishment, or to the restriction of its use, should be undertaken and encouraged (Principle 7).

Whilst this represented, at least on paper, a step forward, the call to abolish solitary confinement fell largely on deaf ears and did little to stem its use across the world. The United States in particular saw in fact a massive increase in the use of solitary confinement. From the mid-1990s and throughout the 2000s, supermaximum security (or ‘supermax’) prisons, designed specifically to hold many hundreds of people each in strict and prolonged solitary confinement, proliferated across the United States. At their peak, across the US, they housed an estimated 80,000 people, typically in 8x8 foot boxes, containing an open toilet/basin combination, a concrete plinth for a bed and a small concrete table/stall unit, for 23+ hours a day, separated from the world at large as well as their peers, and completely dependent on prison staff for the provision of all their basic daily needs.

Access to these prisons from outsiders was (and is- the UN Special Rapporteur on Torture’s repeated requests to visit have been refused), extraordinarily tightly controlled, feeding into a myth of super-predatory individuals locked up in these ‘supermax’ prisons, and from whom society allegedly needed protecting. With big economic advantages to rural communities from the large high-tech prisons and pressure from prison guard unions to minimise the risk that their members were said to face in their places of work by isolating all prisoners in single cells, the spread of supermaxes proceeded largely unchecked.

Perhaps unsurprisingly following the events of September 11th 2001, and the launch of its declared ‘war on terror’, the US needed somewhere to place people suspected of terrorism who were apprehended by its armed forces in Afghanistan, it looked to its own prisons for inspiration. The Supermax model was deemed to be suitable for detaining (without charge) ‘enemy combatants’, and the now notorious Guantanamo Bay prison was directly modelled on a US Supermax (Miami Correctional Facility in Indianapolis).

As conditions and practices at Guantanamo Bay and the legal status of those detained there became more widely discussed, calls to close it became more widespread (Cohn, 2011; Smith, 2007). Interestingly, though, highlighting of practices in Guantanamo Bay did not translate into a greater focus on supermax prisons in the US itself. In 2009, I had the dubious good fortune of visiting two supermax prisons in the course of making a documentary film in 1999 for an American TV network, which meant that doors (and a great number of them need to be unlocked to get in the guts of a supermax- I counted ten doors and gates from entering the prison site to a cell) were miraculously opened. The days we spent in Pelican Bay Secure Housing Unit in California and the Special Management Unit in Arizona remain perhaps the most memorable days of fieldwork in my many years of visiting solitary confinement units. Although a small but persistent and group of US based colleagues have worked tirelessly to

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3 Although a small but persistent and group of US based colleagues have worked tirelessly to
fact, supermax prisons remained in such high use that when the then US President Barack Obama announced that he intended to close Guantanamo, the idea of transferring the detainees to the Federal Supermax in Denver, Colorado, was mooted and rejected, as the prison was reportedly ‘too full’ (Finely, 2009).

The US courts, while on occasion clearly outraged by some of the practices in supermax prisons, have stopped short of declaring that the strict and prolonged solitary confinement experienced by prisoners is, in itself and for all prisoners, cruel, inhuman, or degrading treatment or punishment. Despite some successful class action lawsuits ordering significant modifications in their operation, supermax prisons are still in use across the United States, with solitary confinement remaining the key mode of incarceration in them. The compact and rigid architectural design of supermax prisons, which is entirely centred around the single solitary cell and allows for little or no communal spaces, means that changing their function would in any case be near impossible (Shalev, 2009).

The specific brand of supermax confinement as exercised in the US did not cross the Atlantic into Europe where most jurisdictions, by and large, rejected the worst excesses of the US prisons and ‘resisted punitiveness’ (Snacken, 2010). But, as Committee for the Prevention of Torture (CPT) reports show time and time again, the (mis)use of solitary confinement in closed institutions remains a problem in many European jurisdictions too. The European Court on Human Rights has stated that:

*Complete sensory isolation, coupled with total social isolation, can destroy the personality and constitutes a form of inhuman treatment which cannot be justified by the requirements of security or any other reason.*

Ramirez Sanchez, 2006.

Yet, when asked to determine whether solitary confinement was a form of torture, inhuman and degrading treatment, in violation of Article 3 of the European Convention on Human Rights, the Court has found that, although undesirable, “the prohibition of contact with other prisoners for security, disciplinary or protective reasons does not in itself amount to inhuman treatment or punishment” (Ibid. § 123. See also Rodley & Pollard, 2009; Morgan & Evans, 2002; Shalev, 2011).

It was not until the adoption by the UN General Assembly of the Istanbul Statement on the Use and Effects of Solitary Confinement in 2007, and the revision of the UN Standard Minimum Rules in 2015 (renamed as the Nelson Mandela Rules), that the age-old practice of solitary confinement begun receiving...
concentrated attention in the human rights world, including the first ever international law definition of what ‘solitary confinement’ actually means.

The Istanbul Statement on the Use and Effects of Solitary Confinement was initially drafted by Peter Scharff-Smith and me and then expanded, revised, and introduced to participants of the International Psychological Trauma Symposium in Istanbul in 2007. Peter has written an article for this very journal providing background on the Istanbul Statement, so I shall not elaborate here, other than to note that much of the ensuing language around the use and regulation of solitary confinement dates back to the Istanbul meeting.

A crucial actor at the Istanbul meeting and later efforts to promote a reform of solitary confinement practices was the then UN Special Rapporteur on Torture (SRT), Manfred Nowak. He engaged in quiet but energetic diplomacy throughout the conference – for example, being the go-between when our Turkish hosts who wanted so-called ‘small-group isolation’, such as that practiced in the infamous F-Type prisons in Turkey (Human Rights Watch, 2001) to be included in the definition of solitary confinement, whereas others, myself included, thought that ‘solitary confinement’ should mean exactly that. The final text of the Istanbul Statement was presented to conference participants and endorsed by them. In 2008, the SRT introduced the Statement to the UN General Assembly and gained endorsement for it. Later that year, my ‘Sourcebook on Solitary Confinement’ (Shalev, 2018), which brought together for the first-time various aspects of solitary confinement, including its health effects and medical ethics in prison health work, was published. The Sourcebook filled an important gap and helped to stimulate and inform a public and professional debate on solitary confinement and international efforts to reform the practice.

The excellent work of the UN Special Rapporteur on Torture advocating against the extensive use of solitary confinement around the world continued and intensified with the appointment of the next Special Rapporteur on Torture, Juan Mendez. His influential 2011 report on solitary confinement and ongoing engagement with reform efforts spurred on and fed into the eventual revision of the UN SMR (UN, 2011).

The revision of the UN SMR was formalised at the Crime Commission’s meeting in Cape Town, South Africa in March 2015, where a consensus was reached on the text of the Rules, which were renamed the Nelson Mandela Rules (for background see Huber, 2016).

Solitary confinement and the Mandela Rules: achievements and some remaining issues

The Mandela Rules, with a new section focusing entirely on solitary confinement practices, prohibiting the use of indeterminate or prolonged (defined as longer than 15 days) solitary confinement, calling for a reduction in its use to an absolute minimum, and placing a strict limit on its duration, present a tremendous achievement which many people worked hard to achieve. Of particular note are efforts led first by Penal Reform International’s Policy Director, Mary Murphy, and later by Andrea Huber who replaced her and, alongside Olivia Rope, energetically took forward work on revising the SMR. Starting in 2010, PRI convened a series of expert meetings, which I took part in, to discuss the proposed revisions and help draft the new SMR sections, one of which was to address solitary confinement. In consultation with Hernan Reyes and Jonathan Beynon, I drafted some suggestions for the solitary confinement related text. The proposed revisions were discussed, modified, and put forward to the
minds on the harms of solitary confinement, and the fine line between permissible treatment and inhuman treatment. But the Rules leave open some questions and issues, including the role of health professionals in solitary confinement units.

The remainder of this article examines the contribution of the Mandela Rules, some open questions, and some of the shortcomings of the Rules, with regard to provisions related to the use of solitary confinement.

**Defining solitary confinement**

One of the key contributions of the Mandela Rules is the offer of a definition of ‘solitary confinement’. According to Rule 44:

> For the purpose of these rules, solitary confinement shall refer to the confinement of prisoners for 22 hours or more a day without meaningful human contact.

This definition may seem obvious, but one of the most persistent issues around the use of solitary confinement, ever since the early days of its use in the 19th century and to date, is one of definition.

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6 For example, see a tweet accompanying a video issued by New Zealand’s Department of Corrections in October 2017 which read: “We don’t use solitary confinement - but sometimes we have to restrict prisoners’ contact to keep everyone safe. We call this segregation.” (https://twitter.com/CorrectionsNZ/status/925579921677737984). Having written three reports about practices in New Zealand’s prisons, I can categorically say that practices there absolutely constitute solitary confinement as defined in the Mandela Rules (See my reports at: www.solitaryconfinement.org/new-zealand ).

Prison authorities in particular are not keen on the term, and throughout its long history solitary confinement has been known by a variety of names, typically indicative of the purpose that the name-giver wanted to ascribe to the unit- ‘Intervention and Support Unit’; ‘Special Management Unit’; ‘Structured Interventions Unit’; ‘Control Unit’ and so on. The physical space bearing all these different names has though, throughout the years, remained remarkably similar.

There is a reason for this. Renaming solitary confinement enables the name-givers to distance themselves from the damages of solitary confinement and present their (solitary confinement-like) practices, to themselves and to others- as something completely different. It also enables prison authorities to respond to legal challenges and judicial interventions condemning their solitary confinement practices by saying that they no longer practice solitary confinement, and therefore any criticisms are no longer valid.

A recent example of this is the introduction of Structured Intervention Units (SIUs) in Canada as an alternative to the much criticised ‘Administrative Segregation Units’ to resolve ongoing legal challenges to practices amounting to solitary confinement. Informed critics note, however, that the change of name and declared intentions have not in fact been...
reflected in any change in practices on the ground (Wright, 2019).

Meaningful human contact
The origins of the term ‘meaningful human contact’ can be traced back to the Istanbul Statement. It is interesting to note that, originally, we did not intend for the term ‘meaningful human contact’ to define solitary confinement. Rather we attempted to describe what solitary confinement looks like in practice across jurisdictions, regardless of what it was called, or the official reasons for imposing it. This is an important point, because, as discussed below, the term has proven to be problematic.

The Istanbul Statement defines solitary confinement as:

**Solitary confinement is the physical isolation of individuals who are confined to their cells for twenty-two to twenty-four hours a day. In many jurisdictions prisoners are allowed out of their cells for one hour of solitary exercise. Meaningful contact with other people is typically reduced to a minimum. The reduction in stimuli is not only quantitative but also qualitative. The available stimuli and the occasional social contacts are seldom freely chosen, are generally monotonous, and are often not empathetic.**

In the Mandela Rules, the term ‘meaningful human contact’ becomes part of what distinguishes between permissible and prohibited practice. Rule 44 states: “Solitary confinement shall refer to the confinement of prisoners for 22 hours or more a day without meaningful human contact.”

The drafting of the Mandela Rules suggests that, so long as the isolated individual can enjoy some ‘meaningful human contact’, and so long as their solitary confinement does not become prolonged (longer than 15 days) and hence prohibited, their solitary confinement is permissible. Further, the term ‘meaningful human contact’ has proven to be problematic and difficult to demonstrate or disprove. Even in jurisdictions keen to adhere to the Rules, the term has led to what I can only describe as petty accountancy, with prison authorities documenting every interaction, even ones lasting a few minutes, in the hope that these will amount to sufficient, demonstrable ‘meaningful human contact’.

The Essex Expert Group, which convened for the purpose of providing guidance on the interpretation and implementation of the Mandela Rules, suggested that, for contact to be ‘meaningful’,

**Such interaction requires the human contact to be face to face and direct (without physical barriers) and more than fleeting or incidental, enabling empathetic interpersonal communication. Contact must not be limited to those interactions determined by prison routines, the course of (criminal) investigations or medical necessity.**

PRI, 2017:88-89

This precludes strictly utilitarian interactions such as giving a prisoner their food tray or escorting them to the exercise yard, although these activities may well involve ‘meaningful interaction’. Indeed, in some prisons I found that yard time was used by segregation unit staff to interact with segregated prisoners and gauge their state of health and wellbeing, whereas in others cell and yard doors are operated remotely, eliminating the need for face-to-face interaction altogether.

But how do you measure and assess ‘meaningful human contact’? What constitutes ‘meaningful human contact’? How long does the contact have to last for it to be ‘meaning-
ful? who does it need to be meaningful to? and importantly, is ‘meaningful human contact’, whatever it is, sufficient to maintain the health and wellbeing of someone in solitary confinement? I am not convinced that it is.

Is there an ‘acceptable’ duration in solitary confinement, and if so, what is it?
The Mandela Rules, following the Istanbul Statement, set the timeframe for a practice to fall under the definition of ‘solitary confinement’ at ’22 hours or more a day’. As noted above, the inclusion of this timeframe reflected the Istanbul Statement’s attempt to describe what solitary confinement entailed in practice, and many jurisdictions allow even isolated individuals to spend an hour or so outside the cell. We felt that not specifying a timeframe might lead to any practice which is short of 24 hours alone in cell being not deemed to be solitary confinement.

But this definition raises some issues: first, it focuses the mind on this artificial cut-point of 22 hours, rather than on the practice itself. Secondly, it puts into question practices that look and feel like solitary confinement but involve less than 22 hours in the cell. Where do you draw the line? 21.5 hours in cell? Third, this definition does not allow for nuance, reflecting the fact that different individuals react differently to solitary confinement, and that some are more susceptible to its damages.

Measuring psychosocial pain and who should be excluded from solitary confinement

Proponents of solitary confinement often point to attempts to quantify its adverse effects as showing that the pain of solitary confinement is no worse than the pain of prison more generally (Morgan et al., 2016), or, in one case, suggesting that solitary confinement may even be beneficial to health (O’Keefe et al., 2013, but see Haney, 2018; Shalev & Lloyd, 2011). Others point out to those who survived long periods in solitary confinement seemingly unscathed (O’Donnell, 2014) and to the ability of human spirit to thrive even in the darkest of places (Jeffreys, 2013).

Whilst it is true that human beings can survive the most unimaginable experiences, I think that we should be careful not to hold the strength of the human spirit as ‘proof’ that locking up another human being in a small cell, alone, for weeks, months or years, can be anything but painful and damaging.

Recognising the particular vulnerabilities of certain categories of people, Mandela Rule 45(2) stipulates that:

The imposition of solitary confinement should be prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures. The prohibition of the use of solitary confinement and similar measures in cases involving women and children, as referred to in other United Nations standards and norms in crime prevention and criminal justice, continues to apply.7

Texas’s administrative segregation units are virtual incubators of psychoses-seeding illness in otherwise healthy inmates

Federal Judge in Ruiz, 1999:37

7 Rule 22 of the Bangkok Rules (United Nations, 2010) states that “Punishment by close confinement or disciplinary segregation shall not be applied to pregnant women, women with infants and breastfeeding mothers in prison". Rule 67 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (United Nations, 1990) states that “disciplinary measures constituting cruel, inhuman or
These prohibitions are based on the knowledge that the effects of solitary confinement on children, young people, people with disabilities, and those who are mentally unwell, can be particularly harmful. A US Federal judge noted that prolonged solitary confinement in a ‘supermax’ prison “may press the outer bounds of what most humans can psychologically tolerate”, and for those with pre-existing psychiatric disorders it was “the mental equivalent of putting an asthmatic in a place with little air to breathe” (Madrid, 1995).

With regard to children, as a joint statement from the British Medical Association (BMA), the Royal College of Psychiatrists (RCPsych) and the Royal College of Paediatrics and Child Health (RCPCH) asserted, “children are still in the crucial stages of developing socially, psychologically, and neurologically, and there are serious risks of solitary confinement causing long-term psychiatric and developmental harm”. The Statement called for children and young people in detention to never be subject to solitary confinement (BMA, RCPsych, RCPCH, 2018). Yet, children and young people are regularly isolated in prisons across the world. In Australia, for example, children as young as 15 were reportedly routinely held in solitary confinement (Victorian Ombudsman, 2019). An inspection report from England and Wales made similar findings (HMIP, 2019).

Mothers and pregnant women are also routinely segregated. My study of the use of solitary confinement in women’s prisons in New Zealand, for example, found that despite being a highly vulnerable population with high levels of trauma and multiple and complex needs, women (mostly Māori) were segregated significantly (73%) more often than men, including stays lasting several months (Shalev, 2021). My research suggests that women may experience the pains of solitary confinement even more acutely than men, and the rate of self-harm amongst segregated women is particularly high (ibid.).

People suffering mental illness are similarly placed in solitary confinement in prisons worldwide – because there are no other institutional solutions for them, or because they disturb other prisoners in the prison’s general population, or because they are awaiting a bed in a psychiatric hospital. This is the case despite wide consensus that solitary confinement is even more painful for people who are mentally unwell. Mandela Rule 45(2) excludes from solitary confinement people with disabilities “where their conditions would be exacerbated by such measures” (Rule 45(2)). But this, in my view, is problematic. Is it right to wait until someone, who may have had no previous mental health issues, develops a psychiatric disorder before asserting that they must not continue being subjected to a practice known to cause mental illness?

I would have liked to see the Mandela Rules mandate a complete prohibition on the use of solitary confinement for people with mental illness, for children and young people, and for women.

Who should review solitary confinement placements?
Nelson Mandela Rule 45 requires for solitary confinement placements to be subject to ‘independent review’.
But who this ‘independent reviewer’ should be, and the degree of authority they have in the process, remains open to national interpretation and application. International experience with various forms of independent reviews shows that these often leave something to be desired.

For example, in 2000, as part of efforts to limit the use of solitary confinement, Israel introduced a law requiring any extension of solitary confinement stays for longer than 6 months (already a very prolonged time, of course) to be authorised by a judge (Dagan & Shalev, 2021). However, an analysis of 354 court decisions made in the course of 20 years found that whilst judges recognised the harms and particular pains of solitary confinement, they nonetheless approved 93% of requests to extend solitary confinement stays, including very prolonged ones. The study suggests that structural factors and the use of ‘techniques of neutralisation’ and forms of denial\(^8\) allowed judges to “explain away the ‘pains of solitary confinement,’ and diminish their own role in authorising and inflicting those pains” (Dagan & Shalev, p. 16) potentially hampering their effectiveness as independent reviewers.

Canada opted for a system of Independent External Decision Makers (IEDMs) for deciding on extended solitary confinement placements, but a study of the work of the IEDMs found that they approved the prison authorities’ decisions in the vast majority (87%) of cases (Sprott, Dobb and Ifene, 2021). Further, an ‘Implementation Advisory Panel’ set up for the specific purpose of monitoring the newly set-up Structured Interventions Units in 2019 was dissolved a year later as the Canadian Department of Corrections failed to allow members access to the units or to data, casting doubt on the utility of this form of independent review.

Even given good access to prisons, prisoners, and prison administrative records, an independent reviewer needs good knowledge and understanding of prison procedures and practices. They also need maintain a relationship which is co-operative, but not too close, with prison staff, as well as gaining the trust of prisoners. This is not always an easy balance to achieve. Even when access is provided and a cordial distance is maintained, follow up is often poor, and adherence to recommendations difficult to monitor, as the Canadian experience demonstrates.

What role should physicians and other health professionals have in solitary confinement units?
In many jurisdictions a doctor or a nurse need to sign a form asserting that a person is able to withstand isolation. Indeed, this is considered to be a safeguard against ill treatment. The original text of the UN SMR of 1955 stipulated that

Rule 32
(1) Punishment by close confinement or reduction of diet shall never be inflicted

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\(^8\) The term ‘techniques of neutralisation’ was coined by American criminologists Gresham Sykes and David Matza (1957) to explain the way in which people rationalise their criminal conduct and its associated guilt. The five main ‘techniques’ are: denial of responsibility; denial of injury; denial of the victim; condemnation of the condemner; and appeal to higher loyalties. This was further developed by Stanley Cohen’s (2001) framework for understanding the manner in which human suffering can be either denied or acknowledged, including: Literal denial (it didn’t happen); Interpretive denial (the facts themselves are not denied but are given a different interpretation or ‘spin’); and implicatory denial (the implications of what happened are denied). These forms of denial allow the individual to avoid fully acknowledging the reality of human suffering and thus to feel no compulsion to act to mitigate this suffering.
unless the medical officer has examined the prisoner and certified in writing that he is fit to sustain it.

The Mandela Rules attempt to walk a tightrope between, on the one hand, a wish to ensure that detainees always have access to a doctor and, on the other hand, the ethical requirement for health professionals not to take part in practices which are not geared towards maintaining and improving their patients’ health, and, specifically, not to participate in assessing their ‘fitness for isolation’.  

Nelson Mandela Rule 46
1. Health-care personnel shall not have any role in the imposition of disciplinary sanctions or other restrictive measures. They shall, however, 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.
2. Health-care personnel shall report to the director, without delay, any adverse effect of disciplinary sanctions or other restrictive measures on the physical or mental health of a prisoner subjected to such sanctions or measures and shall advise the director if they consider it necessary to terminate or alter them for physical or mental health reasons.
3. Health-care personnel shall have the authority to review and recommend changes to the involuntary separation of a prisoner in order to ensure that such separation does not exacerbate the medical condition or mental or physical disability of the prisoner.

The Mandela Rules make clear that medical staff have an important role to play in safeguarding the wellbeing of prisoners who are isolated, but how is ‘keeping a close eye’ different to ‘certifying fitness’ for isolation? This is an unresolved, and a difficult, issue. Whilst we would not want to advocate less human contact, and certainly not with doctors, I think that we should be clearer about what exactly it is that health professionals are asked to do, and how does that square with their broader role. It is important that doctors are associated with healing and cure, and not seen as facilitators of ill treatment to those perceived as able to withstand it.

The future: is the tide turning?
In the United States, the birthplace of the use of prolonged solitary confinement for mass warehousing of people in prison, there are signs that the tide of solitary confinement may have started turning (Washington Post, 2014). Several States have now successfully implemented significant reforms to their use of solitary confinement – for example, Colorado banned the use of solitary confinement for longer than 15 days in 2017 (Raemisch, 2019), and policy changes in North Dakota achieved a 74.28% reduction in the use of solitary confinement between 2016 and 2020, with no associated increase in prison misconduct (Cloud et al. 2021).

It is not clear to me that this reversal will be sustained in the United States, and it is unclear whether other countries will follow.
It is in any case unlikely that prison authorities across the world would give up entirely the legal right and physical space to segregate a prisoner from their peers. But the more examples of successful alternatives there are, the more likely prison authorities are to consider using this extreme tool in a different way. Rather than being places of deprivation and punishment, the units where the prison’s most vulnerable and most challenging individuals are housed can become places of investment and growth, of trauma informed practice and a focus on meeting individual needs.

We should also take comfort in the fact that the term ‘solitary confinement’ is now widely used, and is associated with negative, painful practices. This, in itself, is an achievement.

But, in my view, we need to push for further, and more radical, change.

Having studied solitary confinement for close to three decades, and having visited numerous places of detention where people were held in small concrete or metal cubes with few personal belongings, with little personal autonomy and control over their daily lives, and with incredibly limited access to the outside world, it is increasingly clear to me that as well as being immensely harmful to health and wellbeing and inefficient in dealing with prison violence, prolonged solitary confinement is morally and ethically wrong. It should be abolished.

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Refugee children’s mental health and development - A public health problem in Europe

Edith Montgomery

Abstract
Knowledge about refugee children’s mental health has developed considerably during the last 30 years. From believing that children’s reactions largely depend on their parents, it has become clear that children are influenced both by their own experiences, by the reactions of their caregivers and by the social environment in which they live. While psychological problems are frequent in children close to arrival in exile, follow-up studies have shown that the magnitude of the problems is reduced over time. Aspects of social life as well as stressful events in exile seem to be of paramount importance for children’s ability to recover from early traumatization. Prolonged asylum procedures, temporary residence permits, delayed family reunifications, many school-moves and xenophobic attitudes is counteracting healthy development. The results of research on refugee children and youth indicate the existence of a large public health problem which calls for policy change and political action.

Introduction
The scientific knowledge of how children react to various forms of traumatic experiences has developed considerably during the last 40 years. Until about 1980, only a few studies of children’s reactions to various forms of traumatic events existed (Benedek, 1985) and these consisted primarily of collections of clinical case descriptions. The diagnosis, post-traumatic stress disorder (PTSD), was included in DSM-III in 1980; however, no diagnostic criteria for traumas in children were reported before the publication of DSM-III-R in 1987. In the early 1980s, Leonore Terr described the reactions in a group of children who had been kidnapped and buried alive in a school bus (Terr, 1981 & 1983). She documented how normal children reacted to their experience with a number of psychological symptoms; however, her observations were not immediately acknowledged by health professionals. In a review from 1985 (Garmazy & Rutter, 1985), it was further concluded, based on previous studies, that although some children could react with emotional difficulties to immediate and serious events, the reactions were short-term in most of the cases. At this early stage of the research within the field, the children’s reactions were viewed, first and foremost, as being dependent on their parents’ reactions; if their parents remained calm, the children would not react to serious events. Simultaneously, clinical documentation from working with referred children suggested that traumas could lead to serious cognitive and emotional disturbances and possibly lead to a permanently disturbed personality development, unless the experiences were treated with, for instance, therapy (Eth
My research on trauma in refugee children was initiated in the end of the 1980s at the Rehabilitation- and Research Centre for Torture Victims (RCT) in Copenhagen, where I worked as a clinical psychologist. Mainly through the clinical work, the importance of the family environment for traumatized children became obvious. The individual trauma perspective, focusing on the links between specific traumatic experiences and resulting psychopathology, was then complemented with a systemic-constructionist perspective with its focus on meaning-making processes and the socially constructed ‘realities’ in relation to which the families understand their lives and organise their experiences. Later, both through clinical experience and research findings, the importance of the wider social network for the children’s mental health and development became more apparent, and I became interested in the ecological perspective where people’s reactions are studied and understood in relation to the various contexts within which their lives are embedded, and where the focus for research and intervention is the relations between various factors contributing to psychopathology as well as to resilience. When I started my research, very little was known about the magnitude of the problems within unselected populations of refugee children. From my early clinical studies of the mental health consequences of torture and organised violence for children, I therefore expanded my research to non-clinical populations of asylum-seeking and refugee children to be able to identify and understand risk and protective factors and processes in the children’s social ecology. Over the course of my early work in the field, I found that it is through the interplay of quantitative and qualitative research methodologies that we are provided with the most thorough understanding of central themes on which to base our interventions. Thus, modern epidemiology seemed relevant for this purpose, in combination with qualitative methods.

Taking the child’s perspective
I have learned early on the consequences of any given experience for a child depend both on the way in which the child understands the event and the meaning he/she attaches to it. Children often experience things different from adults. Fatimah is one of the children whose parents participated in my research early in the 1990s:

Fatimah was 4 years old when she arrived in Denmark with her mom and dad. They had escaped war and her father had been in jail shortly before they were able to escape. When they arrived to the refugee camp in Denmark, the father was questioned by the police and afterwards separated from his family and placed in the camp’s prison, while Fatima and her mother were placed in the family unit of the same camp. The mother next day told me that Fatimah in her homeland had experienced how her father was picked up by soldiers and later was returned to the family beaten up and in very bad shape. Now Fatimah cries, clings to her mother, and insists that her father will never come back. The parents had told her that when they came to Denmark, they would be free, and no one would take her father away again. Fatimah thinks that her father is starving and when she hears the shooting from the nearby military camp, she shouts in distress, “now they shoot my father”. She does not believe it when told that nothing would happen to her father in the prison here.

Fatimah’s father was never in danger in the prison in Denmark, but Fatima did not believe that. Her experience told her that being
put to prison had devastating results, and she had to experience otherwise before she would believe it.

Early research has shown that families who come to Denmark or other European countries as refugees often have a past marked by violence, deprivation, insecurity, and anxious waiting (Montgomery, 1998). The parents have chosen to flee from areas of war or other forms of organised violence out of a desire and hope to create a better future for themselves and their children in another country. Where they end up is often a coincidence. Every family member has their own story and need to be heard and understood.

The trauma of refugee children
Studies of children’s psychological reactions to war, other organised violence, and being a refugee, became more frequent during the late 80s and 90s and documented a high prevalence of psychological symptoms (for an overview see e.g. Lustig et al., 2004). Children who arrive alone, without their parents, or who are separated from their parents, are at greater risk for developing psychological problems and need particular attention.

An important discovery was that conceptualizing trauma reactions in children in terms of PTSD is not sufficient. Epidemiological studies, among them my own (Montgomery, 1998 & 2001), showed that children’s reactions to traumatic experiences are not necessarily PTSD specific, but can be much more varied. The children often react with some form of anxiety, they may appear sad and upset, suffer from sleep disorders, have difficulties with concentration, and become restless and aggressive. How serious the reactions are depends, among other things, on the parents’ condition and how quickly and effectively the family is helped to a safer life in exile.

Research from the early 90s (see Montgomery, 1998) also documented that refugee children often have had their own traumatic experiences of, for example, war, imprisonment, persecution, and flight. At the same time, they may have lost or been separated from significant caregivers for a longer period of time if, for example, the father has been at war or in prison, or if one or more family members have died. Many children have lived in a refugee camp under difficult circumstances before or during the escape, they have experienced shootings, sought protection against bombing, have witnessed killings and assaults against their family or others, and have had to leave their homes and belongings, often in a hurry (Baro, 2006; Montgomery, 1998). Only a few of the children in my own research had themselves been subjected to torture, whereas 30% of the parents had been imprisoned and tortured (Montgomery & Foldspang, 1994) so that more than half of the children were living in a torture surviving family (Montgomery, 1998). However, other studies have documented a high number of tortured children particularly among unaccompanied refugee children, child soldiers, children living in extreme poverty, and abandoned children (Alayrian, 2009).

Although early studies suggested that both the traumatic experience and factors related to the family or the exile situation could be associated with the children’s psychological problems, few studies in the early 90s utilized a multivariate statistical method when analysing the associations between traumatic life circumstances and psychological problems among refugee children. More such studies were published during the following years. A conclusion in my own research from the 90s was that having lived during prolonged conditions of organised violence rather than experiencing specific events, was asso-
associated with anxiety at arrival, however, later it appeared that also the cumulative trauma (number of types of traumatic events experienced by the child or the family) as well as living with a parent, who had been tortured, had a profound effect on the children’s reactions shortly after arrival.

**Intergenerational transmission of trauma**

‘Intergenerational transmission of trauma’ is a concept that has been used to describe the phenomenon of children reacting to their parents’ traumatization with trauma-related symptoms. The children do not necessarily have traumatic experience themselves; however, the trauma is passed on and communicated to the children through their parents’ reactions and the impact of these reactions on the parents’ ability to be actively present and attentive to their children’s needs.

The importance of intrafamily support and the interrelationship between children’s and parents’ situations and reactions have been documented in both my own and other research up through the 90s and 2000s (Arakelyan & Ager, 2021; Dalgaard, Thøgersen & Riber, 2020; Bryant et al, 2018; Montgomery, 2011). Three potential and mutually interlinked pathways were suggested for this relationship: post-traumatic disruptions in parental attention to the child because of the parents’ own problems; family violence or neglect secondary to organised violence; and aspects of trauma-focused family communication.

We know from clinical experience that parents who are traumatized following exposure to torture or organised violence can have difficulties in living up to their children’s demands for empathy, sensitivity, and presence. Secure attachment and children’s trust in their parents’ ability to protect them against danger are important prerequisites for healthy development. Studies have pointed to the role of refugee trauma in disrupting attachment security in both children and adults as well as to the protective role of safe attachment representations in reversing the impact of traumatic events in children (Haene, 2009). Furthermore, the transgenerational transmission of trauma has been found associated with overall family functioning, and particularly with a pile-up of stressors within the family such as serious physical illness, financial problems, worries about the extended family in the country of origin, worries about residence permits/citizenship, having a disabled child, or the family’s housing situation (Dalgaard & Montgomery, 2017).

Parental trauma has been proposed as a central risk factor for family related violence in refugee families (Timshel, Montgomery & Dalgaard, 2017). In a systematic review (Montgomery, Just-Østergaard & Jervelund, 2019), parents who had been exposed to traumatic events, especially parents who had been diagnosed with PTSD, were found to be at risk of perpetrating child abuse, particularly when the family was living in otherwise stressful life circumstances (e.g. war, poverty, exile). Bryant et al (2018) found PTSD in refugee parents to be associated with harsh parenting styles, leading to adverse effects on their children’s mental health.

Communication between family members about traumatic experiences can foster resilience and serve a buffering role during critical times in the life of a child, but the quality of the communication depends on the way the family is experiencing its life story and situation as refugees. In a qualitative study, communication in the family was conceptualised in relation to ‘stories told’ and ‘stories lived’ (Montgomery, 2004). When the ‘stories told’ were in contradiction to the ‘stories lived’, a situation of ambiguity and uncertainty arose; for instance, this could be the case when the
parents insisted on their children not knowing anything about imprisonment and torture, and on it not being spoken about (the story told), at the same time as the father, in his desperation, at times would talk about details from his experienced torture in the presence of the children (the story lived). The meaning-providing contexts for making sense of the family history of violence and exile could be more coherent, less coherent, or contradictory which might directly result in a strengthened relationship or confusion, powerlessness, and action paralysis. One conclusion from this qualitative research was that information about parents’ experiences of imprisonment and torture is not in itself helpful in relation to the children’s ability to cope with their traumatic past. The ability to create meaning of the family’s history depended more on the manner in which the parents and the children communicate with each other about the events than on what is actually communicated to the children – the relationship between children and parents thus seems to be the most important factor.

An interesting finding from my own follow-up study was an association between the parents’ health and the observed difference between parents’ ratings of their children’s health and the children’s self-ratings: When the father suffered from a somatic disease, both parents tended to underestimate their children’s symptoms, while parents in families in which the father suffered from psychological problems tended to overestimate their children’s problems (Montgomery, 2008b). Somatic illness in the parents can reduce their attention towards their offspring’s problems because of difficulties in coping with the challenges of daily life. On the other hand, parents who are anxious or nervous can tend to worry more about their children’s future in exile. This can have great clinical importance when refugee children and youth are referred for examination and treatment as well as for understanding research on refugee children with only one informant (often a parent).

Long-term consequences of trauma

Do the psychological problems in refugee children persist over time? Not necessarily, but to understand the long-term trajectory of psychological problems, follow-up studies are necessary. However, such studies are rare, and most of them have a relatively small population (below 100) and the follow-up period is, in many cases, limited to a 1-3 year time period. A few studies that have included more than two observations suggest that many years can pass before a high initial symptom level is reduced, e.g. after 6 years or more (Hjern & Angel, 2000; Sack et al, 1999; Sack et al, 1993).

Studies with a longer follow-up period – among them my own research conducted 8-9 years after the baseline (Montgomery, 2008a) – have shown that the magnitude of the psychological problems is considerably reduced over time. Most refugee children and youth integrate well into the society, go to school, get work, learn the language, and find local friends. But although the high prevalence of psychological problems at arrival was considerably reduced over time, I found that it was still higher 8-9 years after arrival than what was found in populations of youth without a refugee background. While the children’s traumatic background at arrival only to a limited extent seemed to determine their long-term mental health, the amount of life stressors in exile, including the experience of discrimination (Montgomery & Foldspang, 2008), was found to be of prime importance in my follow-up study.

To further understand the relative impact of previous traumatic experience and exile-related stress on psychological problems in exile,
at arrival and follow-up, I compared children with no psychological problems at both arrival and follow-up (the spared), with children who had problems at arrival, but not at follow-up (the adapted) and children with problems at both points in time (the traumatised) (Montgomery, 2010). The number in types of traumatic experiences before arrival in Denmark distinguished the spared from the traumatised, while the number in types of stressful life conditions in exile distinguished the adapted from the traumatised. Thus, stressful life conditions in exile exerted impact on the children’s ability to adapt following initial problems at arrival rather than previous traumatic experience-related violence. This study stresses the importance of environmental factors for children and young people’s ability to adapt in a healthy way after traumatic experiences related to war and other organised violence. Refugee children with traumatic experiences prior to arrival are vulnerable, but the long-term effects of these experiences depends on further exposure to individual, family, or society-related risk factors. This does not, however, mean that the traumatic experiences are without significance in the long run, but rather that the traumatic experiences from the home country are thrust into the background as other factors get a more direct influence on the child or youth’s mental health. An overall conclusion is that refugee children can show a remarkable resilience; however, being resilient does not imply immunity to negative life events.

The relative importance of traumatic experiences and exile-related factors changed over time which, among other things, was found in a follow-up study of refugee children in Sweden fleeing from Chile and the Middle East: while previous traumatic experiences was found to be the most important predictor at arrival in Sweden, family-related stress was found to be a significant predictor as well at the follow-up study after 18 months of residence in Sweden, and 6–7 years later, current family-oriented stress was found to be the most important predictor for the children’s psychological problems (Hjern et al, 2000).

Studies point to the following factors as especially important for the long-term psychological reaction of children and youth: Aspects of social life (including schools, friends and parents’ education and behavior), and Stressful events in exile (including discrimination).

The negative factors relate, to a large extent, to the difficulties associated with trying to integrate into the society. Networks of friends, supporting institutions and groups, such as schools, can be deciding factors for how well refugees will be able to cope with life in the new society.

Thus, whether or not traumatic experiences have long-term consequences for the child’s development and mental health depends to a large extent on what happens to the child after arrival in the country of exile. (Re)establishing a supportive social ecology around the child and his/her family is of prime importance for the healthy adaptation and development. Community interventions should attempt to establish a secure, predictable, coherent, and stable life context within which positive experiences can enhance healthy development. One aspect of such interventions could be to actively combat discrimination and negative attitudes towards refugees within, for instance, the school setting. Another intervention would be to support refugee parents in understanding and dealing with their children’s reactions. Teachers and prosocial peers can play an important role by providing compensatory or additional support when parents are too traumatized themselves to help their children. Some children will need extra support and professional treatment due to their traumatic experiences, their social life circum-
stances, and family relations. Interventions aimed at enhancing protective factors and reducing risk factors within the various life contexts of the child will have a positive influence on the child and might prevent psychopathology in the long run.

The changing paradigm on refugees in Europe
The United Nations Convention on the Rights of the Child is a legally-binding international agreement setting out the civil, political, economic, social, and cultural rights of every child. It was adopted in 1989 and the Nordic countries were among the first in the world to ratify it. Four general principles are set out: nondiscrimination; the best interests of the child; the right to life, survival and development; and the right to be heard. Asylum-seeking and refugee children are specifically mentioned and the convention states the rights of such children to receive appropriate protection and humanitarian assistance (Jørgensen, Leth & Montgomery, 2011).

During the last 20-30 years, we have witnessed a considerable change in the way refugees are perceived and talked about in Western countries. From primarily perceiving refugees as human beings in need of protection, the main discourse now seems to be how to protect Europe from the influx of new refugees and the general trend in Europe has been towards more and more restrictive migration policies (Gauffin, 2020). Studies have documented how the post 9/11 ‘War on Terror’ has had a negative effect on Muslim children and youth in the West, and how parental identity formation among Muslim parents living in the West is highly influenced by the negative portrayals of Islam within mass media (Dalggaard, 2016).

This changing paradigm has had a profound influence on the rights of asylum-seeking and refugee children, and has in several ways prevented the existing knowledge about the need of such children from being put into practice. The social and political environment in a country often has a greater impact on what is done, than what is known to be in the best interest of the child. We know for example that prolonged asylum procedures, temporary residence permits, delayed family reunifications, various school-moves, and xenophobic attitudes is counteracting healthy development, but that doesn’t stop such praxis.

The way forward
Understanding refugee trauma in general, and in children in particular, is a relatively new field. What has been clearly demonstrated in research and clinical practice during the last 30-40 years, however, is the need to think much broader than in terms of individual psychopathology (Arakelyan & Ager, 2021). To capture the complexities involved, psychological trauma in refugee children and adolescents must be studied and understood in the context of a range of risk and protective processes involved in the pre-, peri- and post-flight life conditions of the child or the young person. Programs to enhance refugee children’s mental health should always involve the family, considering that not only the nuclear family in exile, but also the extended family in the country of origin, can have a profound influence on the children. Treatment for traumatized refugee families should be made easily and early available and both parents and children should be targeted. Furthermore, initiatives aiming at reducing stress arising from the environments in which the potentially traumatized families live should be taken early on, e.g., in the form of financial or material support, educational activities for adults and children, and establishing emotional support groups.
Finally, in a time with growing anti-refugee rhetoric, xenophobia and restrictions of refugees’ rights to apply for asylum and family reunification, mental health researchers and practitioners need to apply their knowledge in social action and advocacy for refugees working together with researchers and practitioners from other fields.

The results of research on refugee children and youth indicate the existence of a large public health problem which calls for policy change and political action. A critical review of procedures and practices regarding the reception and treatment of refugee families is necessary and mental health professionals need to play their part, e.g. by letting their voices be heard when refugees are treated in manners that counteract healthy development. It’s a huge loss for both the young refugees and for the community, if refugee youth are allowed to grow up with a feeling of alienation.

References


Healing and reintegration of former child soldiers: a relational resilience perspective

Michael Wessells

Abstract
The author advocates for a psychosocial and community perspective in the work with child soldiers, as torture survivors.

Worldwide, armed conflicts inflict massive violence on children, defined under international law as people under 18 years of age. Some of the worst exposures to violence occur in the lives of boys and girls who are recruited into armed forces (state armies) or armed groups such as paramilitaries, guerilla, or opposition groups (Wessells, 2006). Forced recruitment often occurs at gunpoint, and the children may be forced to kill members of their community as a means of blunting their hopes of escape and return home. Much recruitment, however, is not forced, as children themselves decide to join the armed forces or groups due to a mixture of push and pull factors (Brett & Specht, 2004). Prominent push factors include an abusive family, hunger or starvation, ongoing insecurity, or lack of education and training. Pull factors may include money, food, medical supplies, revenge, finding a surrogate ‘family’ in the armed group, the power and prestige of wearing a uniform and carrying a weapon, or, as in the case of Islamic State, the promised glory of martyrdom.

Inside armed forces or armed groups, children may suffer attacks, physical wounds and disfigurement, gender-based violence, multiple losses, substance abuse, and mistreatment by commanders, among many others. Armed with small weapons such as AK-47 assault rifles, which in sub-Saharan Africa can be obtained for the cost of a chicken, and encouraged or threatened by their commanders, many child soldiers perpetrate violence. Regardless whether they become perpetrators, child soldiers are victims of torture since they are intentionally subjected to severe physical and psychological suffering with the intent to change their identity in ways that serve the desires of the State or the non-State actors that had recruited them.

This mass exposure to violence and deaths has stirred media concerns about child soldiers being a “Lost Generation” that is irreparably damaged by the mass traumas and resocialization for violence that they have experienced. Their plight has led Western psychologists and psychiatrists to take a deficits approach that emphasizes former child soldiers’ trauma and mental disorders and to use clinical, individualized approaches to healing and reintegration. This essay challenges this medicalized, deficits approach and argues for a more holistic, relational approach that features the agency and resilience of young people and the communities into which they return following the armed conflict.

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The limits of clinical, deficits focused approaches

Clinical approaches to healing former child soldiers typically define the problem as mental disorders such as Post-Traumatic Stress Disorder, depression, anxiety, and related disorders. These are understood as individual disorders that negatively affect a person’s functioning and well-being, social relations, and views regarding peace. Treatment for these clinical maladies usually entails the use of Westernized therapies such as Cognitive Behaviour Therapy-Trauma, Narrative Exposure Therapy, or Interpersonal Therapy.

To be sure, these evidence-based therapies have their place in the healing and reintegration of former child soldiers. Yet they are far from comprehensive, and they frequently lead to decontextualized approaches that may not address the lived experiences of former child soldiers. For example, girls who had forcibly been recruited in sub-Saharan Africa and had been sexually abused by their captors often become young mothers inside the armed group. When the fighting has ended, their highest priority is usually to insure their children’s well-being. Living in collectivist societies, they do not view their suffering in individual terms but in relational terms—to be well means to be a good mother and to provide for the children’s food security, health care, education, and so on (McKay et al., 2011). They see their problem not as trauma or depression but as their lack of livelihoods and inability to care properly for their children. Members of the family and the community, too, tend to see the young mother’s well-being and prospects for reintegration as tied to her ability to perform well in the expected role of mothering.

Clinical approaches tend to overlook the felt priorities of former child soldiers. Formerly recruited children tend to identify two nonclinical problems—lack of livelihoods and stigma (Betancourt et al., 2019)—as their greatest concerns. The lack of income creates significant everyday distress and disrupts their abilities to find a meaningful role and place in civilian society. Some return to armed groups or become mercenaries as a result. Also, many former child soldiers identify stigma as their greatest source of suffering and a significant impediment to successful reintegration. Well intentioned mental health approaches can inadvertently increase the burden of stigma for former child soldiers. To be viewed as “crazy” by seeking mental health care can add significantly to the stigma associated with having been part of a group that had attacked and killed villagers. From a Do No Harm perspective, then, narrow clinical approaches should be viewed critically.

Westernized, clinical approaches typically overlook or even marginalize local idioms of distress and Indigenous approaches to healing and reintegration. The importance of these came home to me during the Angolan wars, where former child soldiers were being reintegrated without attention to Indigenous cosmologies. In discussions about their situation, former child soldiers identified spiritual issues as their greatest problem. A 14-year-old boy, for example, said he could not sleep because he had killed a man, whose spirit came to him at night and asked “Why did you do this to me?” In the boy’s culturally constructed understanding, the spirit was very powerful and could kill him or jump into and harm other people. A significant part of the boy’s stigma was grounded in community perceptions that he was spiritually contaminated,
making reintegration impossible. Fortunately, the children in different provinces identified traditional healers, who conducted communalized ‘cleansing rituals’ that ridded children of their spiritual impurities and restored harmony between the living and the ancestors. The conduct of these rituals as part of a wider integration process played a key role in enabling the community acceptance of the former child soldiers, thereby significantly improving their social relations and enhancing their prospects for reintegration (Wessells & Monteiro, 2001).

Clinical approaches tend also not to support children’s agency since it is adults who diagnose the problem, decide the intervention, and administer the therapy. Yet agency is a fundamental determinant of children’s well-being and sense of dignity, and enabling children’s agency can enable children’s own creative thinking about how to achieve reintegration.

**Toward a relational, resilience approach**

The outlines of a more agentic, relational, and resilience oriented approach to healing come from participatory action research with young mothers conducted in Uganda, Sierra Leone, and Liberia 2006-11. This work, which included a mix of urban and rural sites, was facilitated by 11 international NGOs who worked with four international researchers (including myself) under the leadership of Susan McKay (McKay et al., 2011). The effort centered around the knowledge, decision making, and collective action of formerly recruited young women (approximately 16-24 years), many of whom had become mothers while inside the armed group.

Before the action research, the young mothers were badly stigmatized, as many of them had been with rebel groups that had attacked villages, and their children had been born out of wedlock. Many young mothers survived by means of sex work, and most were concerned about their inability to earn sufficient money to enable their children to obtain education or health care. Community members said that many of the young women were like animals who fought, drank, and engaged in unruly behaviour. The young women sat literally and figuratively at the edge of their communities but could not attend or speak at community meetings.

In a total of 22 different communities, the formerly recruited young mothers met in groups of approximately 25 people and discussed their situation and their needs, with the young mothers themselves deciding what and how to discuss. For several months, the young mothers talked about their situation and mostly about their future in a mutually supportive way. Having decided that their principal needs were economic, the young mothers explored diverse livelihoods options and received basic business training to support their efforts. Together with community advisors and NGO facilitators, the young mothers learned about the local economies and which approaches were likely to succeed. With the aid of small grants, most groups decided to engage in group economic activities such as raising and selling goats, baking and selling baked goods, hairdressing, or collaborative farming. Other groups decided to enable individual livelihood activities such as doing petty business or selling soap. As the young mothers worked over the next two years, trusted community advisors worked with their respective communities to raise awareness of the situation of the young women and their children, and to call attention to their self-guided efforts to be effective mothers and good community members.

Both survey and ethnographic data indicated a significant transformation in the behaviour and the social relations of the
young mothers and their children. The young mothers ended their involvement in sex work and engaged in respected economic activities. Communities accepted the young mothers, who were seen as ‘serious’ and ‘good mothers,’ and who were able to participate in community meetings and activities. The young mothers’ children were also accepted as they attended school and played regularly with neighbors’ children. This social healing and reintegration, coupled with the ongoing peer support that the young mothers provided for each other, enabled the young mothers to feel confident, valued, and hopeful about their future. To be sure, challenges remained, as some young mothers struggled with husbands who were jealous of their wives’ earnings and increased status. Also, the livelihoods work of some young mothers was impaired by difficult economic circumstances and currency fluctuations. Yet the results show the power of the young mothers’ agency, the relational dimensions of healing, and the resilience of the young mothers and their communities.

The importance of social relations and collective resilience in the reintegration of former child soldiers was evident also in work done by Christian Children’s Fund (now ChildFund) following the end of the decade-long war in Sierra Leone (Wessells & Jonah, 2006). In Koinadugu District, young men who had fought on opposite sides of war were returning to the same communities, where local people feared the ex-combatants and were highly stressed over concerns that fighting would re-erupt. A high priority was to build positive relations between the ex-combatants from different sides and between the communities and the ex-combatants.

To address this situation, communities engaged in dialogues about the situation of their children and what was needed to support them. Each community also selected a project such as repairing a damaged health post or rebuilding a school as a means of helping their children. Next, men who were skilled at working with youth conducted cross-group dialogues with former young male soldiers who had a peaceful orientation and were willing to dialogue and work which youth on the other side. The former soldiers agreed to cooperate as part of work crews that would implement the community selected project. As the former youth soldiers worked, they earned a stipend, which they said was essential in enabling them to leave the military and to carve out a new life as civilians. Equally important, as the young men repaired the health post or rebuilt the school, community people observed them giving back to their communities, thereby providing a sense of restorative justice. As the young men collaborated, positive relations increased across the group lines and also between the ex-combatants and the community people. As community tensions decreased, people reported having an increased sense of well-being, and they also said they had begun to see the connections between their own community situation and peace, which had previously seemed to be an abstraction. This work illustrates how peacebuilding processes and psychosocial well-being go hand in hand, with each reinforcing the other. It also illustrates how collective action and community resilience can help to build positive social relations and well-being.

Both these examples illustrate the wider point that healing is not all about addressing trauma and working at the individual level but also entails work to repair social relations and enable community resilience. They also show the importance of a holistic approach that interweaves social, and psychological processes. To be sure, comprehensive reintegration efforts must include specialized psychological support for people who have mental
disorders, which complements more socially oriented efforts. Yet our work on healing should be as much about repairing social relationships and enabling relational resilience as on addressing individual wounds of war.

This paper also underscores the importance of livelihoods, which are crucial for not only meeting survivors’ basic needs but also enabling their ability to function well in society. In most conflict-affected settings, people have a collectivist orientation and see themselves as well only if they are able to help support their families. Having a livelihood enables survivors to help meet their families’ basic needs and also to achieve a positive social role and status that improves their social relations. In many settings, to have cash that one has earned is to be a productive person and a contributing family and community member. Particularly in settings of deprivation and chronic poverty, livelihood supports should be seen as necessary components of a holistic approach to enabling survivors’ well-being.

References
Violence against women is perhaps the most shameful human rights violation, and it is perhaps the most pervasive. It knows no boundaries of geography, culture, or wealth. As long as it continues, we cannot claim to be making real progress towards equality, development and peace.

These were the words of former United Nations Secretary-General Kofi Annan in 1999 addressing the Inter-Agency Videoconference for a World Free of Violence against Women. He emphasized that the United Nations was doing something to combat such abuse, referring to States having “adopted international instruments prohibiting violence against women” and the International Criminal Tribunal for Rwanda defining rape as a crime of genocide. (Annan, 1999). Kofi Annan made these comments at the end of nearly a decade of attention to violence against women by UN bodies. The topic was addressed and refined during that time as a result of efforts by feminist lawyers, NGO representatives, government delegates, special rapporteurs and independent treaty body experts. Many of them criticized that, despite the prevalence of violence against women, the leading legal instrument aimed at preventing and punishing torture and ill-treatment, the 1984 Convention against Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment (“the Convention”) (UN, 1984) and its monitoring committee, the Committee against Torture (“the Committee” or “CAT”), seemed to ignore addressing the violations faced by women, primarily because of the definition of what constitutes action by a “public official” (Byrnes, 1992; Copelon, 1994; Joachim, 2003; Edwards, 2006; 2011; Hall, 2014).

In this article, we will examine how the official treaty monitoring body, the Committee against Torture, demonstrated that violence against women was indeed a serious human rights problem that fell squarely within the purview of the Convention against Torture. Because States parties to the Convention are required to report about their compliance with the Convention routinely, the Committee developed a substantial data base on national practices and policies. In the course of examining these periodic reports of States parties, and then consolidating findings and conclusions into two general comments, the UN Committee Against Torture integrated violence against women in its jurisprudence on torture and ill-treatment by showing that existing provisions could and did incorporate the obligation to protect against and provide redress for torture and ill-treatment directed against women. Initiatives to raise these issues show how the Committee “placed the range of gender violence—from public to private –
squarely within the frame of the Torture Convention” (Copelon, 2008, 242). The article will recall how the adoption of two general comments to the Convention firmly integrated gender-based violence as a subject of concern under the Convention: General comment no 2 (2008) addressed Article 2 on the State obligation to prevent torture and ill-treatment and General comment no 3 (2012) focused on Article 14 which concerns the obligation to provide redress to victims of torture.

Both authors have been members of the Committee during these important years¹, and it is our aim to provide an overview of the significant processes and decisions taken by the CAT that resulted in the strengthening of the Committee’s inclusiveness and comprehensiveness in the struggle to prevent torture. Finally, we will reflect on some future challenges faced by main anti-violence bodies as part of global efforts to fight violence against women.

**Early steps**

Violence against women was not understood to be a violation of women’s human rights until the 1990s. While “battered women and violence in the family” were mentioned in the Program of Action from the 1980 Copenhagen World Conference on Women, the subject was presented primarily as a “physical and mental health issue” affecting abused victims. In 1985, the Nairobi Forward Looking Strategies described violence against women as an “obstacle to the achievement of peace” – whose victims needed attention, again in the context of health, not human rights, physical integrity and certainly not torture. States were urged to prevent violence against women, assist the victims, and provide education.


Reports of rape and other abuses against women in the armed conflicts in Rwanda (1990-1994) and former Yugoslavia (1991 – 1995) brought even more attention to the subject (UN, 1993a). Seeing the issue as the closest to physical integrity issues and the kinds of violations already addressed by human rights bodies and finding widespread agreement in all world regions about the prevalence of this form of abuse, NGOs made it the centerpiece of their advocacy aimed at the June 1993 World Conference on Human Rights. There, the Vienna Declaration and Program of Action (VDPA) (UN, 1993c) declared that abuses against women were “an inalienable, integral, and indivisible part of universal human rights”. Significantly, the VDPA called for adoption by the UN General Assembly of a Declaration on Violence against Women and for the Commission on Human Rights to appoint a special rapporteur (an independent expert) to study and report on violence against women.

¹ Felice Gaer was elected a member of CAT in 1999 and served until December 2019, much of it as Vice-Chairperson. Nora Sveaas was elected in 2005 and served until 2013. From 2014 until today she has been a member of the Subcommittee on Prevention of Torture (SPT).
against women. Both recommendations were approved soon after Vienna, and the topic of violence against women was slated as a major topic for the 1995 Beijing World Conference on Women (UN, 1998a). Indeed, the Beijing Platform for Action devoted more than 25 pages to the issues of violence against women, trafficking, and armed conflict. Significantly, the Beijing world conference also called for accountability of the perpetrators as well as assistance to the victims. Beijing’s Platform further identified a wide range of abuses as forms of violence against women, and asked for them to be prevented, criminalized, and punished. These included: female genital mutilation, rape; sexual abuse and harassment; trafficking in women and forced prostitution; forced sterilization and forced abortion; female infanticide; murder, rape, sexual slavery and forced pregnancy in armed conflict; as well as physical, sexual, and psychological violence in the family, including battering.

Observers began to remark on the failure of the Convention against Torture and its monitoring body to address violence against women. For example, international law scholar Andrew Byrnes in 1992 suggested that women’s experiences are neglected both in international legal provisions and interpretations of torture, in large measure because the definition in the Convention against Torture focuses on direct violations by State actors (public officials), a conceptual framework that “renders invisible…many of the objective violations that women suffer” from private actors (Byrnes, 1992). Byrnes argued that many of these violations were acts affecting women in the family, unfortunately considered by the drafters of the Convention to be private and outside the purview of state officials. Consequently, Byrnes argued that abuses directed against women were notably absent in the work of the Committee against Torture in its early years of activity. Moreover, he added, the Committee had not even addressed case examples of violations that women suffer in the public sphere. He called on CAT members, at a minimum, to “ascertain whether there are particular forms of torture or other ill-treatment which are directed mainly against women” (Byrnes, 1992; Gaer, 1998).

Convention against Torture and its monitoring committee, CAT

Observers and practitioners may not be familiar with the distinctiveness of the Convention against Torture and the scope of responsibilities and authoritative status of its monitoring body, the Committee against Torture (“CAT” or “the Committee”). The Convention against Torture, recognizing that torture was prohibited in international law, obligated all states that ratify the 1984 treaty to “take effective legislative, administrative, judicial or other measures to prevent” acts of torture or ill-treatment. Such ratification thus entails a wide range of obligations for States. The Convention itself mandated creation of a “Committee against Torture,” a body composed of 10 independent experts who are elected by the States that have ratified the Convention. In addition to the consideration of state reports, the CAT has the mandate to receive individual complaints on torture and to undertake inquiries when systematic torture is alleged (OHCHR, 2022).

All States parties are required by the Convention’s article 19 to provide an initial report within one year of ratification. Thereafter, reports must be submitted every four years describing measures taken to prohibit and prevent torture and ill-treatment. Questions are raised by the Committee members to the state representatives, and the replies from the state are presented in public meetings. Based on this exchange, called a “con-
constructive dialogue,” concluding observations are formulated and adopted by CAT, submitted to the States, and made public. In this way, the Committee, which the Convention authorizes to “establish its own rules of procedure,” sets forth its understanding of what constitutes “effective measures” to implement the Convention’s prohibition on torture and ill-treatment (Sveaass, 2017).

General comments of a human rights treaty body constitute an interpretation of the treaty by the expert bodies mandated to oversee its implementation, reflecting findings and conclusions by the relevant treaty body’s experts that result from their examinations of State party reports and other decisions. In this sense, general comments both consolidate the substantive case-by-case, country-by-country findings of the treaty body, and also reflect interpretive insights that are gained from the treaty body’s in-depth examinations of the States parties’ experiences of seeking to comply with their treaty obligations (Gaer, 2008).

The general comments adopted by CAT not only set out general obligations of states to prevent torture and ill-treatment and to provide redress, but also clarify some specific obligations of states in relation to violence against women under the Convention against Torture. As such, these general comments present significant guiding principles for tackling violence against women in the context of torture. As former Special Rapporteur on Torture Theo van Boven has written, the general comments adopted by the Committee against Torture “must be appreciated as an authoritative statement ‘in response to evolving threats, issues and practices’” (van Boven, 2008).

**Human Rights Secretariat asks why CAT ignores violence against women**

In 1998 the Office of the UN High Commissioner for Human Rights (OHCHR) published a “Report by the Secretary-General” examining how various UN bodies, including five treaty-monitoring bodies, addressed and integrated gender related concerns into their jurisprudence (UN, 1998b). The report, entitled “Integrating the gender perspective into the work of the United Nations human rights treaty bodies”, in its second part summarized the steps that had been taken by human rights treaty “bodies to increase attention to gender aspects in their work” and suggestions were made with regard to areas where more efforts were required and further attention to the gender dimension needed.

According to the Secretary-General’s report, CAT’s involvement with issues demonstrating gender sensitivity were minimal, indeed barely existing. The 1998 review concluded that, “over a five-year period, during which the situation in approximately 60 different States parties was examined, none of the Committee’s concluding comments made reference to the situation of women. This is particularly noteworthy as Committee members have either asked specific questions or made comments focusing on women or gender issues in approximately one fourth of the reports considered” (UN, 1998b, 50).

This 1998 report reflected further on what CAT could and should be addressing: “... there are a number of issues the Committee could raise. In this regard, guidance can be obtained from the Platform for Action adopted at Beijing. Two of the areas discussed in the Platform, violence against women and women and armed conflict, contain provisions and recommendations that are pertinent to the Convention and the Committee’s work.” (UN, 1998b, p. 44). The issues that had been raised in the
context of CAT addressed a) rape and sexual offences; (b) segregation of male and female prisoners; (c) situation of pregnant women.

In other words, despite the initiatives and adoptions referred to above, the Committee against Torture was not addressing violence against women, whether in peacetime as in war, as constituting torture or cruel, inhuman, or degrading treatment or punishment falling under the Convention against Torture.

The absence of attention to violence against women by CAT was also criticized precisely because other authoritative UN bodies had addressed the issue so strongly in the years just before the Secretariat’s report.²

International courts and tribunals paved the way for a stronger focus on sexual violence in conflict as war crimes and crimes against humanity. In 1993 the Statute of the International Criminal Tribunal for the former Yugoslavia included, as already noted, rape as a crime against humanity, as well as the crimes of torture and extermination. The International Criminal Tribunal for Rwanda (ICTR) decided that rape constituted a war crime and a crime against humanity and was the first international court to find an accused person guilty of rape as a crime of genocide. Finally, the Rome Statute of the International Criminal Court, in force since July 2002, includes wartime sexual violence in its list of crimes against humanity and war crimes (art. 7 & 8) and defines sexual violence as “rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence of comparable gravity” (Roma Statutes, 1999; Prinn, 2021).

International law expert Alice Edwards explained that this activity reflected a focused attempt to place these abuses within mainstream norms and institutions that resulted in “some significant advances…towards guaranteeing protection against and redress for women-specific and women-related torture and other forms of ill-treatment.” (Edwards 2006, 350-51). Edwards found that “there has been an attempt to update traditional notions of torture to their contemporary setting.”

The Convention against Torture and violence against women

The Committee against Torture later took some small steps to address acts of torture or ill-treatment directed against women. In a review of Tunisia in late 1998, CAT expressed concern over reports that female relatives of detainees had been “subjected to violence and sexual abuses” or threats to punish their relatives, by public officials or their agents (UN, 1999, para 99); while concluding observations cited this as a concern, no specific recommendation was made in this regard. Later, in May 2000, the Concluding observations on the review of China’s report to CAT expressed concern over gender-based violence against women conducted by State officials. CAT stated: “The Committee expresses concern about reports of coercive and violent measures resorted to by some local officials in implementing the population policy of the

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² The widespread rapes of women during the war in the former Yugoslavia galvanized global attention: The Security Council’s Commission of Experts to investigate violations of international humanitarian law in the former Yugoslavia (Resolution 780, 6 October 1992) identified systematic sexual assault as a priority in its report. (UN, 1993a; UN, 1998) and the Council’s resolution 798 (18 December 1992) which identified “massive, organised and systematic detention and rape of women, in particular Muslim women, in Bosnia and Herzegovina” as “acts of unspeakable brutality” and urged further investigation. The Commission of Human Rights appointed a special rapporteur on violence against women whose medical experts concluded that the sexual violence served as “instruments of ethnic cleansing” (UN, 1993b; UN, 1998).
State party, contrary to the relevant provisions of the Convention” (UN 2000, para 122). While the Committee identified concern over this practice, it did not carry over this concern – referring both to reports of routine coerced sterilizations and forced abortions by public officials --into a specific recommendation. Nonetheless, its presence in the section on concerns marked a major step, recognizing these forms of gender-based violence against women and that they fall under the Convention’s purview. As recounted elsewhere (Gaer, 2021) the Committee chair initially resisted any reference to this subject – claiming it had no relationship to the Convention itself – but relented after a member offered a detailed explanation of why it fit firmly within the purview of the Convention and the country rapporteur on the China review also expressed support.

In 2001, the Committee expressed concern about domestic violence and trafficking in its conclusions on Greece and Georgia, both of which were urged to take measures to prevent and punish violence against women (UN, 2001), and more of this followed. Not long after, the Committee began to consider preparation of a general comment on article 2 of the Convention, which specifies that states parties have an obligation to “take effective legislative, administrative, judicial or other measures to prevent acts of torture.” In 2005, two new female members were elected to the Committee, bringing the total number of women to three. Questions about treatment of female detainees and about government failure to protect victims of rape and other forms of violence against women not only proliferated but were increasingly reflected in the conclusions of CAT.

In 2006, Alice Edwards concluded that “the Committee against Torture now openly views women-specific or gender-related harm as being of the same nature or severity as torture under article 1 of the UNCAT.” Among the topics she cited that appeared in the CAT conclusions were female genital mutilation, forced abortion, forced marriage, rape, and domestic violence (Edwards, 2006, p. 370).

**General Comment 2 on effective measures to prevent torture**

In 2004, members of the Committee against Torture began to draft a general comment to clarify the “distinct interrelated and essential principles that undergird the Convention’s absolute prohibition against torture” in Article 2 of the Convention. This effort, which would conclude in November 2007, addressed the obligations set forth in the text of the treaty as to what constitute “effective legislative, administrative, judicial and other measures to prevent acts of torture.” General Comment No. 2 (“GC2”) not only collected and summarized the Committee’s experiences from its first 15 years of reviewing country compliance with the Convention, but also offered States parties a guide for future reporting and action in accord with their treaty obligations (UN, 2008; Gaer, 2008; 2013). As Professor Rhonda Copelon wrote: “The General Comment is particularly significant because it consolidates this understanding as the considered and formal interpretation of the Convention against Torture that will guide its review of State reports. It thus encourages non-governmental submissions respecting gender violence, signals an end to the era of discriminatory application of the norm of torture as well as underscores the urgency of State responsibility to exercise due diligence to prevent, punish and eliminate it” (Copelon, 2008, 243).

GC2 of CAT notably points out that States bear international responsibility not only for the acts but also for the omissions of their offi-
cials as well as the acts of State agents, private contractors, and others acting in official capacity or on behalf of the State or under its direction or control. It points out that each State party has obligations to prohibit, prevent and redress torture and ill treatment in a wide variety of contexts in which it has control: this can include prisons, hospitals, schools, institutions that care for “children, the aged, the mentally ill or disabled, in military service, and other institutions as well as contexts where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm” (para 15). GC2 thus clarifies the Committee’s longstanding practice of inquiring as to how the Convention applies outside prisons and that the Convention is engaged by the failure of State officials or their agents to prohibit, prevent or redress torture and ill-treatment in these diverse contexts.

GC2 clarifies that a systematic failure to provide protection against ill-treatment or torture and to hold the perpetrators accountable would engage the Convention’s attention. It also emphasizes the Committee’s practice of addressing such situations “where State authorities or others […] know or have reasonable grounds to believe that acts of torture or ill-treatment are being committed by non-State officials or private actors and they fail to exercise due diligence to prevent, investigate, prosecute and punish […]”. It explains that such inaction becomes a “form of encouragement and/or de facto permission” (18).

GC2’s explicit discussion of the concept of due diligence clarifies that systematic failure to protect persons from torture or ill-treatment amounts to acquiescence, and that the Committee’s monitoring includes examining both private violence and public responses to it.

Article 1 of the Convention against Torture identifies prohibited acts set forth in the definition when carried out for “any reason based on discrimination of any kind […]”. GC2 explains that laws on obligations under the Convention must be “in practice applied to all persons” regardless of such factors as race, age, religious belief or affiliation, gender, sexual orientation, transgender identity, mental or other disability (para 21). In keeping with the concept of due diligence, GC2 specifies that each State party has an obligation to protect members of these or other groups especially at risk of torture “by fully prosecuting and punishing all acts of violence and abuse against these individuals […]” (para 21). GC2 makes it clear that private individuals and groups made vulnerable by discrimination must be protected under the Convention.

Also explained by GC2 is the view that “The contexts at which women are at risk include deprivation of liberty, medical treatment, particularly involving reproductive decisions, and violence by private actors in communities and homes […]” (para 22). Significantly, CAT asks States parties to identify such situations and report on the measures taken to punish and prevent them.

Article 2 not only obligates States parties to take administrative, legislative, judicial, and other measures to prevent torture, but also that these measures must be effective. CAT calls on States to re-evaluate preventive measures for their effectiveness and to revise and replace them as needed.

GC2 further informs States parties that, under the Convention, “effective measures” require more than words: they require continual evaluation. Such evaluation is to be conducted by CAT, which requires information about compliance with the norms of the Convention in regular periodic reports from the States parties (para 23). Moreover, it specifies that such information should include disaggregated data to enable the Committee to identify, compare and recommend steps that would
otherwise go unnoticed and unaddressed. This has enabled CAT’s ongoing monitoring of acts of torture or ill-treatment which were once invisible – for example, domestic violence, rape, trafficking, and other items mentioned in GC2 itself.

The impact of GC2 has been substantial. The Committee expanded its attention to violence against women, and routinely referenced different manifestations of this abuse in its examination of States parties reports and the conclusions and recommendations that resulted. Data is requested in lists of issues sent in advance of the submission of reports and questions are commonly raised to follow up on this in the “constructive dialogue” between CAT members and the State party’s delegation. The number of such references to diverse aspects of violence against women rose dramatically after the adoption of GC2 (Gaer, 2012, p. 1111-1113). Again, in the words of Rhonda Copelon, “The General Comment combines both an important theoretical as well as practical approach to monitoring the broad range of gender violence… It underscores the urgency of and the priority that must be given to the project of prevention” (Copelon, 2008, p. 263).

**General Comment 3 on the right to redress and violence against women**

In 2012, CAT adopted another General Comment: it deals with the right to redress, which is one of the distinctive elements in the Convention against Torture. The right to redress for victims of torture is formulated in Article 14 as the obligation of each member state to “ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible” (UN, 1984, art. 14). General Comment No. 3 (GC3) (UN, 2012), highlights that “redress” refers both to effective remedy and reparation, and that the “reparative concept therefore entails restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition and refers to the full scope of measures required to redress violations under the Convention” (GC3, para 2).

The range of reparative measures, as summarized by GC3 is wide. GC3, based on the jurisprudence of CAT, defines, and provides advice on reparative measures for victims of gender based/related violence, and the conditions under which such violence is considered acts of torture. GC3 notably clarifies the responsibilities of States parties both in relation to violence against women, including domestic violence and violence by non-state or private actors – namely the obligations to prevent, to protect, to investigate, to punish perpetrators (all discussed earlier under GC2) and the obligation to provide redress, reparation and/or rehabilitation to victims of such violence (Sveaass, Gaer & Grossman, 2020).

GC3 spotlights some of the principles and requirements of the right to redress as laid out in GC3, with a special focus on violence against women. First, the principle of non-discrimination is essential to ensure that victims of torture or ill-treatment in fact can enjoy the right to redress. The Committee “considers that article 14 is applicable to all victims of torture and acts of cruel, inhuman or degrading treatment or punishment (hereafter “ill-treatment”) without discrimination of any kind, in line with the Committee’s General Comment No. 2” (GC3, para 1). GC3 reiterates that structural violations linked to various forms and grounds of discrimination, such as gender, sexual orientation, disability, political or other opinion, ethnicity, age, and religion, must be addressed, to ensure that the access to restitution is not denied due to discrimi-
natory reasons (GC3, para 8). The need to establish effective rehabilitation services and programs in each State party is paramount. These must be accessible for victims without discrimination and take into account variations in victims’ “culture, personality, history and background” (GC3, para 15).

Ensuring redress, including rehabilitation, after acts of violence against women, requires the existence of fair and non-discriminatory procedures both in judicial and non-judicial proceedings. GC3 refers to the need for gender sensitive procedures, impartial judiciary and equal weight to be given to the testimony of women and girls, as it should be for all other victims, as these are essential to avoid “re-victimisation and stigmatisation of victims of torture or ill-treatment” (GC3, para 33).

The Committee further considers that “complaints mechanisms and investigations require specific positive measures which take into account gender aspects in order to ensure that victims of abuses such as sexual violence and abuse, rape, marital rape, domestic violence, female genital mutilation, and trafficking are able to come forward and seek and obtain redress” (GC3, para 33).

CAT advises States to establish and fully guarantee in national legislation the rights to redress of victims of torture and other cruel, inhuman, or degrading treatment to enforce this right.

In GC3, weight is given to the requirement to use gender sensitive approaches to train “relevant police, prison staff, medical personnel, judicial personnel and immigration personnel, including training on the Istanbul Protocol” (GC3, para 34, 35). Similarly, GC3 emphasizes the need to prepare health and medical personnel to inform victims of gender-based and sexual violence about the availability of physical as well as psychological emergency procedures. For example, in the Concluding observations on Chile, CAT advised the State to “incorporate a gender policy encompassing training and awareness-raising for the officials responsible for dealing with the cases of victims of assault or sexual violence; increase the efforts in regard to repARATION, compensation and rehabilitation so as to ensure fair and appropriate reparation for all victims of torture” (UN, 2009a).

The need to highlight the obligation regarding training on gender related issues, was based upon CAT’s observations over the years that lack of preparedness, lack of gender informed approaches and lack of knowledge in the health care system as well as in the police and judiciary systems represent serious obstacles for women subjected to violence to come forth with their experiences and claims. In general, the adoption of GC3 clarified the Committee’s positions on violence against women, including by defining victims of such violence as entitled to redress, compensation, and rehabilitation.

As referred to above, the failure of the State to prevent and protect victims from gender-based violence, such as rape, domestic violence, female genital mutilation and trafficking, is considered a violation of the obligation to prevent such impermissible acts, and, as such, as a violation of the Convention (GC2, para 18). It follows from this that the right to redress is established for individuals where the State’s failure to protect has resulted in acts of torture or ill-treatment, including at the hands of non-state actors. GC3 refers to this in paragraphs on restitution (8), on guarantees of non-repetition (18) and on the right to redress (7).

CAT’s recommendation to Portugal called for it to “Ensure that all cases of gender-based violence, especially those involving actions or omissions by State authorities or other entities which engage the international responsi-
bility of the State party under the Convention, are thoroughly investigated, that the alleged perpetrators are prosecuted and, if convicted, punished appropriately, and that the victims or their families receive redress, including adequate compensation” (UN, 2019c, para 42). In this way, CAT draws attention to the principle that both State action and failure to act – omissions – fall under the purview of the Convention and that States need to recognise their obligation to avoid both leading to torture or ill-treatment.

The rights to redress for women exposed to forms of sexual violence perpetrated during armed conflict have been raised regularly by the CAT. When Peru’s report was considered in 2013, (UN, 2013a), CAT referenced “underreporting of cases of sexual violence against women and girls during the armed conflict, the limited number of investigations, the absence of sentences and the lack of effective redress to victims of sexual violence during the conflict….”

GC2 pointed out (UN, 2008 para 22) that women and girls are at risk of torture or ill-treatment in the context of medical treatment, particularly involving reproductive decisions. Violations of reproductive rights may include rights to legal abortions or denial or even criminalization of abortions, forced abortions, forced sterilizations, treatment of women in labor. Recommendations have been provided to Peru (UN, 2013) and Slovakia (UN, 2015) with regard to forced sterilizations. The fact that women are denied abortions after incest and rape, even in situations where the mother herself is only a child, and the criminalization of doctors who perform abortions after such violations, as well as of the women, have been raised as issues of serious concern in the reviews of Nicaragua (UN, 2009b), Paraguay (UN, 2011), Poland (UN, 2013b; 2019b), Niger (UN, 2019a) and others. And as noted earlier, CAT’s Concluding observations on China (UN, 2016) cited concern over “Use of coercive measures in the implementation of the population policy”.

Like GC2, GC3 has had great impact, principally on redress and rehabilitation for victims of torture and ill-treatment. The way that redress, in its different forms were laid out in the general comment, as well as the groups for whom redress was defined as a right, has contributed to a strengthened and more nuanced awareness about the obligations under art 14.

Below, we look into some of the work and challenges facing CAT following the adoption of the two general comments as well as the higher profile of gender-based issues in the Committee’s ongoing work.

Approaching violence against women – from the perspective of torture- takes root

As CAT was refining its attention to gender-based violence and its relevance to torture and ill-treatment in the early 21st century, many stakeholders took notice of these developments. For example, in 2008, the City University of New York’s Law School held a symposium that focused on CAT’s GC2 and its significance regarding gender-based violence against women (Gaer, 2008). Two former special rapporteurs on torture, the gender adviser to the ICC Prosecutor, and two CAT members, participated along with several academics. The Special Rapporteur on Torture, Manfred Nowak, organised a workshop in September 2007 on “Strengthening the protection of women from torture” which was incorporated in his 2008 report to the Human Right Council (UN Special rapporteur, 2008). The report included chapters on torture and ill-treatment of women in the public sphere as well as in the private sphere. On torture and violence against
women Nowak concluded: “In regard to violence against women, the purpose element is always fulfilled, if the acts can be shown to be gender-specific, since discrimination is one of the elements mentioned in the CAT definition. Moreover, if it can be shown that an act had a specific purpose, the intent can be implied” (para 30; p. 7). His report also addressed justice, rehabilitation and reparation for women survivors of torture. The Rapporteur’s report was important in the later discussions in CAT and has also frequently been quoted and referred to in discussions on women, violence and torture (see Mendez & Nicolescu, 2017). In her 2014 book on the gender dimensions in relation to torture, Ronli Sifris described some of the steps forward on ways the Committee dealt with gender related issues and reproductive rights under the Convention (Sifris, 2014).

CAT’s GC3 was the centerpiece of a Chatham House program on redress and rehabilitation (Gaer, 2013). Members of CAT were invited to brief other UN experts on their efforts — including treaty committees like CEDAW and special rapporteurs, at their annual meeting of experts. NGOs began to advertise that CAT was a forum to consider with regard to documentation on gender-based violence against women. For example, the highly regarded University of Minnesota Law Library’s human rights documentation website featured a page on sexual violence against women which stated “Women’s advocates may use the Committee against Torture and other cruel, inhuman or degrading treatment or punishment” to promote women’s rights…” It explained that “The Committee against Torture” views violence against women, including sexual violence and trafficking, as gender-based acts of torture and within the purview of the Committee” (Human Rights Library, 2003).

Similarly, a blog at the London School of Economics highlighted that “The UN Special Rapporteur on Torture and the Committee against Torture have both acknowledged the devastating impact of violence against women and argued for its inclusion in the anti-torture framework” (see https://blogs.lse.ac.uk/vaw/int/treaty-bodies/convention-against-torture/).

In addition, the World Organization against Torture (OMCT) ran a feature series of video interviews that featured two CAT expert members timed to run on the international day to mark violence against women, November 25th, in 2017. While the remarks on these videos were made in the individual, private capacity of the members, each speaker reflected on the achievements of the Committee as a whole and spoke positively about measures to prevent violence against women that had been adopted by the treaty body.

Like other UN human rights treaty bodies, CAT’s membership rotates; each of its ten members are elected to 4-year terms of office. In 2015, there was high turnover at the CAT elections: out of 5 persons elected, 4 were new to the Committee. In 2017, when five others were up for election, three more new members were elected.

With so much change in Committee membership, some questioned — after years of progress— whether gender-based violence issues should continue to be addressed by the CAT or relegated to the CEDAW Committee. This has been a relatively common refrain heard by CAT members, and one which notably seems to marginalize the human rights of women rather than integrate those rights into the work

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3 “Felice Gaer and the UN Committee against Torture say no to violence against women.” Available online at https://vimeo.com/244666803 and “Nora Sveaass says no”, available online at https://vimeo.com/244371568 ]
of UN human rights mechanisms and treaty bodies. In fact, according to the World Organisation against Torture (OMCT), the non-governmental organisation that coordinates the presence and presentation of information by non-governmental organisations from all over the world at the meetings of CAT, a tendency exists in Geneva for human rights violations against men to be addressed by the general human rights treaty bodies, but “women’s human rights violations are dealt with by the UN Committee on the Elimination of Discrimination against Women...” (World Organization against Torture, 2018, p. 3).

**Clarifying progress on violence against women and torture in international human rights bodies**

Beginning in 2015, a series of briefings were initiated by CAT on topics on which it might offer conclusions and recommendations, and which were of concern for the CAT members either because of new cases, new data or new questions being asked. Between 2015-2019, 15 such sessions were held, including briefings on the right to rehabilitation, on non-repellent, on victim and witness protection systems, on overcrowding, on psychiatric institutions and on ill-treatment and children. When CAT members asked for a briefing on gender-based violence against women, the Secretariat invited a non-governmental group, World Organization against Torture, (OMCT) to organise it.

According to the concept note, a thematic briefing on “Protecting women from violence through the UN Convention against Torture” was conducted on 4 December 2018 for two meetings of the CAT (OMCT, 2018). The concept note explains: “The purpose of the briefing is to inform a discussion amongst members of the Committee against Torture (CAT) on the gender dimensions of torture and other cruel, inhuman, or degrading treatment or punishment and to explore together how the CAT can provide an enhanced prevention and protection framework for women and girls...” Further: “A major step forward came in January 2008 when the CAT adopted General Comment No. 2, clarifying in paragraph 18 that where State authorities fail to exercise due diligence to prevent, investigate, prosecute and punish non-state actors, “its officials should be considered as authors, complicit or otherwise responsible under the Convention for consenting to or acquiescing in such impermissible acts.” OMCT also referenced the important analytic contributions on gender-based violence against women of Special Rapporteurs on Torture, Manfred Novak in 2008 and Juan Mendez in 2016 (Mendez, 2016), as well as a number of case decisions in regional and international courts.

The briefing for Committee members was quite wide-ranging and compelling. It was sponsored by prominent non-governmental organisations, Women’s Link Worldwide and the World Organization against Torture (OMCT), and co-sponsored by Amnesty International and the Global Justice Center. Briefers were distinguished professionals in the field of torture prevention: The first major address was provided by the Special Rapporteur on Torture, Nils Melzer, who reminded the CAT members that gender-based violence against women was the result of “rampant discrimination” and often wrongly justified on the pretext of tradition, culture or religion. He discussed violence against women in both custodial and non-custodial settings and advised how and when rape constituted torture within the meaning of the Convention, and about States’ responsibility to ensure that their authorities exercised due diligence. A wide range of other forms of violence against women fall within the scope
of the Convention, he explained, from female genital mutilation, trafficking, domestic violence and early marriage to so-called honor crimes and exculpatory provisions for rapists. Denial of safe abortion services and the practice of forced sterilization also fell within the purview of the Convention. Significantly, the Rapporteur called on CAT to make it “absolutely clear” that gender-based violence against women “amounted to nothing less than torture” and to join him in recognizing that when States fail to exercise due diligence in preventing such practices, they become complicit in the commission of acts of torture and ill-treatment and incur international responsibility under the Convention (UN Document CAT/C/SR.1713, paras. 9-17).

The Special Rapporteur’s detailed presentation was followed by other experts, including a judge on the European Court of Human Rights, the President of the International Law Association, several academic experts and human rights advocates from diverse parts of the world and with diverse experiences, including with the CAT, as well as a member of the CEDAW Committee and a Special Rapporteur of the Human Rights Council (UN Docs. CAT/C/SR.1713 and CAT/C/SR.1714, 10 December 2018).

At the request of the Committee members, the World Organization against Torture (OMCT, 2019) subsequently prepared and published a summary of the briefing on its website. The briefing offered presentations and discussions with CAT members on torture against women under international law; trafficking in women and girls; rape and other forms of sexual violence; country cases; protection of women from torture; and access to justice and reparation, including rehabilitation.

A key take-away lesson of the briefing was that CAT’s efforts on gender-based violence were indeed substantial, very much in line with the jurisprudence of regional and international courts and mechanisms and had influenced the other bodies substantially. Briefers concluded it was “essential that the Committee should continue to systematically address gender-based violence against women in its work, and approach its mandate and work in a gender-sensitive manner” (CAT/C/SR. 1714, para 46).

This message was not lost on CAT members. In the days and sessions that followed, the CAT’s Chairperson often referred back to the definitive analyses offered by the many experts and jurists at the briefing. As a result, Committee members have continued to address gender-based violence against women as a form of torture or ill-treatment within the scope of the Convention.

**Future perspectives and reflections**

One question that has frequently been asked over the years, by a few States but by no means a majority and as well as certain Committee members, is whether CAT conclusions should be gender neutral and information on gender-based violence could be sent instead to the CEDAW Committee. The authors note that some of these objections are not substantive but reflect an ongoing concern about treaty body harmonisation and are actually about administrative streamlining of the treaty body system. We wish to emphasize again that the Beijing World Conference on Women affirmed that “women’s rights are human rights” and this understanding has been demonstrated time after time in the ongoing reviews and other work of CAT, as well as in other UN human rights bodies. Today, the gender mainstreaming agenda and policies of the UN are not optional and are certainly not open to be marginalized as in the past. Further, the scheduling of country reviews, the extensive reservations to the CEDAW convention, and the differing states parties that have ratified each treaty must
be borne in mind. If all gender-based violence issues were assigned to CEDAW, cases of gender-based violence could easily fall through the cracks of the human rights system. Furthermore, the authors of this article wish to point out the views of former Special Rapporteur on Violence Against Women, Rashida Manjoo, who recalled that so-called gender-neutral texts can themselves be gender-biased when they ignore or suppress attention to gender-based treatment or impact (Manjoo, 2004). On its 20 years journey, CAT has successfully and firmly integrated a gender perspective into their ongoing activities and they have elevated both the attention and responses to this previously ignored topic.

It is now recognised that violence against women and girls satisfy both the severity threshold for torture and the purpose or intent requirement, because of discrimination ‘of any kind.’ GCs 2 and 3 on articles 2 and 14 have provided guidance on gender-based violence that influenced other torture prevention bodies including regional courts, UN expert mechanisms, and the work of the Convention’s Subcommittee on Prevention. Significantly, the expert briefers demonstrated to everyone working in and with the UN Secretariat, CAT, and a wide array of torture prevention organisations, that blindness to women’s experiences of torture has been ended at the international level.

One of the important ways in which concerns and criticisms can be expressed, and states can be urged authoritatively how to protect and prevent violence against women, including by private actors, is for CAT to continue to focus on this issue routinely. How these questions are dealt with in the treaty body can have a considerable multiplier effect. The nature of information that is provided to CAT by NGOs changed when the Committee indicated an openness to discuss violence against women. Similarly, the kinds of issues the Secretariat staff members would prepare as background to inform CAT members has changed along with the increased Committee interest in issues such as rape, trafficking, domestic violence, and other forms of violence against women.

The inputs from and dialogue with civil society organisations have always been of priority to CAT as they often ensure that critical points and recommendations are disseminated and create pressure for implementation and follow-up. At the same time, CAT’s work and awareness on and interest in forms of torture and ill-treatment that affect women and girls have provided tools and inspiration for others working to eradicate torture at the national, regional and international levels, including non-governmental representatives and lawyers. Last but not least, recommendations of CAT have had an important influence on other torture prevention bodies as well as on governmental actors at the regional and national levels. We began this article with a quote by Kofi Annan, and we would like to end by reiterating that it is essential that the Committee against Torture continue its important efforts to apply the Convention in the global fight against “the most shameful human rights violation…. and perhaps the most pervasive.”

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Operational psychology, professional ethics, and democracy: a challenge for our time

Stephen Soldz

Abstract
The post-9/11 United States abusive detention and interrogation program brought attention to the critical roles of health professionals generally and of psychologists more particularly in the modern administration of torture and other detainee abuse. Over a decade of controversy in the American Psychological Association (APA) and an independent investigation finding APA collusion with the Bush administration’s torture and coercive interrogation programs led to 2015 policies restricting the activities of psychologists in national security interrogations and illegal detention sites like Guantanamo. This controversy expanded to evaluation of a broader set of issues regarding the ethical roles of psychologists in furthering military and intelligence operations, or what has become known as Operational Psychology. Controversy over the extent to which Operational Psychology activities are consistent with psychological ethics has expanded since 2015 with critics calling for policies restraining Operational Psychologists from involvement in activities that cause greater than trivial unstipulated harm, lack informed consent, or are absent plausible independent ethical monitoring (due, for instance to security classification). Operational Psychologists have pushed back against any constraints on their actions other than US law and government regulations.

This debate also raises a broader issue: are there limitations on the extent to which we, as members of democratic societies, can tolerate the use of psychological science and expertise to manipulate unwitting people?

Operational psychology, professional ethics, and democracy: a challenge for our time

The post-9/11 United States (US) abusive detention, interrogation, and (sometimes) torture program brought attention to the critical roles of health professionals generally, and of psychologists more particularly, in the administration of torture and detainee abuse. Health professionals assessed prisoner tolerance for interrogations and identified vulnerabilities to be targeted, attended to victims between episodes of abuse, monitored the physical and psychological effects of abuse, and researched the effects of torture. In the US, psychologists went so far as to develop and administer “enhanced interrogation” torture techniques for the Central Intelligence Agency (CIA; Senate Select Committee on Intelligence, 2014).

There has been considerable controversy regarding the appropriate roles for psychologists in interrogations and military and intelligence operations more broadly. Military psychologists and their allies have defended past actions by their colleagues and oppose any restrictions on psychologists other than
those embodied in US law. However, after a decade of internal conflict and an independent investigation of the organisation’s complicity (Hoffman et al., 2015), the leading US psychological organisation, the American Psychological Association (APA), followed psychiatrists and medical professionals in 2015 by issuing a policy banning psychologists from any direct involvement in national security interrogations as well as any involvement with detainee affairs at detention sites, like Guantanamo, judged by the United Nations to be operating in violation of international law (Aldhous, 2015a, 2015b; American Psychological Association, 2015). These policy changes moved the APA toward the position of their psychiatrist colleagues in the US and worldwide—that psychiatrists should have no direct role in interrogations, whether for national security or law enforcement purposes (American Psychiatric Association, 2006; Pérez-Sales et alt 2017, Miles, 2017; Soldz, 2017).

The decade of controversy regarding the proper role of psychologists in national security detention and interrogations has also raised broader questions about the ethics of Operational Psychology, the speciality area in which psychologists participate in furthering military and intelligence operations (Palarea, 2007; Staal & Harvey, 2019; Staal & Stephenson, 2006; Williams et al., 2006). In addition to interrogation support, Operational Psychologists participate in personnel selection, including for high-risk missions; monitor mock torture “resistance” trainings; assist hostage negotiations; and destroy adversaries’ reputations via manipulation of online messages; among other activities. While definitions vary, most notably in regard to whether the specialty includes domestic law enforcement consultation, Williams et. al. (2006, pp 193-194), define Operational Psychology as: the actions by military psychologists that support the employment and/or sustainment of military forces (in particular, military commanders) to attain strategic goals in a theater of war or theater of operations by leveraging and applying their psychological expertise in helping to identify enemy capabilities, personalities, and intentions; facilitating and supporting intelligence operations; designing and implementing assessment and selection programs in support of special populations and high-risk missions; and providing an operationally focused level of mental health support.

These Operational Psychology activities contrast with the usual clinical role of psychologists in treating soldiers and prisoners of war (Kennedy & Zillmer, 2006).

Operational Psychology has a long history in the US (Capshew, 1999; Soldz et al., 2018a), dating back at least to psychologists’ development of tests for military personnel selection in World War I. It has developed more recently in other countries (i.e. Dimitrovska, 2017, 2018). The development and implementation of testing on such a massive scale in the war played a major role in establishing psychology as an area of professional practice in addition to its earlier recognition as a behavioral science. Operational Psychology efforts expanded in World War II and included the creation of psychological profiles of enemy leaders, the development of wartime propaganda, and the training of spies. These wartime efforts were largely uncontroversial within the psychology profession, as evidenced by the support for these psychologists in the major psychology journals. This extensive aid to the war effort from psychologists helped garner support for state licensure of psychologists in the postwar era (Capshew, 1999).

As professional psychology grew and diversified in the Cold War era, so too did Op-
eral Psychology. Especially notable was the development of Operational Psychology research, raising – and often bypassing – profound ethical questions. For example, Mitchell Berkun conducted research for the military on severe stress induced in servicemembers without their consent. In one of his papers:

> Army trainees unaware that they were serving in an experiment were, under controlled conditions, led to believe that either (1) an aircraft in which they were passengers was about to make an emergency crash landing, (2) their outpost was now an artillery impact area, or (3) they had caused serious injury to a buddy by a mistake in wiring up explosive charges

Berkun, 1964, p. 92.

During the same period, dozens of psychologists funded by the CIA’s secret MKUltra research program sought to uncover the secrets of mind control and successful interrogation (Greenfield, 1977; Kinzer, 2019; Marks, 1991). Thousands of people were unwittingly given LSD; prisoners and people hospitalized with a mental health condition were subjected to harmful experiments without consent in institutions across the United States. A renowned psychiatrist at McGill University in Canada attempted to wipe patients’ minds clean and replace them with thoughts of his own, causing long-term harm to many.

Furthermore, as recently revealed by a declassified CIA document, psychologists helped write the infamous KUBARK interrogation manual that formed the basis for the US promulgation of torture in much of Latin America (Central Intelligence Agency, 1963; Office of Medical Services, Central Intelligence Agency, 2007). These research projects violated the ethical guidelines for research that the US military established for the doctors on trial after World War II, which stated in Principle 1: “The voluntary consent of the human subject is absolutely essential” (“The Nuremberg Code (1947),” 1996). Despite these ethical breaches, much of this CIA-funded research was published in mainstream psychological and medical journals, and the researchers were esteemed members of the psychological and medical communities.

Given this problematic history, as well as the wide range of activities currently undertaken by the specialty’s practitioners, Operational Psychology is in great need of independent ethical analysis. This analysis should be twofold. One set of questions concerns which of these activities are ethically appropriate for professional psychologists, and which are not. Separate from the issue of professional ethics are questions regarding the limitations a democratic society should place upon the use of psychological knowledge for purposes of manipulation.

Psychological ethics in the US and many other countries are based on fundamental values including beneficence, nonmaleficence, transparency, and universal respect for all peoples. As none of these are fundamental values for military or intelligence establishments, there are likely to be significant conflicts between these two sets of values.

To address these conflicts, several psychologists who led the struggle resisting psychological complicity with US government interrogation abuse convened a workshop in 2015 at the Boston Graduate School of Psychoanalysis. The workshop participants comprised fellow psychologists, other medical and social science professionals, military and intelligence professionals, and ethicists. The group discussed and evaluated ethical conundrums in actual cases of Operational Psychology practice.
The workshop refined a model of ethical and unethical behaviour in Operational Psychology developed by psychologists Jean Maria Arrigo and Roy Eidelson together with retired Army interrogator Ray Bennett (Arrigo et al., 2012). With significant input from the participating military and intelligence professionals, the workshop produced the Brookline Principles on the Ethical Practice of Operational Psychology (Soldz et al., 2017). These Brookline Principles emphasize the centrality of non-maleficence or avoidance of harm, informed consent, and the availability of independent ethical monitoring of all psychological practice specialties, including Operational Psychology.

To be considered ethical under these Principles, Operational Psychology activities must meet three criteria. First, they must risk only minor, foreseeable and implicitly or explicitly agreed to (“stipulated”) harms. Second, they must involve a reasonable degree of informed consent. And third, they must not be so shrouded in secrecy that independent ethical monitoring is implausible. This would allow, for example, traditional Operational Psychology roles of screening applicants such as pilots or special forces for high-risk missions and screening personnel such as non-coercive interrogators or hostage negotiators for highly sensitive positions. However, direct participation by psychologists themselves in the interrogation of individuals, whether coercive or non-coercive, would not be allowed as consent is lacking and even non-coercive interrogation has substantial potential to cause unstipulated harms. It remains to be determined whether participation in interrogations conducted according to the recently released “Mendez Principles” would be considered ethical under these Principles (Association for the Prevention of Torture, 2021; Brandon & Fallon, 2021; Principles on Effective Interviewing for Investigations and Information Gathering, 2021).

The Brookline Principles were perceived as a serious threat by many from the Operational Psychology community. A leader of that community and past president of the Military Psychology division of the APA ignored the content of the Brookline Principles while launching ad hominem attacks on the Workshop’s participants (Harvey, 2015). She called on Operational Psychology’s allies to instigate protests regarding the Workshop’s leadership with the APA and its Ethics Committee; she later made public accusations of unethical behaviour against me for speaking about Operational Psychology without ever having been in the military. Operational Psychologists made similar claims against a colleague in a formal complaint to the APA Ethics Committee (Aldhous, 2018; Reisner, 2017).

The ideas central to the Brookline Principles were later the basis for a more scholarly debate, which appeared in the journal Peace and Conflict, between some of the Workshop participants and another leader within the Operational Psychology community (Soldz et al., 2018a, 2018b; M. A. Staal, 2018a, 2018b). In this debate, Soldz et al., proposed five ethical consideration that we argued are central to evaluating the ethical practice of Operational Psychology:

1. Historical and prospective cases of [Operational Psychology]. The history of abuses in the area demands close examination moral risks....
2. Analogous professions. The historical courses of operational medicine, psychiatry, anthropology, and the chaplaincy offer unexamined warnings for the future of [Operational Psychology]....
3. Institutional exigencies and pressures. The findings of social, organisational,
and cognitive psychology and techniques of applied ethics must be adapted to the high-risk, high-stakes, hierarchical situations of [Operational Psychology], as in determining the “infrastructures of responsibility” (G. Williams, 2006).

4. The entirety of operational psychologists in the security sector. [Operational Psychology] ethics must encompass all security-sector operational psychologists, including the heretofore unacknowledged defense contractors with their corporate allegiances (e.g., U.S. Government Accountability Office, 2008).

5. Monitoring and accountability. There is a long history of failure of internal accountability in operational social and health sciences, and no plausible mechanism of internal nor external accountability has been proposed. Standard 1.02 of the 2002 APA Code of Ethics (American Psychological Association, 2002) enshrined this omission by waiving ethics standards that conflicted with work assignments for government employees (Soldz et al., 2018b, p. 461).

The Operational Psychologist who participated in this debate ignored all our proposed considerations while making it clear that these psychologists would not accept any limitations on their activities arising from psychological ethics, arguing in response to critiques of psychologist participation in national security interrogations: “Either an activity is ethical, or it isn’t. If ethical, then psychologists should be allowed to provide their expertise to whatever problem or issue is presented” (M. A. Staal, 2018b, p. 458). This argument negates the very concept of professional ethics and the existence of psychology as a profession. One of the defining characteristics of a profession in our society is that members undertake ethical obligations beyond those carried by nonprofessionals (Tjeltveit, 1999).

The preface to a recent anthology by Operational Psychologists calls upon their allies to join the struggle against the threat posed by developers of the Brookline Principles and by those who have opposed psychologist participation in the abuses at Guantanamo and CIA black sites. The preface author argues that psychologists opposed to Operational Psychology must not only be defeated on the battlefield of ideas, but must be expelled from the profession:

To fully appreciate and achieve these expressed aspirations and interests of our profession, we must ensure we are able to dislodge the opposition to Operational Psychology from within our profession. The most vocal and frequent of this opposition is too often thinly veiled in the shadows of distorted, disingenuous, and discredited diatribes that serve to distort the knowledge and facts, undermining trust both within and for our profession.

Emphasis added, Williams, 2019, p. x.

As I was working on this essay, APA submitted for public comment a draft of Proposed Guidelines for Operational Psychology. These Guidelines were the product of the Operational Psychology Practice Guidelines Task Force, appointed and chaired by an Operational Psychologist and past president of the APA’s Military Psychology division, the same person who participated in the scholarly debate described above. The Task Force included psychologists nominated by three unspecified national security agencies.

These draft Guidelines illustrate the danger of Operational Psychology to the antitorture movement and to the psychology profession’s ethics. They fail to call upon Operational Psychologists to abide by the restrictions put in place by the APA in a series of
policy resolutions culminating in the 2015 ban on national security interrogation involvement and participation in detention operations at illegal detention sites, such as CIA “black site” prisons or Guantanamo. They fail to call upon Operational Psychologists to abstain from involvement in coercive interrogations if the interrogations are permitted by US government policy. The furthest the Guidelines go in this direction is to state that “Operational Psychologists strive to avoid participating in practices that are illegal or unjust, or that unnecessarily infringe upon or violate others’ rights” (emphasis added; Operational Psychology Practice Guidelines Task Force (OPPGTF), 2022, ll. 334–335).

Additionally, the Guidelines ignore existing relevant international law, such as the Convention Against Torture (United Nations General Assembly, 1984). If these Guidelines are approved by the APA, it will free Operational Psychologists to participate in any future US government sanctioned abuses, undoing nearly two decades of efforts to constrain involvement in such abuses. The Guidelines also pose a danger in that, if approved, they may encourage psychologists linked to national security agencies in other countries to pursue such opportunities as well.

The recent experience of psychologist participation in torture and other detainee abuses has raised serious questions about the ethics of Operational Psychology for psychologists, who as members of a profession are bound by a specific code of conduct. However, our societies, confronted with various applications of psychological knowledge by Operational Psychologists and other practitioners, are also faced with a broader issue. Regardless of professional ethical concerns, are there limitations on the extent to which we as members of democratic societies can tolerate the use of psychological science and expertise to manipulate unwitting people?

I do not have an answer to that crucial question, but I know that as psychological knowledge and technological power increase, so too will the ability to manipulate. As our societies’ recent experiences with political advertising and with social media demonstrate, we must confront this issue of limits on psychological manipulation or surrender the ideal of democratic self-government. While this article focuses on US experience and on the profession of psychology, the questions about limits on appropriate, ethical uses of professional knowledge confront other health professions and social and behavioral sciences in all would-be democratic societies.

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Strategic litigation against torture: Why domestic courts matter

Masha Lisitsyna

Abstract

Purpose: Strategic human rights litigation is often associated with filing cases before international and regional courts and treaty bodies. This article examines ways in which significant advances in protecting the rights of victims of torture and similar crimes can be achieved through domestic courts, even in countries with limited respect for the rule of law.

Methodology: This article does not cover universal jurisdiction or transnational cases, but rather focuses on how domestic courts can be used to address torture that takes place in the same country. It is not a review of global practice; rather, it is based on observations drawn from the author’s personal experience of over 25 years of strategic litigation and advocacy against torture; lessons learned from the work of partner organizations and lawyers from around the world; and the results of three research projects commissioned by the Open Society Justice Initiative (OSJI): one on the impact of strategic litigation on torture in custody in Argentina, Kenya, and Turkey (OSJI, 2017); another on how domestic courts in Latin America handle reparations for torture and similar human rights violations (Garcia Garcia, Fierro Ferráez, & Lisitsyna, 2019); and a third on strategic litigation against torture in Asia (Bokhari, 2020).

Conclusion: While acknowledging continued challenges, the author demonstrates that domestic courts are often better placed than their international counterparts to address several aspects of human rights litigation and protection of victims’ rights and in some circumstances can have broader impact.

Introduction

This article examines the extent to which strategic human rights litigation can work in domestic courts, even in countries with limited respect for the rule of law. The Open Society Justice Initiative (OSJI) defines “strategic human rights litigation” as the use of litigation to advance a process of legal, social, or other human rights change that goes beyond the immediate goals of the complainant (OSJI, 2017, p. 14). Alexander Gerasimov’s case is one example of such efforts.

In March 2007, Gerasimov, a 38-year-old construction worker, went to the local police station in Kostanay, Kazakhstan, to inquire about his stepson, who had recently been arrested. The police accused elder Gerasimov of murdering an elderly woman, held him for 24 hours, and interrogated and beat him severely in an attempt to coerce a confession. The police inflicted heavy blows to his kidney area and threatened him with sexual violence. They then tortured him with a tactic called “dry submarino,” in which they forced Gerasimov face down on the ground and put a plastic bag over his head. The next morning,
Gerasimov was released without charge. Immediately following his release, Gerasimov suffered from intense headaches, nausea, and pain throughout his body. He was admitted to the hospital that evening and diagnosed with a major head injury and bruising to the right kidney. He spent 13 days in the neurological unit. In August 2007, Gerasimov was diagnosed with post-traumatic stress disorder and received in-patient treatment for nearly a month in a psychiatric hospital. In 2012, the UN Committee against Torture (UNCAT) found that Gerasimov’s rights had been violated, and urged Kazakhstan to conduct a proper, impartial, and effective investigation in order to bring to justice those responsible for the complainant’s treatment; to take measures to ensure that the complainant and his family would be protected from any forms of threats and intimidation; to provide the complainant with full and adequate reparation for the suffering inflicted—including compensation and rehabilitation—and to prevent similar violations in the future. In 2013, the lawyers from the Kazakhstan International Bureau for Human Rights and the Rule of Law, with advice from OSJI, used UNCAT’s decision to file a civil lawsuit and argue in a Kostanai court that the government owed damages to Gerasimov. I did not have high expectations of success (Lisitsyna & Miller, 2021, pp. 36-38). Too much seemed to be working against Gerasimov: Kazakhstan’s judiciary’s lack of independence; a perfunctory criminal investigation against the police into torture allegations that had gone nowhere; and the fact that the only witnesses to Gerasimov’s torture were the police themselves. At the same time, we had clear advantages that are often absent in torture cases. Gerasimov’s case was straightforward: he had been held overnight, tortured, and released the next day without charge. He was consistent in his account of what happened, and his medical records corroborated his allegations.

Despite the likely impediments to success, Gerasimov decided to go forward with the case, and in November 2013 he won. He received compensation that was meaningful to him—around $13,000—if inadequate given the abuse he suffered. In its decision, the Kostanai city court stated that international treaties ratified by Kazakhstan supersede national legislation, and that decisions of UN committees are binding (Lisitsyna and Miller, 2021, pp. 37-38). The court agreed with the petitioner’s arguments based on the articles 26-27 of the Vienna Convention on the Law of Treaties, which states that “[e]very treaty in force is binding upon the parties to it and must be performed by them in good faith,” and “[a] party may not invoke the provisions of its internal law as justification for its failure to perform a treaty.” Kazakhstan’s law on international treaties has similar provisions. According to the national legislation, the Ministry of Foreign Affairs monitors implementation of international treaties but, in fact, it never replied to the 2012 UNCAT decision Gerasimov’s case or took any action to afford reparations to Gerasimov. The courts, on the other hand, cited the UNCAT decision and granted Gerasimov compensation. This decision was sustained on appeal and then confirmed by the Kazakhstan Supreme Court, in what appears to be the first decision in the world by a national court that establishes states’ mandatory obligation to implement the decisions of UN committees in individual cases. UN human rights treaties, such as the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (UNCAT), do not provide clear guidance on the obligation of the state-parties to implement the decisions of related treaty bodies. This has led to ongoing debates among international law
specialists on the nature of states’ obligation “to give effect” to the decisions (also known as Views) of UN committees, and states have taken widely differing approaches (Fox Principi, 2017). In light of this, it was especially important for us to obtain a judicial ruling in a domestic court that agreed with our interpretation of the obligations entailed in acceding to a UN treaty, thereby increasing legal protections for the victims of human rights violations. Kazakhstan does not have a system of legal precedent and courts are not bound to apply the same standards in future cases (Lisitsyna and Miller, 2021, at p. 38). The decision in the Gerasimov case set an inspiring example and provided a roadmap for developing arguments in similar cases in Kazakhstan, Kyrgyzstan, and Mexico (see Cherkasenko, 2014; Pervomaisky District Court Case No. GD-839/18.BZ, 2018; I(dh)eas, 2021.)

1. Advantages of pursuing strategic human rights litigation in domestic courts

A report published by OSJI found that the use of strategic human rights litigation in cases involving torture in custody can yield significant human rights gains (OSJI, 2017). The study, which analysed the use of this approach in Argentina, Kenya, and Turkey over a 30-year period, focused to a large extent on cases litigated before domestic courts. This research identified many forms of domestic legal, judicial, institutional, and policy change resulting from litigation concerning torture in detention, such as: the conviction of perpetrators; changes in detention conditions in facilities where torture was practiced; payment of compensatory damages to victims and their families; the creation of broader reparation schemes; and formal recognition of and apologies to victims. There are also indications that strategic human rights litigation, combined with other forms of oversight and accountability, has had a deterrent effect on torture in detention. The study also shows that these impacts, and progress in the fight against torture in custody more broadly, have not been linear, as setbacks often follow advances. The litigation process also had significant negative effects on some survivors and anti-torture advocates, including death, further torture, and arbitrary detention.

Drawing on the 2017 OSJI report, a study on strategic litigation against torture in Asia (Bokhari, 2020), research on domestic courts awarding reparations for the victims of violations of the right to life and personal integrity in Latin America (García García, Fierro Ferráez, & Lisitsyna, 2019), and personal experiences, below I outline numerous insights into the practice of strategic human rights litigation in domestic courts that can aid other litigators and social movements seeking to end torture and other human rights abuses.

Domestic courts are part of the social and political fabric of every society. They pose advantages and challenges as compared to international tribunals. Well-known challenges include corruption and the lack of independence of many domestic courts; coercion of judges, lawyers, and victims; and high court fees when filing cases. However, engaging with domestic courts has its advantages. They include, but are not limited to, the potential for domestic courts to be bolder in highlighting the systemic state problems that lead to rights violations; a wider range of strategic litigation choices available to victims and litigators; the ability to use evidence of torture to help defendants in criminal cases; and the ability, in some countries, to file lawsuits in the public interest, thereby seeking broader impact and minimizing risk for individual victims.

1.a. Domestic courts can be bolder in highlighting systemic problems
While international and regional courts and treaty bodies play important roles in determining the understanding and interpretation of rights, these bodies are limited by treaty terms and must be careful not to open themselves to the claim that they are impinging on national sovereignty. In some instances, domestic courts can thus be bolder in outlining their concerns regarding systemic state problems or government failures. They are more familiar with a nation’s problems, and they are part of the apparatus that defines state policies. Even if courts are formally limited by the legal standards promulgated by legislatures, their role extends beyond the mere application of the law.

The Constitutional Court of Colombia, for example, found that various cases of internal displacement of people (often due to the conflict) and prison overcrowding demonstrated systematic and continual violations of human rights. Its decisions stated that such violations represented an “unconstitutional state of affairs,” underlining the structural causes of such violations and requiring the government to take effective measures to remove these causes (García García, Fierro Ferráez, & Lisitsyna, 2019, see also Constitutional Court of Colombia, T-025/2004 and T-388/2013). The Federal Supreme Court of Brazil issued a similar decision on precautionary measures in relation to Brazilian prisons, concluding that the inhumane conditions of the country’s penitentiary system likewise constituted an unconstitutional state of affairs (see Supreme Court Of Brazil, ADPF 347 Mc / Df). There are also examples of domestic courts making similar decisions based on international treaties that have not been ratified by the government. For instance, despite the fact that the Pakistani government is not a party to the International Convention for the Protection of all Persons from Enforced Disappearance, the Supreme Court of Pakistan referenced the convention in a decision criticizing the Pakistani state for engaging in enforced disappearances (Bokhari, 2020 and Supreme Court of Pakistan, Yaseen Shah case).

1.b. Victims and litigators have a broader choice of legal avenues to pursue

In international human rights litigation the range of available forums is typically quite limited. In contrast, litigators and activists in domestic courts generally have a wider array of choice when it comes to deciding which legal avenues to pursue. Criminal, civil, and constitutional lawsuits can all be part of strategic litigation against torture. Criminal investigation is aimed at establishing the circumstances in which the crime was committed, and the identity and degree of involvement of those responsible; and obtaining the eventual punishment of the perpetrators. Victims can also pursue civil litigation in order to identify those responsible, and to seek various forms of reparation. The burden of proof in civil claims is generally lower than in criminal cases (REDRESS, 2021, p. 21). In some countries, a separate Constitutional Courts or Constitutional Chambers of the Supreme Courts will consider claims related to state violations of constitutional rights, while in others such lawsuits are brought before regular courts. In some jurisdictions (such as Kenya), an individual can seek reparations, including compensation, as part of a constitutional complaint.

When researching the impact of strategic litigation on torture in custody for the OSJI report, the team saw dramatic differences among the three countries studied when it came to the choice of legal avenues preferred by activists and litigators (OSJI, 2017). Argentinian civil society prioritized criminal accountability of perpetrators, while Kenyan litigators and activists focused on securing damages through
domestic and transnational civil lawsuits. In Turkey, the most important litigation efforts were focused on international litigation—on preserving issues for the European Court of Human Rights and bringing the Court’s practice closer to home by organizing the first-ever in-country hearings for the Court.

In recent years there has been an increasing number of examples in which litigators turned to less typical avenues, such as administrative lawsuits, while still arguing cases on the basis of human rights norms. For example, lawyers from human rights NGOs in Mexico turned to Mexico’s administrative court system and filed claims seeking reparations for damages under the state’s financial liability regime (Responsabilidad Patrimonial del Estado), which makes government offices responsible for any damages caused to individuals. In Mexico, civil claims cannot be brought against governmental agencies. An important feature of state financial liability litigation in Mexico is that the state agency responsible for the violation bears the burden of providing compensation, which should create incentives for the agency to reform (Garcia Garcia & Melon Balles teros, 2017). While awards in administrative cases rarely include measures other than compensation, the law in Mexico provides a possibility to seek them. Using state financial liability, the NGO Centro de Derechos Humanos Miguel Agustín Pro Juárez (Centro Prodh) filed a case in an administrative court in Mexico and secured compensation for three indigenous women who spent three years in arbitrary detention after wrongful prosecution. In February 2016, OSJI submitted an amicus curiae brief in this case, setting out the state’s international human rights obligations to provide reparations where there is a violation of international human rights standards. In this case the applicants—unusually for an administrative case—requested that the state apologise to the victims. The Federal Court of Administrative Justice granted this request and ordered the federal prosecutor’s office to issue a public apology to the three women, which was delivered in February 2017 at a special event at the National Museum of Anthropology in Mexico City (Centro Prodh, 2017).

In Thailand, lawyers also turned to administrative litigation to gain compensation for victims of unlawful detention and injuries inflicted by the military in the south of the country (Bokhari, 2020). The region was under martial law and administrative lawsuits appeared to be the only legal avenue available to bring the military to justice. The case involved two university students who were tortured and held incommunicado in military detention. In its November 2011 decision, the Songkhla Administrative Court stated that officials are responsible for the acts that they commit as well as those committed by people under their command. The court recognized the possibility of awarding compensation to victims, applying the 1996 Tortious Liability of Officials Act B.E. 2539 (The Ismael Tae and Amizi Manak Case, 2011). In October 2016, the Supreme Administrative Court affirmed this decision and specified that the victims were due compensation with interest due to the emotional distress and physical injuries they had suffered. The court confirmed that 305,000 baht and 200,000 baht were owed to plaintiffs Mr. Ismael Tae and Mr. Amizi Manak, respectively, and that they should also receive an additional 7.5% per annum in interest incurred since the day the case was filed.

1.c. Victims can pursue different legal avenues simultaneously
Each legal avenue has its own advantages and pitfalls. Legal avenues that could be used and might be effective differ for each case. Victims might have strong preferences with regard to
the type of accountability and reparations that they are seeking. In domestic litigation, some legal avenues can be used concurrently.

Seeking reparations through civil and administrative lawsuits or through reparations programs supplements, but does not replace, the need to hold perpetrators criminally responsible. Torture is a crime and criminal investigation is the proper societal response. But the criminal process requires the highest burden of proof in the legal system, which can be difficult to meet when it comes to individual perpetrators, who may not even be identifiable. In principle, as is possible in many legal systems, a civil claim pursued as part of criminal proceedings against the alleged perpetrators, can be an effective way for victims to seek reparations. In practice, however, criminal investigations into torture and similar crimes are often closed or “suspended” for several years, with no likelihood of proceeding to trial, let alone conviction. While states should continue improving their investigative and prosecutorial practices to respond to this challenge (OSJI, 2021), victims should also be able to seek reparations in civil or administrative courts independently of the outcome (or existence) of a criminal case against the alleged perpetrators. In addition, civil or administrative proceedings launched independently of criminal investigations help shed light on the abuses the victim suffered. At the same time, however, these proceedings might be as protracted as criminal cases, and many victims find the civil justice process ultimately unsatisfactory, often resulting in insufficient settlements. While participating in several legal processes places an additional burden on the victim, sometimes civil or administrative lawsuits can provide victims with a sense of agency. Also, civil and administrative judges are often less inured to accounts of violence and pay more attention to victims’ suffering. In some cases, when police and prosecutors refuse to even undertake criminal investigations into allegations of torture, civil or administrative cases might be the only option available for victims seeking their day in court. In some countries and contexts, victims might be also able to access at least partial reparations through different administrative programs, such as the Victims Commission in Mexico (Comisión Ejecutiva de Atención a Víctimas) or the Criminal Injuries Compensation Authority in the UK.

In some countries, for instance Kyrgyzstan, litigation for reparations faces an additional obstacle: victims may only sue for compensation and other reparations if the perpetrators have been convicted in criminal court. This requirement violates international human rights standards, and it is important to challenge and change this rule where it exists. UNCAT states that, “Notwithstanding the evidentiary benefits to victims afforded by a criminal investigation, a civil proceeding and the victim’s claim for reparation should not be dependent on the conclusion of a criminal proceeding. The Committee considers that compensation should not be unduly delayed until criminal liability has been established.” (see UNCAT, General Comment 3, para 26; also UNCAT, Gerasimov v Kazakhstan, para 12.8). Decisions of the UN Human Rights Committee include similar findings (see Akmatov v Kyrgyzstan, para 10).

In Kyrgyzstan, OSJI provided advice to lawyer Sardor Abdukholilov who used the decisions of the UN Human Rights Committee to convince civil courts that victims of torture should be able to receive compensation without waiting for the criminal conviction of the perpetrators—even in cases where the plaintiff in the civil suit is not the victim identified in the relevant criminal case (e.g. the plaintiff might be a relative of a deceased victim). In October 2018, the Pervomaiski District Court of Bishkek ruled on a civil case in which the brother of Turdubek
Akmatov (who died at the hands of police in 2005) sued the government for reparations. The court disputed the claim of the police investigator, who stated that only Turdubek’s late father could be the plaintiff in the civil case, as the father was recognized as the victim in the criminal case. The court instead pointed to a UN Human Rights Committee decision, stating, “In this matter, the court considers it is necessary to be guided by the UN Committee’s Views, which states that persons whose rights have been violated independently of any related criminal proceedings have the right to compensation for moral damage... The court believes that the plaintiff, being the brother of the deceased, has also experienced moral suffering. However, this circumstance should affect the amount of compensation.” (Pervomaisky District Court Case No. GD-839/18.BZ, 2018). In addition to paving the way for the brother of the deceased to receive compensation, this decision resolved an important procedural hurdle. As Kyrgyzstan does not have a system of legal precedent, this court decision itself does not solve the structural problem of requiring criminal conviction before reparations may be awarded. It does, however, demonstrate that it is possible to overcome it in individual cases.

It is important not to be deterred by these procedural obstacles. Often, the key elements of strategic human rights litigation that open new avenues for seeking justice are focused on procedural questions, such as the relationship between reparations proceedings and criminal conviction. Another important element is the innovative collection of evidence.

1.d. Evidence of torture can help defendants in criminal cases

Treaty bodies and regional human rights courts generally state that they do not “rehear” domestic cases to establish guilt or to adjudicate a civil claim. (The International Criminal Court and other international criminal justice tribunals serve a different function, follow different rules, and are not included in this discussion). While treaty bodies and regional human rights courts take into account evidence related to alleged human rights violations, as a general rule evidence needs to be presented to and evaluated by domestic courts. In domestic settings, litigators and activists around the world continue to develop new skills in collecting evidence, including relying on new technological tools and sophisticated medico-legal examinations, and improving interview techniques in line with international standards. While often ignored in practice, article 15 of the UN CAT prohibits the use of evidence obtained as a result of torture (Fair Trials and REDRESS, 2018). Credible evidence of torture can throw into question evidence presented by the prosecution in cases where victims of torture are themselves standing trial for alleged criminal actions.

Within the last few decades, the UN has adopted two manuals—known as the Minnesota Protocol (1991; revised 2016) and the Istanbul Protocol (1999, revised 2004, currently being updated)—that respectively offer guidance on investigations of summary or arbitrary executions and of torture and cruel, inhuman and degrading treatment. Before the Protocols, in many jurisdictions state forensic experts—often employed by the same institutions as alleged torturers and other abusers—were the only available source of medical and forensic evidence. Litigators can challenge state forensic reports and introduce independent expert evidence. Even if domestic law does not specifically provide for the introduction of such evidence, in most instances there is no prohibition on trying. Independent reports might not always have the same probative value as official forensic reports, but
they are still useful and can have an impact on the decision of the court. In addition, human rights activists have engaged in training of forensic experts in order to improve the quality of official reports.

A recent example of the successful use of the Istanbul Protocol was in the so-called “Red Room” case in Rio de Janeiro. In 2018, the Brazilian military tortured several young Black men following a large military operation in one of the city’s favelas. The young men stood trial on drug-related charges. Their initial medical examination was perfunctory, and the Public Defender’s office of Rio de Janeiro requested that the judge order an additional medical examination given their allegations of torture. OSJI provided advice on strategic litigation approaches to the Public Defender’s office in this case. The International Bar Association’s Human Rights Institute (IBAHRI) collaborated with the Rio de Janeiro Forensic Institute, which is part of the civil police, to conduct the examination in line with the Istanbul Protocol. IBAHRI invited Pau Peres-Sales and Marina Parras, two medical experts from Spain specializing in medical and psychiatric forensic work, to join its team and accompany Brazilian forensic doctors. This was the first time an official examination in line with the Istanbul Protocol had taken place in Brazil. Peres-Sales and Parras trained local doctors on the medical elements of the Istanbul Protocol, IBAHRI’s Veronica Hinestroza and two consultants conducted training sessions on its legal aspects. Seven Istanbul Protocol evaluations were conducted and signed by Peres-Sales and Parras and one Brazilian doctor on behalf of the national Forensic Institute. The men’s defense team introduced the reports in court. Referring to these reports, the judge suggested that the credibility of the military’s statements was tainted by “the hateful practice of torture,” and acquitted the defendants. Such acquittals are extremely rare in Brazil. (Lisitsyna, 2020). In February 2022, an appeals court affirmed the acquittals. In a related case concerning three other young men, the defense could not undertake a thorough medical examination like the one discussed above. But the Public Defender’s office requested the opinion of a forensic doctor from Colombia, who reviewed one of the official medical reports, which he found to be inconsistent with the Istanbul Protocol. Despite the absence of a specific procedure to submit independent medical reports, the judge accepted the report and cited it in the decision, which also led to an acquittal. (OSJI, 2022)

The comprehensive medico-legal examinations in the Red Room case not only served as evidence that the defendants were tortured; they were also crucial for the men’s acquittal. If not for the reports, the state’s evidence—though “tainted by torture”—would have appeared legitimate. Such individual cases serve as important examples of how entrenched practices—perfunctory medical evaluations, the “presumption of truth” of the testimony of police and military officials, the use of evidence that might have been obtained through coercion—can be successfully challenged in domestic courts. At the same time, while individual cases can provide inspiration and pave the way for other human rights litigators to follow, the scale of the challenge often requires actions that target systemic problems.

1.e. Cases can be filed in the public interest to seek broader impact

In most cases, victims and their representatives turn to litigation to seek protection, reparations, and accountability for specific human rights violations. But in some jurisdictions, lawsuits can be filed in the public interest and, if successful, can have broader
impact. Lawsuits filed in the public interest are often, but not always, influenced or connected to individual cases. There are also examples of strategic litigation seeking broader impact through collective petitions, such as collective habeas corpus, on behalf of certain groups.

For instance, in November 1998, the Bangladesh Legal Aid and Services Trust (BLAST), along with two other organizations and five individuals, filed a writ petition in Bangladesh’s High Court in the form of public interest litigation. The suit challenged sections of the Criminal Procedural Code (CrPC) and other legislation that allowed police to abuse their powers of arrest and magistrates to abuse their powers of remand by placing individuals in pre-trial detention. BLAST and others decided to bring this lawsuit following significant public outcry after the police arrested, without a warrant, a 20-year-old student who was found dead five hours later. Though the lawsuit was not brought on behalf of the student’s family, it was in direct response to his death, which sparked broader national attention to the problem of the abuse of police powers in Bangladesh. In its 2003 decision on this writ petition, the High Court found respective sections of the CrPC to be inconsistent with fundamental constitutional rights. (Blast and others vs. Bangladesh). The Court also issued a comprehensive set of recommendations regarding necessary amendments to the CrPC, as well as Bangladesh’s Police Act, Penal Code, and Evidence Act. It also issued a set of fifteen guidelines with regards to exercise of powers of arrest and remand. The case was considered on appeal by the Appellate Division of the Supreme Court in May 2016, which endorsed, with some modifications, the guidelines formulated by the High Court. These guidelines were directed at law enforcement agencies and magistrates. The Supreme Court’s Appellate Division reiterated the binding nature of the guidelines and clarified that it had the authority to issue them, pending the enactment of law (Bokhari, 2020).

In Argentina, litigators have successfully used collective habeas corpus petitions to protect people in detention. In November 2001, the NGO Centro de Estudios Legales y Sociales (CELS), supported by a large group of individuals and other NGOs, lodged a collective habeas corpus petition arguing that prison conditions in Buenos Aires amounted to the widespread violation of the rights of incarcerated individuals. In 2005, the Federal Supreme Court issued a wide-reaching and ground-breaking judgment. It found that the prison system should comply with the UN Standard Minimum Rules for the Treatment of Prisoners—and that prison conditions fell short of national and international human rights standards. The judgment linked detention conditions to the state’s obligations to prevent torture and found that the state was violating the human rights of people in prison. The case also catalyzed debate on the procedural means of securing access to justice in collective cases concerning structural human rights problems. By accepting the right to lodge collective habeas corpus actions in this case, the judiciary effectively created new avenues for developing subsequent litigation (OSJI, 2017, pp. 45-46).

In 2020, when the COVID-19 pandemic hit, Association XUMEK, an NGO in the Argentine province of Mendoza, filed a collective habeas corpus petition requesting the release of at-risk individuals being held in detention. This resulted in a court order requiring the government to review all cases of at-risk individuals who could be moved from detention and placed under house arrest. The court also urged authorities to supply people in detention with personal protective equipment and
hygiene items and authorized their temporary use of mobile telephones while family visits were suspended. The judicial decision allowed many people to serve their sentences at home. (OMCT, 2022, p. 9).

1. Cases filed in the public interest can minimize risk for victims

Another reason why anti-torture litigators turn to lawsuits in the public interest is to protect victims from retaliation.

Security concerns are a central part of the planning of any legal action on torture or other human rights violations. One way to minimize risk is to file a petition in public interest without naming any individual victims. In Mexico, at the beginning of the COVID-19 pandemic, the NGO Centro Prodh filed a constitutional complaint in the public interest that called for the protection of people in detention from the spread of COVID-19 (Centro Prodh v Governor of Morelos et al). OSJI served as advisor to counsel and helped Centro Prodh develop and build evidence for this case. As the lawsuit was filed in the public interest, Centro Prodh acted as a plaintiff and did not name any victims, which mitigated the risk to individuals in detention, who might have otherwise been subject to retaliation by the prison administration and other state agencies.

However, this choice required a trade-off. The case would have been stronger with a plaintiff who could have provided a detailed description of their treatment and lack of protective measures. Centro Prodh was ultimately allowed to serve as a public interest plaintiff, but the court could have denied this request. Moreover, in this case, there is no recourse beyond domestic courts, whereas an individual plaintiff or a group of plaintiffs could have filed a complaint to the Inter-American Commission on Human Rights or to a UN treaty body. In this case, the first-instance court dismissed the complaint a year after filing, arguing that the government demonstrated in its written submission that it was taking necessary measures. The appeal court has not yet taken up the case.

Public interest litigation and collective complaints can be powerful tools for seeking change. However, these lawsuits are also easier to dismiss for procedural reasons and their implementation is patchy. Nonetheless, each case—whether individual or collective, whether it was won or lost in court, settled, or withdrawn—can become a building block on which litigators and activists can construct the next case, advocacy, and campaigns.

2. Strategic human rights litigation is more than a single high-profile case

The impact of strategic litigation is rarely apparent from the outcome in a single case, but rather can be observed and assessed by considering several cases over time, especially when combined with advocacy and other tools (OSJI, 2017).

2.a. Strategic litigation often involves multiple cases over time

Many important and impactful judicial decisions were made possible because several “smaller” cases came before them and removed procedural obstacles or led to substantive decisions on similar, but less controversial, matters. Sometimes, a case similar to the ones dismissed in the past comes at the right political moment. Whether a country does or does not have a system of legal precedent also informs how much one case builds on others, although even in countries with legal precedent—such as the United States—important decisions might be overturned. One of the most progressive judges on the US Supreme Court and an icon of gender equality and women’s rights, Ruth Bader-
Ginsburg, was famously “not very fond of” *Roe v. Wade*, the landmark Supreme Court decision that in 1973 established a constitutional right to abortion. She noted that the ruling tried to do too much, too fast, leaving it open to fierce attacks. “Doctrinal limbs too swiftly shaped,” she said, “may prove unstable” (Gupta, 2020). Due to a number of reasons—such as legal restrictions or the will of the victims involved—building on a series of “small wins” over time can often be the most effective strategic litigation strategy (OSJI, 2017).

OSJI’s 2017 report describes one dramatic example of a successful litigation strategy based on “small wins.” In 1998, the Argentine NGO Abuelas de la Plaza de Mayo filed a case against police officers Simón and Del Cerro for abducting a baby during the period of Argentina’s military dictatorship of the late-1970s and early 1980s. NGOs hoped the case would demonstrate the absurdity of Argentina’s amnesty laws—enacted in the mid-1980s to appease former officials of the dictatorship—which permitted the state to charge the police for abducting the child but not for the kidnapping, torture, and murder of her parents. At the end of 2000, CELS filed a legal action concerning the disappearance and torture of the baby’s parents. In 2001, the federal court investigating the case declared the amnesty laws unconstitutional and indicted Simón for crimes against humanity, a decision confirmed by higher courts. Simón was sentenced to 25 years’ imprisonment and absolute disqualification from public service for life, and the decision paved the way for Argentina’s Congress to declare null the amnesty laws, and for the Supreme Court to subsequently confirm the nullification of the amnesty laws (OSJI, 2017, pp. 41-42).

Strategic human rights litigation often means several cases build over time. Just as importantly, these cases need to be part of a broader movement seeking change in laws and in practice.

2.b. Strategic litigation combines court cases with advocacy and other tools

Litigation is just one of many possible catalysts of social change. Others—including mass mobilization, public protests, advocacy, and legal aid—are commonly used in concert with, and sometimes as a prerequisite for, strategic litigation (OSJI, 2017, p. 14). All examples of cases discussed in this article were accompanied by advocacy campaigns.

Strategic human rights litigation helped end the use of rubber bullets in Catalonia. Like many others, activist Ester Quintana lost an eye when she was hit by a rubber bullet when participating in a protest. She sued the state and adopted a vigorous legal strategy. The plaintiffs argued that use of rubber bullets constituted torture. Quintana underwent a comprehensive medico-legal examination by medical professionals associated with NGO SIR(a), which specializes in medical and psychiatric forensic work for strategic litigation. The examination consisted of multiple assessments, including medical, surgical and psychiatric, over a year and a half, and found that there was little justification for the use of rubber bullets, which had been deployed as the protest was ending. As significantly, it detailed the many negative physical and psychological effects of Quintana’s eye loss, including nine surgeries. Quintana’s experience became one of the key stories in a small but active civil society campaign against police use of rubber bullets. Amnesty International and other international NGOs expressed support for the campaign, and small political parties on the left addressed the issue in Parliament, leading to an independent investigation. The court in its preliminary decision found that Quintana was a victim of torture,
even if the identity of the perpetrator was not known (Perez-Sales, 2019). The government chose to settle the case by paying significant financial reparations to Quintana (€261,000), who agreed not to pursue the case any further (Bueno, 2015). While the litigation was still ongoing, Catalonia banned the use of rubber bullets (Baqué, 2014).

Challenges of strategic human rights litigation in domestic courts
There are many challenges involved in strategic litigation against torture, whether the case is brought to a domestic or international forum. These include risk of retaliation against victims, their lawyers, and other representatives, including threats, physical violence, pressure on families, and defamation lawsuits; and the challenge of implementing judgments. Below I briefly discuss some of the difficulties involved in relying on domestic litigation for human rights cases.

Lack of independent judges
While members of international courts and other bodies can be subject to political influence, the pressures at the domestic level generally are greater: domestic judges are more susceptible to corruption given that their salaries and careers are wholly dependent on domestic authorities, they often are poorly paid, and their security risks are higher. Sometimes it is impossible to win however well one argues the case, as the decision would have political and personal consequences for the judge, who might already be ambivalent about the protection of human rights. At the end of the day, domestic judges are part of the state system. In some cases, judges are disciplined by shocking acts of violence against those who step out of line. For instance, in 2011, Judge Patricia Acioli was shot to death outside her home in Rio de Janeiro after receiving numerous death threats. Acioli was known as an uncompromising judge who sentenced approximately 60 police officers involved in death squads and militia groups. The Brazilian Association of Judges reported that the number of judicial workers requesting government protection increased 400 percent after Acioli’s killing (Human Rights Watch, 2012). The message to other judges was clear.

In many jurisdictions, there is often little hope for a fair trial in cases with high political stakes for the government. These cases are not decided in the courtroom. For instance, Azimjan Askarov, a human rights defender who in 2010 was accused by the government, without any evidence, of being a key instigator of ethnic violence in the southern Kyrgyzstan. Askarov was tortured and sentenced to life imprisonment in an unfair trial. While decisions of the UN Human Rights Committee were crucial in persuading the Kyrgyzstan courts to order reparations for other victims, families of those who died in police custody, the courts ignored the Committee’s 2016 decision calling for Askarov’s immediate release. Askarov died in prison in 2020, allegedly after contracting COVID-19 (Listysyna & Miller, 2021, at p.40).

Procedural and bureaucratic obstacles
There can also be multiple procedural obstacles to pursuing human rights cases in domestic court systems—such as statutes of limitations, or, as discussed above, the requirement that criminal conviction must precede reparations. In Nepal, for example, the 1996 Torture Compensation Act provided victims with 35 days in which to file their request for compensation. Following years of advocacy and litigation, in 2020 the Criminal Procedure Code was amended, raising the statute of limitations for torture cases to six months, which is still grossly inadequate (Advocacy Forum-Nepal, 2020). In many jurisdictions
police and military officials benefit from overarching statutory immunity and the legal presumption that they are telling the truth, which effectively denies victims the right to seek redress. Some countries adopted blanket amnesties for prior violations committed during a conflict or specific historical period.

Some procedural obstacles have been successfully removed in different countries through strategic litigation and advocacy. For example, the Constitutional Chamber of El Salvador’s Supreme Court ruled in July 2016 that the country’s 1993 amnesty law is unconstitutional and must be stricken (Roht-Arriaza, 2016). A number of NGO representatives and victims of rights violations brought a complaint alleging that the amnesty law, covering the crimes of both sides in a civil war that claimed over 75,000 lives, was illegal and violated El Salvador’s international commitments and constitution. The Court first dismissed the procedural illegality argument but held that the legislature had to balance the need for reconciliation with the need for justice for the victims.

In some jurisdictions, such as Mexico, a judge can only mandate that the agency directly responsible provide compensation to victims of human rights violations, and that agency must also be a respondent in litigation—all of which makes it difficult to seek reparations that involve multiple agencies, especially when some, such as health authorities, might not have played any role in violations but have a role to play in repairing the harm. This is not a problem in international human rights tribunals, where the decision is issued against a state as a whole. At the same time, not all countries have such limitations. For example, courts in Colombia can include different agencies in their reparation orders.

Bureaucratic red tape at domestic level can entangle human rights cases for years and pursuing justice for victims is often a protracted process. This is often due to small violations of technical requirements—a blank signature, the lack of a stamp that is impossible to obtain, a missing confidential document held by a government agency—that can cause major setbacks. International bodies, by contrast, can be more forgiving when claimants are unable to comply with their procedural rules as a result of state recalcitrance or incompetence.

Costly legal fees
Domestic litigation can entail costly filing fees, especially for cases involving compensation, and lawyers’ fees can be prohibitive. In some jurisdictions, the practice known as “no win, no fee” can encourage lawyers to reach settlements that ensure their own costs are covered, even if the plaintiffs might have received higher compensation if their case had gone to court. Many successful cases have been litigated pro bono by lawyers associated with human rights NGOs, but NGOs only have the capacity to represent a small fraction of victims.

Lack of trained medical professionals
Medical professionals are vital for litigating torture cases as they are the ones who can identify whether the victims’ account is consistent with their psychological and physical injuries, which are often invisible. They also can describe the consequences of abuse for the victim. However, many jurisdictions still lack medical professionals trained in the Istanbul and Minnesota Protocols, and, as discussed above, government forensic services are often not independent or reliable. Medical evaluations of victims can be superficial and retraumatizing for victims. They are often performed in the presence of police and other security services, and medical professionals might follow the directions of those
state agents, misrepresent their medical findings, and issue a medical report that bolsters the case against the victim. Some independent medical and other experts, while willing to conduct evaluations and issue reports, are unwilling to make time to testify in court. In the case of foreign experts, unless testimonies are possible through video conferencing or other remote means, the need to appear in a court in a different country might just not be feasible. Expert testimony is rarely necessary in international human rights litigation but is expected in many domestic judicial systems.

**Lessons learned**

Twenty years ago, when working in Kyrgyzstan, I viewed filing domestic complaints against torture as a way to “exhaust domestic remedies” before bringing a case before an international human rights body. Reflecting on the work of strategic human rights litigation over the last decades, however, I now see domestic courts as crucial venues for the protection of human rights.

Below are several general takeaways from the expansion of domestic human rights litigation against torture:

*Losing is part of litigation*

One cannot always win. Losing a case might offer strategic value and contribute to future positive change. However, in torture cases, the victims’ own objectives for litigation and the potential effect on their well-being must be weighed seriously before engaging into strategic litigation where there is a high likelihood of a negative outcome in the courtroom.

*Strategic litigation often must be accompanied by advocacy for broader reforms*

For example, if all forensic experts in a jurisdiction work under the auspices of the police or other law-enforcement agencies, long-term efforts for change might involve documenting human rights violations that are facilitated by the lack of independent doctors and overall challenges of conducting effective medical examinations in such systems and developing policy proposals for reform combined with the domestic and international advocacy for such reforms. In the short-, and medium-term, the training of independent doctors, the solicitation of expert reports from doctors abroad, engagements with health authorities to adopt appropriate protocols for medical examinations, and other complementary non-litigation efforts might be necessary.

*Courts should be treated seriously, even if they do not appear independent*

Presenting serious evidence, amicus briefs, and expert opinions can be meaningful, even in cases with a low likelihood of success or before courts that lack independence. Sometimes litigators and activists assume that there is no hope in the domestic system, but then they see that the government does not necessarily deploy the full arsenal of repressive tools against each case, and wins are possible. Often, strategic human rights cases need a boost—a political opening, a thorough and courageous judge—but they should always be as strongly argued as possible on their merits. There are, at the same time, cases where the hope for fair result is even lower than usual, for example in cases where a negative outcome is all but guaranteed due to the politically charged nature of the case.

*Strategic litigation often involves trade-offs*

Litigation involves constant trade-offs. There are limited resources. Victims and lawyers might disagree on what approach to take to seek accountability, or on what strategy is most likely to succeed. Some legal avenues might just be too dangerous in some cases—
for instance, seeking individual criminal accountability can lead to retaliation against the victims or their representatives. Sometimes, the best option is to bring a case in the public interest without naming individual victims. For some victims, holding perpetrators accountable is the most important objective. Others find reparations more meaningful because they serve as an acknowledgement of state responsibility. Some want to forget and move on with their lives. Victims’ opinions and commitment might evolve and change during the often protracted litigation process, and the litigation needs to be adjusted. If adherence to all international human rights standards could be guaranteed, these trade-offs would not be relevant but, unfortunately, the reality forces both victims and litigators to be strategic and make imperfect choices.

Successful strategic human rights litigation depends on building a strong evidence base
In international human rights law and jurisprudence on torture, the burden of proof often rests with the state, which must provide a plausible explanation for the harm inflicted on the victim. In most domestic cases, however, the burden of proof often rests on the victim seeking accountability and reparations for human rights violations. It thus is important to build a strong evidence base to help ensure a positive decision. This often means relying on new technology and experts from a range of disciplines. For example, medico-legal reports, including those conducted by independent health professionals, have become a key form of evidence in anti-torture litigation. In some cases, advances in technology and the growing experience of practitioners have allowed medico-legal evaluations to be conducted remotely. Security cameras and mobile phone videos have also been critical in seeking accountability for police violence, for example in the United States. The COVID-19 pandemic, meanwhile, highlighted once again the need to engage scientists, such as epidemiologists, or physicians when calling for humane conditions for those in detention.

The application of international law by domestic courts in one country shows what is possible elsewhere, even in vastly different legal systems
The decision in Kazakhstan on the Gerasimov case, which addressed Kazakhstan’s obligations under international treaties, inspired litigators in Kyrgyzstan and Mexico and led to similar legal victories. For example, in Kyrgyzstan, courts issued several decisions similar to the decision in Gerasimov that emphasized the state’s obligation to implement the rulings of the UN Human Rights Committee. And in Mexico, the Supreme Court issued a decision mandating the state to follow Urgent Action requests issued by the UN Committee on Enforced Disappearances (Garcia Garcia and Gutierrez, 2021; Lisitsyna and Miller, 2021).

Conclusion
In recent years, there have been an increasing number of examples of important human rights breakthroughs in domestic courts addressing torture and similar human rights violations. While judges around the world still often ignore forced confessions, side with alleged torturers, or are simply reluctant to challenge the system in which they operate, we have also seen how successful cases can contribute to social change. Moreover, the impact of strategic litigation is not always measured by success in court—the failure of litigation can serve to expose injustice and galvanize movements for change. Litigating in domestic courts, when used strategically, has distinct advantages. When it is deployed as part of a broader project of civil society organizations and social movements to advance
human rights, strategic litigation can help victims obtain a measure of justice and lead to policies that curtail abuses.

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Visions from the past: reflecting on the history of epidemiological research in the refugee and post-conflict mental health field

Derrick Silove

Abstract
Epidemiological research has made a major contribution to the knowledge-base in the field of refugee and post-conflict mental health in the last 30 years. There is a tendency however to question the cultural validity of study findings, or, alternatively, to argue that we have sufficient data to predict the mental health and psychosocial (MHPSS) needs of future populations exposed to mass conflict. This paper attempts to address both issues. Specifically, it is argued that, rather than an indicator of cultural inaccuracy in measurement, the large variation in symptom prevalence rates observed across studies may reflect a genuine difference given the unique profile of risk and protective factors that characterize refugee populations based on their individual histories of conflict and current conditions of resettlement. There are compelling reasons therefore, where feasible, to include epidemiological studies in the comprehensive approach of data gathering in assessing MHPSS needs - and to monitor changes over time - in current and future populations exposed to mass conflict.

Epidemiological research has played an instrumental role in establishing the knowledge base on which the modern field of refugee and post-conflict mental health field has been built. The last three decades has witnessed an upsurge in research in the field coinciding closely in time with the lifespan of the Journal, a platform which has played a unique role in the dissemination of information to all actors in the field. It is fitting therefore to reflect on the history of epidemiological research in the field as a contribution to the celebration of the 30th anniversary of the Journal – a task I am honoured be able to undertake.

In offering this personal reflection, I am deliberately selective in the studies I cite – I do so simply to illustrate my comments, not to provide a comprehensive overview or review of the field. I rely heavily on some of the research of my group, no doubt revealing my biases in so doing; if some my assertions and conclusions are regarded as contentious and stimulate debate, all to the better; as Socrates taught, knowledge can only be advanced via a process of dialectical discourse.

By identifying some of the challenges and complexities that confront the field, my intent is not to discourage future researchers from entering the arena; to the contrary, my motivation is to provide some guidance in avoiding the pitfalls that I and my contemporaries faced over past decades. To those with the passion and commitment to enter the field, I offer unreserved encouragement; there is no other activity that I have experienced that is as intense, absorbing and challenging. If conducted appropriately, epidemiological research
in the field offers a unique opportunity for engagement with communities that have lived through the most egregious experiences – the process generates a platform for mutual learning that is beneficial to all, and ultimately contributes significantly to the knowledge base on which mental health and psychosocial services (MHPSS) are built.

Although there is no precise point of in history that marks the commencement of the epidemiological enterprise in our field, the work conducted amongst survivors of concentration camps following WWII stands out as a sentinel milestone. The work and life of Leo Eitinger is an exemplar amongst leading researchers of the time. As is well known, Eitinger was a survivor of the concentration camps, returning to take up the position of Professor of Psychiatry at Oslo University after WWII where he devoted the remainder of his long career to studying the mental health of fellow concentration camp survivors (a tradition of research continued amongst refugees within the department ever since). There can be little doubt that Eitinger’s personal experiences influenced his ideas and insights in the pursuit of his understanding of the psychiatric reactions and wider forms of adaptation exhibited by concentration camp survivors; it is noteworthy, however, how he managed to maintain a scientific perspective in his inquiries, regularly commenting on the methodological constraints he and his colleagues faced at the time (Eitinger, 1960).

During the epoch in which Eitinger worked, it was the custom to admit patients for relatively long periods of time to psychiatric wards, making it possible for him and his colleagues to conduct extensive observations of the extraordinary range and depth of psychiatric reactions and adaptive responses that survivors of human rights abuses exhibit (Eitinger, 1960; Eitinger, 1969). In his work can be found descriptions of patterns of behaviour that were only “discovered” again much later in the field, including states of post-traumatic explosive anger and paranoid-like thinking, and extreme conditions of withdrawal, passivity, and social alienation (described as the “Musselman” syndrome).

Debates with colleagues during that epoch (Eitinger, 1965; Eitinger, 1969) are echoed in the literature in the field of modern traumatology, for example, surrounding the role that subtle brain changes and physical health play in shaping mental health presentations amongst survivors; whether there is a specific traumatic syndrome arising from exposure to gross human rights violations (then referred to as the concentration camp or KZ syndrome); the extent to which pre-existing constitutional factors influence patterns of long-term adaptation following exposure to extreme abuses; and the complex interactions that occur between past traumatic experiences and broader social conditions in the recovery environment in determining the capacity to function, for example, in employment.

In later decades following WWII there was a relative lull in epidemiological research in the field. As late as 1988, a review of contemporary studies on the mental health of torture survivors concluded that the database in this area was slender, in spite of the ubiquitous use of this form abuse around the world (Goldfeld et al., 1988). There were some outstanding epidemiological studies undertaken in the more general field of Migration Mental Health, but these inquiries did not always distinguish clearly between the stressors of migration and refugee-specific traumatic events in determining mental health outcomes (Krupinski, Stoller & Wallace, 1973).

From the mid-1970s onwards, several factors converged to provide the impetus that
generate the “birth” of the modern field of refugee and post-conflict mental health as we know it. An important catalyst was the international movement to ban torture in which mental health professionals played a leading role, sensitizing them to the psychosocial needs of survivors who were refugees in western countries. Advocacy by these leaders led to the establishment of the first specialist rehabilitation services for torture survivors in Europe, and then around the globe. An added factor in the 1980s was the large outflow of persons fleeing the wars in countries of Southeast Asia (Vietnam, Cambodia and Laos), producing the largest movement of refugees the world had witnessed since WWII. Hundreds of thousands of refugees were confined for prolonged periods in camps in the region prior to being re-settled in western countries. This influx prompted pioneers in the field to establish culturally-appropriate mental health services across North America, Europe and Australasia.

Around the same time, in the USA in particular, the discipline of Psychiatry was undergoing a major paradigm shift away from its previous adherence to psycho-analytic principles towards a more biological perspective which aligned the profession more closely with General Medicine. This new approach was reflected in the reformulation of diagnostic categories (referred to as a process of “operationalization”) in the third edition of the Diagnostic and Statistical Manual (DSM-111), published in 1980. DSM-III also took a major step in defining more clearly the category of posttraumatic stress disorder (PTSD), a development that led to an exponential growth in clinical work and research in the field of psycho-traumatology. These developments in turn had an important influence on the growing field of refugee and post-conflict mental health.

The adoption of what was considered to be the principles of logical positivism in Psychiatry provoked a spirited debate in the emerging refugee and postconflict mental health field (see for example, Summerfield, 1998). Critics asserted that constructs such as “trauma” and “PTSD” were reifications based on western epistemologies in Psychology and Psychiatry. Imposing these constructs on culturally diverse communities served only to “medicalize” normative responses to human rights violations, stigmatizing refugees as “patients” rather than recognizing that they were survivors. It was also asserted that applying western approaches of “trauma therapy” also resulted in weakening traditional recovery and healing mechanisms specific to the cultures of refugee groups.

Although the controversy that followed has largely abated, it left a residue of important lessons that persist, particularly about the central focus that needs to be given to culture in all activities in the field, including in epidemiology. This principle played a key role in the development of the first screening measures for PTSD, depression and anxiety developed specifically for the refugee and postconflict mental health field. Cultural and linguistic adaptation was the first step in the development of these measures, only then followed by psychometric testing to assess indices of reliability and validity (Mollica et al., 1992). Other researchers adapted structured diagnostic interviews developed for general psychiatric epidemiological studies to a range of cultural groups (de Jong et al., 2003).

The large body of epidemiological studies that emerged over the following decades has done much to establish the knowledge base on which our field is grounded. Nevertheless, for the field to progress further, it is important to confront several areas of concern, primarily in the interpretation and use of data...
from epidemiological studies. Measurement remains one of the most enduring challenges – and space does not allow a full exegesis of the complexities surrounding this issue. Most studies in the field have used self-report screening measures (which for many participants are completed with field worker assistance). These measures typically assess the severity and/or frequency of common mental health symptoms of PTSD, anxiety and depression, although the focus has expanded to include other categories such as Intermittent Explosive Disorder (IED), and less commonly, to cultural syndromes.

The majority of studies that have been conducted in the field rely on cross-sectional designs, providing a “snapshot” of the person’s level of psychosocial distress at one point in time. This approach has several inherent limitations for both the interpretation and use of the data. First, symptoms can fluctuate widely over short periods of time both within individual and across populations. This should come as no surprise given the rapidly changing conditions in which refugee and postconflict populations often find themselves (Silove et al., 2014). Second, in populations exposed to recurrent and ongoing traumatic events and stressors, it is particularly difficult to distinguish between transient states of distress and frank mental disorder based on a measure of symptoms at one point in time.

Efforts have been made to address this concern by using calibration techniques in which clinicians undertake structured clinical interviews which are compared with symptom checklists administered independently by field workers. A major concern that is not always addressed is that the symptom thresholds generated for a self-report measure in one culture and context may not apply in another – yet not all researchers undertake the process of re-calibrating measures, simply adopting the “conventional” cut-off that has been reported in the previous literature (Silove et al., 2014).

In reality, however, there is no fail-safe procedure for achieving high levels of accuracy in assigning psychiatric diagnoses in large-scale epidemiological studies in the field. It simply is not feasible to duplicate a full clinical interview undertaken by trained and experienced mental health professionals in these population-wide settings. At best, therefore, the prevalence rates of “disorder” generated need to be regarded as estimates only, suggestive of “probable” or “possible” mental disorder.

This raises an important question whether it is ever justified to derive averaged prevalence rates of mental disorder from systematic reviews of the pooled body of epidemiological studies conducted in the field. These procedures have been conducted with increasing statistical sophistication at intervals over the past two decades (see for example, Fazel, Wheeler & Danesh, 2005; Steel et al., 2013; and Charlson et al., 2019). I will not dwell on the substantive findings of these studies here given that these details are not relevant to the points I wish to make – and can be readily accessed by the reader from the literature.

Perhaps the most important finding of all these reviews – and one that is often overlooked – is the heterogeneity in prevalence rates identified across studies, especially in rates of PTSD, depression and anxiety. This pattern of marked variation in prevalence across studies is true even when the exact same measures and sampling methodologies have been used across studies (de Jong et al., 2003). It is noteworthy that in the most recent review of the literature (Charlson et al., 2019), statistical adjustments were made to control for factors found to increase heterogeneity, such as differences in the sociodemographic characteristics of samples.
Yet this procedure appears to run counter to the core principles adopted by major ecological models in the field (Silove et al., 2017) currently applied in the refugee and post-conflict mental health field which emphasizes the unique aspects of each refugee and post-conflict population and its MHPSS needs. Although sharing many common experiences in the generic sense (such as exposure to pre-migration traumatic events and postmigration stressors), these populations vary enormously in the nature, extent and context in which these challenges occur. They also come from societies with unique histories, cultures, and the resources and capacity to adapt to adversity. For these reasons, heterogeneity in the prevalence of mental disorder in epidemiological studies should be anticipated and interpreted as an indication of the likely accuracy of the findings, rather than as a signal of inaccuracy in the method or a statistical “problem” that has to be controlled for in the analysis. Put simply, there are strong observational and theoretical reasons to raise questions about the pooling of epidemiological data in our field if the aim is to derive averaged prevalence rates at a global level in order to guide future service planning in new refugee situations – and presumably thereby to avert the need to undertake further population-specific epidemiological studies. I suggest that the contrary inference should be drawn, that is, that past findings of heterogeneity together with strong observational and theoretical reasons, argue strongly for the need to conduct further epidemiological studies in new refugee settings in order to obtain as accurate picture of the MHPSS needs in that specific context.

In that regard, there is a strong case to be made that longitudinal studies, although labour-intensive, offer a far more useful source of information than cross-sectional studies in that they indicate the patterns of change in a community over time. In that sense, symptom change (and ideally measures of functioning) can provide an invaluable “barometer” not only of the broad MHPSS needs of the community at any one time, but how these needs change over time. By measuring potentially modifiable sources of stress in the community, planners can use longitudinal data to introduce accurately defined new programs to address these problems and to monitor the impact of these interventions over time.

A further note of caution is warranted in relation to the use of epidemiological data to test theoretical models examining the pathways leading to adverse mental health outcomes, such as PTSD. Path models based on structural equation modelling (SEM) are now commonly used for this purpose given that they confer some key advantages over traditional regression methods in allowing the derivation of latent variables and the identification of direct and indirect pathways leading to symptom outcomes. Again, the majority of analyses are conducted on cross-sectional data and the chronology of events is therefore inferred by the ordering of variables within the model being tested. For example, pre-migration traumatic events invariably are located “earlier” in the model than postmigration living difficulties.

Although the constraints of cross-sectional design are regularly identified in scientific reports, the full extent of this limitation needs to be considered in some detail. For example, it is inevitable given the location of variables in the model (based on the inferred chronology of events) that some are more likely to show indirect pathways than others. This is particularly true in relation to traumatic events and postmigration stressors. In that regard, it is important to recognize that all the data included in the model are collected at one time point. There are many reasons,
therefore, that some experiences may be under-reported, and this is particularly true of traumatic events. The mechanisms involved are multifarious: memory decay over time, psychogenic amnesia, dissociation, active avoidance of events that provoked feelings of humiliation, shame, guilt and anger, and hesitancy in reporting these events to strangers. In some persons with PTSD, there may be a countervailing tendency to report memories of trauma that repeatedly intrude into the survivor’s mind.

More generally, clinical experience teaches us that people living under conditions of extreme duress – which is commonly the case for refugees – tend to focus on their immediate living difficulties, an understandable, adaptive response. Clearly then, when asked, they will emphasize these immediate problems and downplay historical experiences, especially in a single interview. Expectations that the interview may result in further material or psychosocial assistance may accentuate this tendency.

Moreover, all theories of epistemology and development emphasize the cumulative nature of learning in which templates of knowledge are adjusted and reformulated based on the incorporation of serial experiences. Although we may distinguish in our measures between variables such as past traumatic events and current living difficulties, at the information processing level, the task is to integrate all experiences in a far more complex manner, a hermeneutic procedure that currently defies quantification. For that reason alone, it would be surprising if there were not epistemic connections between past traumatic events and current living difficulties reflected in indirect pathways exhibited in SEM models. Caution should therefore be exercised in drawing simple inferences from these findings, such as that current living difficulties have a more “direct” impact on current mental disorder. As a practical example, it is commonplace in clinical practice to observe that seemingly low intensity stressors can trigger the first onset of PTSD; this does not mean that trauma was unimportant in the genesis of the disorder, but rather reflects the “final straw” phenomenon in which the cumulation of events has reached a threshold point where the person is no longer able to assimilate and respond adaptively to the entire history of threat and insecurity that they have endured.

These issues remind us that ultimately, research is an active human endeavour in which there is a constant need to re-evaluate methods, procedures, outputs and analyses, ideally undertaken amongst groups of informed individuals who bring their diverse views to engage in the dialectical process of making sense of the process. Statistical analysis, however sophisticated, is only one of the tools that may assist this process – but of course, the machine won’t think for us.

Finally, it is worth reminding ourselves repeatedly about the basic principles that should be applied in research in the field. It is difficult to justify epidemiological research that is not primarily service focused. For this reason, it is essential that leaders in health and other sectors in humanitarian programs play an integral role in the planning and implementation of studies and in the use of data to maximise service developments.

Extensive consultation with all stakeholders is central to the preparatory process and indeed must be pursued throughout the study. Fortunately, there is a consensus that “parachute” research in which inadequate time and effort has been given to building these relationships with the community, should no longer occur. The aim is to encourage a genuine partnership in which communities participate at all levels, in planning, ownership, leadership
and use of the data. The parallel process of capacity building is a key activity, ideally extending beyond teaching core skills in the research process itself.

In the preparatory phase, it is essential to gather available sources of information via community consultations and informants and where available, reference should be made to the grey literature. In-depth qualitative and ethnographic studies are now essential, both because of the perspective and information they offer in their own right, but also to generate hypotheses that inform future epidemiological surveys.

It is often said that epidemiological surveys in our field are expensive, time-consuming, and slow to produce useful results, particularly in rapidly changing humanitarian settings. The field has reached the point where it is possible address these concerns. There is an ample body of knowledge – and researchers with experience who can be consulted - to advise on structured methods to expedite sampling, selection and adaptation of measures and training and monitoring of field workers. The recording of interview data on mobile electronic platforms allows the rapid transfer, organization, and processing of data so that there can be a quick turn-around of information for use by the community, services planners and wider stakeholder groups.

In conclusion, it is noteworthy that in some of the most recent humanitarian crises, the absence of systematic epidemiological data has been considered to be a major gap in planning population-wide MHPSS services on a rational basis (Tay et al., 2019). Whether the failure to initiate such studies is attributable to resource constraints or to a growing skepticism about the value of epidemiological studies field can only be speculative. If the principles of good practice and careful interpretation of data are followed, future researchers in epidemiology can make an invaluable contribution to the generation of knowledge in the field in a manner that will enhance both the quality and effectiveness of MHPSS programming for refugees and post-conflict populations. In a world in which there is every reason to fear an escalation of humanitarian disasters, we should make use of all the resources we have to ensure that we enhance the knowledge base in order to provide the best MHPSS outcomes for the survivor populations we serve.

References


Rehabilitation for torture survivors: Six evidence myths and their implications for future research

Nimisha Patel and Amanda Williams

Abstract
Whilst it is established that torture survivors suffer from complex, multiple and often severe and enduring physical, psychological, social, welfare and many other difficulties; and that rehabilitation as reparation should be holistic, interdisciplinary and specialist, majority of the research on rehabilitation focuses increasingly and almost exclusively on psychological interventions. Further, assumptions that this research provides evidence of which are effective psychological interventions may underpin and skew services funded and provided to torture survivors. In this paper we challenge some of those assumptions, and discuss the conceptual, theoretical, epistemological and methodological limitations of this research and implications for future research.

Introduction
What is rehabilitation as reparation for torture survivors? At the heart of that question is the fundamental issue of what can restore a ‘sense of being human’ to someone brutalised by torture, from whom it has been stripped (Patel, 2019a). What is meant by the sense of being human is fluid, multifaceted and diverse; it is historically, geographically, politically, socially and culturally contextualised. What, then, should rehabilitation entail, and how do we meaningfully establish the effectiveness of rehabilitation activities and interventions for torture survivors?

Rehabilitation, as a form of reparation for the human rights violation of torture, is defined in the United Nations Convention against Torture’s General Comment number 3 on article 14 (‘General Comment’) as “the restoration of function or the acquisition of new skills required as a result of the changed circumstances of a victim arising from torture or ill-treatment” and as seeking “to enable the maximum possible self-sufficiency and function for the individual concerned, and may involve adjustments to the person’s physical and social environment. Rehabilitation for victims should aim to restore, as far as possible, their independence; physical, mental, social and vocational ability; and full inclusion and participation in society.” It is a definition, arguably, which does not go far enough – or more specifically, if it is taken out of the context of the entirety of the General Comment, it would be easy not to recognise that rehabilitation as reparation is more than health: it is a part of redress.

By contrast with these aspirations in international law, many rehabilitation services for torture survivors and research current in this area focus predominantly on psychological interventions as ‘treatment’ (see Patel, 2020 for a fuller review), and start with a Western framework of psychopathology (to be ‘treated’), as-
sessed by Western standardised instruments, and offering Western-developed solutions, usually individual, and rarely contextualised by culture, political or religious perspectives, or by history. Assumptions on the part of service providers and funders, about what is and is not evidence of effective treatment, skew the conceptualisation of what is available and what should be practiced as rehabilitation. In this paper we challenge what see as the most important of those assumptions.

Our systematic reviews and meta-analyses (Patel et al., 2014; Hamid et al., 2019; see also Patel et al., 2016) found relatively few studies (restricted to randomised controlled trials); all were of individual psychological ‘treatment’, usually compared to ‘no treatment’, and primarily aimed at reducing post-traumatic stress disorder (PTSD), a psychiatric disease category. Benefits of these interventions were few and weak; confidence intervals were wide and methodological biases common, undermining confidence in estimates of ‘treatment’ effects. These conclusions were considerably less optimistic than those of other widely cited reviews of the field (Campbell, 2007; Crumlish & O’Rourke, 2010; McFarlane & Kaplan, 2012; Nicholl & Thompson 2004; Weiss et al., 2016), generating discussion (Pérez-Sales, 2017, Williams, 2017). The reviews and the editorial that discussed their major differences (Pérez-Sales, 2017), and other examinations of the body of research in this field (Montgomery and Patel, 2010; Jaranson and Quiroga, 2011; Carlsson et al., 2014) strongly suggested that reviews, and their constituent trials, were being cited by clinicians and researchers without the critical appraisal common in many other branches of health-related evidence. This is not to disregard the considerable practical problems of conducting research on interventions to improve well-being in torture survivors, nor the difficulty of obtaining scarce funding to do so, but to urge better use of those efforts and resources to build more robust understanding in the field. We therefore address what appear to us to be common myths and misconceptions about psychological research findings and evidence, and make a series of practical proposals to use both in evaluating existing psychological and psychosocial research with torture survivors and in designing future studies.

Evidence myths

Myth 1: Good evidence is research-based

The ubiquitous influence of what has come to be known as evidence-based practice in healthcare, and the many critiques of it (e.g., Kerridge, 2010; Miles, 2009), are relevant to rehabilitation services. However, evidence-based practice, as an approach to the evaluation of the best available research evidence and its application to rehabilitation for torture survivors, is limited in at least two ways. First, rehabilitation is not only ‘clinical’ or health practice, but evaluation focused only on physical or psychological health can only ever be that, and cannot be extrapolated as evidence for holistic rehabilitation (social, welfare, legal, educational, vocational etc.). Second, in applying the methodology of evidence-based practice, initially developed in biomedicine, to rehabilitation of torture survivors, the cultural limitations, or specificity of the research methods, of the underlying ethics and of the interpretation of the evidence, lead to the risk of decontextualising research findings, and ignoring their contextual specificity, or limitations – all of which are obscured in the unquestioning, general application to rehabilitation practice.

The ambition of evidence-based practice approaches - to ensure equitable access to
the best available healthcare interventions in order to maximise positive outcomes and minimise harm - is laudable. Yet evidence-based practice relies on hierarchies of evidence, constructed within realist epistemologies and positivist methodologies for evidence-generation, and the criteria for judging ‘quality’ or ‘best’ evidence are narrowly defined by such hierarchies. Other methods of evidence-generation, which value different types of evidence, are overlooked, leading to a hegemony of a particular (Eurocentric and positivist) research and evidence. Much evidence on what is helpful to torture survivors, their families and their communities, their different contexts, is to be found within the wisdom of families, within communities, within the work of civil society and community-based organisations - which may not adhere to the hegemonic discourse of evidence-based practice, but may have significant and weighty contributions to understanding what helps, and what is valued by those communities.

In making assumptions about what is ‘good’ evidence, based on Eurocentric epistemologies and methodologies, we generalise findings of specific types of research, with specific and narrowly-defined populations, to all torture survivors, and we advance and impose rehabilitation services which are based on our hierarchies of ‘good evidence’, and our narrow understanding of what is rehabilitative, ignoring the lived realities, wisdom and diverse experiences of survivors and their communities.

In summary, basing interventions, rehabilitation services and the funding of those services on unexamined assumptions of ‘evidence-based practice’ leads to epistemic injustice (Spivak, 1998), if not to other harms to torture survivors and their families and communities – the very thing which the evidence-based practice approach seeks to prevent.

Myth 2: All research leads to quality evidence
For years, narrative review was the only way of summarising evidence in health research. All methods were undeclared and nonreplicable, from search and selection of eligible studies to integrating findings, drawing conclusions and making recommendations. This often led to an array of reviews, apparently of the same area, drawing on overlapping bodies of evidence, but weighting that evidence differently and drawing different conclusions. Thus, as a set, these reviews presented an extensive, if not comprehensive, account of past research endeavours, but could not achieve consensus on the implications for people currently receiving health treatment/care. Users of those reviews – health practitioners, funders, commissioners of services – likewise made undeclared selections from the reviews according to what suited their purposes and preferences.

From this chaos arose the movement for systematic reviewing, initially of quantitative studies, using transparent and replicable methods that could cumulatively build a high-quality body of evidence. One of its strengths was combining data from similar studies such that they gave an estimate of size of effect (treatment benefit), rather than a majority view as in narrative reviews. Another was that it took account of weaknesses in research methodology that could bias results or conclusions. For instance, a common bias in psychological intervention studies is to use multiple outcome instruments to quantify, for instance, changes in mood or particular psychological symptoms, and then to report only those (often a minority) that showed satisfactory change with treatment. A second common bias particularly relevant to the area of psychological interventions is that of small size studies, which tend to produce more extreme results. Since those with positive results are more likely to reach publication than those that show no
change or worsening, those small studies tended to inflate the apparent benefits of psychological interventions in narrative reviews and even some systematic reviews (Dechartres et al., 2013), although in the latter case the bias would be noted and lower confidence assigned to the estimate of treatment effects.

The Cochrane Collaboration developed a range of systematic review methods (https://cochrane.org), initially for quantitative research studies, including identification of particular biases and ways of quantifying their detrimental effect on certainty in overall findings; Cochrane reviews are seen as the hallmark of reliability (Chalmers & Altman, 1995) for quantitative research. However, the quality of systematic reviews varies (Dechartres et al., 2013, Maassen et al., 2020), and evidence-based medicine in general has been criticised for discounting valuable clinical experience in deciding on the best treatment for each individual patient in favour of algorithms, and failing to incorporate patients’ values or even to involve them in decisions (Kelley et al. 2015), criticisms also highly relevant to psychological practice. Findings about how well treatments work, on average, become rules applied to all, supplied in guidelines that constitute valuable material for bureaucratic and managerial medicine (Greenhalgh et al., 2014). Greenhalgh and colleagues (2014) argued “for a return to the [evidence-based medicine] movement’s founding principles—to individualise evidence and share decisions through meaningful conversations in the context of a humanistic and professional clinician-patient relationship”.

In the field of rehabilitation for torture survivors, the majority of studies conducted and reported are psychological, reviewing psychological ‘treatments’, using quantitative research methods, adopting the framework of evidence-based medicine and applying it to psychological interventions for torture survivors. From the broadest review level to the smallest individual study of effectiveness of an intervention, there is an assumption that both problems and outcomes can be adequately quantified. In psychology, self-report is the near-universal quantification method, using ‘standardised’ questionnaires that arise from the same roots as clinical diagnoses, and validated against them. Yet there are numerous weaknesses at each stage of that process, each of which can only be addressed very briefly here.

First, many psychological processes, including those of importance in psychological difficulties, are not accessible to consciousness, and even if they are they may be hard to articulate in terms recognisable, meaningful and understandable to Western-trained researchers, or may be subject to self-censorship. Second, questionnaires are constructed to maximise reliability by selecting very similar items and excluding more peripheral ones, yet this is in no way representative of the importance of included or excluded items, nor does it necessarily provide a good approximation to broader everyday experience. For instance, whereas many people who experience anxiety also report some depressive thinking, and many people who feel depressed also experience anxieties, the separation of anxiety and depression in Western psychiatric diagnostic classification systems means that the questionnaires also reflect this artificial and Eurocentric construction of the distinction between the two. Third, the scoring of questionnaires – the translation of frequency or importance of a thought or feeling, for instance, identified by a questionnaire item – arbitrarily assigns weight to each item (usually the same weight to all), and combines them in totals and subtotals that are then matched against ‘norms’ to interpret in clinical terms: to decide that the
client’s score falls within a clinical population or within a non-clinical population. All these processes of questionnaire construction draw on data from largely English-speaking populations, often White (Heinrich, 2020), from the Global North, and compliant with psychiatric classification. Extrapolation to other populations with diverse cultures, languages, beliefs and ways of understanding distress, is fraught with problems (Johnson, 2006; McHorney & Fleishman, 2006; Sousa & Rojjanasrirat, 2011) and is rarely adequately addressed in research. All these speak to the need for a more flexible and inclusive understanding of what kind of research can provide good quality evidence, discussed below.

In summary, not all research leads to quality evidence; and evidence-based practice is highly questionable when based on outcomes of poor research, and when the limitations of the research, including its Eurocentricity, are not addressed when evaluating the quality and the applicability of the ‘evidence’.

**Myth 3: Efficacy of psychosocial interventions can only be demonstrated by randomised controlled trials (RCTs)**

Systematic reviews of treatment efficacy largely restrict eligibility to randomised controlled trials (RCTs), where randomisation of research participants to treatment or control arms is used to reduce the variance in outcomes due to extraneous factors, making it easier to attribute differences in outcome to different effects of the treatment over the control arm/s. The control is often no treatment, a realistic clinical situation, or in psychological trials may be an educational or supportive or other intervention of similar contact time to psychological treatment/interventions, but without the intended therapeutic content. This is in contrast to the simple and common evaluation of psychological interventions that assesses variables of interest before and after interventions on all clients, but cannot distinguish effects of the interventions from those of natural recovery, the benefits of contact with clinicians and, in group settings, contact with other clients, and other extraneous and often unquantified influences.

RCT's have long been regarded as the ‘gold standard’ of treatment efficacy testing, in medicine and increasingly in psychology, although observational methods including single case studies are also highly rated in evidence-based medicine (Howick et al., 2011). However, RCT's have many disadvantages. One of the major ones is that of restricting eligibility for the trial according to population characteristics, discussed under myth 4, but often excluding people with multiple problems, or who are more likely to drop out of psychological care; examples are people with insecure accommodation or undetermined legal status, as is common in torture survivor populations, or who do not speak fluently the language of the rehabilitation service provider. Some RCT's on psychological interventions with torture survivors (see reviews by Hamid et al. 2019; Patel et al. 2014) have recognised these issues and taken a more inclusive approach to recruitment, not without its own difficulties. Another disadvantage is that the interventions are multi-component – they consist of a series of separate or combined components of presumed therapeutic benefit, delivered by a trained therapist – and no RCT can disaggregate the effects of each component from the others, yet the assumption that they are always synergistic, and to all participants, is rarely tested or even raised as a concern.

A further problem is the interaction of interventions (standardised) with client characteristics to produce different outcomes. The assumption of homogeneity of the participant population means that average results are re-
liable and useful for planning, but we cannot easily tell whether results differed in systematic ways according to how those participants were at the start of interventions. However, the clinician/practitioner and client want to know how well interventions will work for that particular person. Single case methods (Morley, 2018, Vlaeyen et al., 2020), where they can be applied, offer the possibility of testing truly personalised care (Howick, 2011). Outcomes for single case studies need to be countable, so rather than using questionnaire scores, personally relevant events such as nightmares, hours of sleep, distance walked or people spoken to per day, are used. While further description is beyond the scope of this paper, the method is far more accessible in clinical practice than are RCTs, although often demanding for the client in terms of repeated data collection.

There are further problems with reliance on RCTs. They are complex and often expensive to run, meaning that economies are made that can compromise quality and confidence in results. One of the most important of these is the problem of small size, described above. In our 2019 systematic review, we analysed 15 trials with a total of 1,373 participants, and a range from 10 (i.e. 5 in each of the treatment and control groups) to 165 per trial. Further economies on staffing undermine efforts at assessment and statistical analysis blind to client assignment, adequate translation or interpretation of assessment and treatment materials, and frequency and length of follow-up. All these make for a field with generally rather small trials with moderate to serious problems of bias, and therefore efficacy estimates that might be in the right direction, but whose size is entirely uncertain.

In summary, the efficacy of psychosocial interventions for torture survivors cannot be assessed only by RCTs, and the reliance on RCTs is problematic on conceptual and methodological grounds, as well as re-casting the impact of torture as a disease category, and rehabilitation interventions as ‘treatment’.

**Myth 4: RCT results can be generalised across all torture survivors as a homogeneous group**

The disadvantage of the RCT design is that, in ensuring minimal variance in the population to be randomised and in the delivery of treatment/interventions, the trial may depart so far from usual rehabilitation practice, with its highly heterogeneous populations and practitioners who are trained to differing levels and deliver interventions in varied ways, that it cannot easily be generalised to wider populations of torture survivors. For instance, many of the studies of psychological interventions for PTSD largely recruit from people who have had road traffic accidents, or suffered violent assault or other crime, but within the context of a relatively safe civil society. While there is no doubt that many of the difficulties that are experienced in these populations – nightmares, flashbacks, high arousal to particular cues, for instance – are also experienced by survivors of torture who may similarly be diagnosed with PTSD, equating the psychological difficulties or needs of the two populations makes huge and unwarranted assumptions (for critiques, see Summerfield, 1991, 2001; Patel, 2011). Yet where RCTs supposedly demonstrate that ‘treatment X’ is effective in road traffic accident survivors for reducing PTSD, or, rather, reducing scores on PTSD questionnaires, ‘treatment X’ will be offered confidently to all other populations whose post-trauma difficulties are seen as the main target of psychological intervention.

In summary, torture survivors, their backgrounds and their experiences of torture, and the aftermath, differ considerably and they are far from constituting a homogenous group, nor a distinct ‘clinical population’. The out-
comes of RCTs on psychological interventions cannot be generalised to all torture survivors, nor do they capture the range of psychological and other difficulties and outcomes of interventions for torture survivors included in the studies reviewed.

Myth 5: Western psychiatric nosologies apply universally

Mental health as the outcome of treatment is rarely defined, beyond the WHO’s original conceptualisation of ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’; absence (or sub-threshold score) of disease is the key concept used traditionally in psychological and psychiatric interventions, or ‘treatment’. This has meant not only that diagnostic systems for identifying and classifying disease have become commonplace in evaluating outcome, but also that our understanding of research outcomes has reduced the complexity, intensity and vast breadth of the experience of human distress and suffering to the measurement of the reduction of assumed ‘abnormalities’ which focus on certain ‘symptoms’ – of distress. These systems of psychiatric disease classification (DSM and ICD) are widely criticised for their application of the biomedical model to psychological and mental health, for pathologizing normal distress and for their Eurocentricity, including in the research on which they draw, and its interpretation and generalisation (see Kirk and Kitchings, 1992; Horowitz, 2015; Rapley et al., 2011; Johnstone, 2009; Fernando, 2003; Boyle, 2003).

Each of these classification systems is repeatedly revised, and except for the very small number of organic symptoms, refer to behaviours and experiences that assume consensus on social normativity or deviance (Rashed & Bingham, 2014), even though these behaviours and experiences change with each revision: for instance, homosexuality was classified as disease in the three earliest versions of DSM. The tendency has been for both systems to expand, and much of the debate concerns whether they include and pathologise ‘normal’ variations in mood, such as depression after bereavement, and temper tantrums in children (both now included in DSM-5 diagnoses), which further questions their applicability to diverse communities with diverse beliefs about what is ‘normal’ and understandable human distress.

The diagnosis of PTSD is highly problematic, not least because it was invented (Young, 1995) for a specific purpose, in that it arose within a particular political and social context, but also because of its widespread and uncritical, reductionist use with torture survivors, with the unexamined assumptions that this disease category has universal conceptual and cultural validity, and that it meaningfully captures, with its array of symptom criteria, the multiple and intersecting impacts of a gross human rights violation such as torture (Summerfield, 1999, 2001, 2009; Patel, 2011). Yet PTSD has become a brand, used as a shorthand for extreme distress following torture, and it is now the currency of researchers, funders and rehabilitation services, and widely used in studies with torture survivors. Like several other disease categories in classification systems, in the most recent DSM-5, PTSD has become far more inclusive by loosening and widening the criteria, so much so that it has been described as ‘amorphous’ (Galatzer-Levy & Bryant, 2013), with the calculation that there are now over 636,000 different ways that presenting symptoms and difficulties can meet the criteria for the diagnosis of PTSD. With each iteration of DSM, the symptoms have broadened to include more that are common transitory responses to stress, and to
identify yet more experiences that are far from those of war or torture as ‘causes’ of PTSD.

ICD-11 has taken a narrower approach (Hyland et al., 2018), and separated PTSD from complex PTSD (CPTSD), developed using statistical methods. It claims to apply better to repeated and multiple trauma, where no escape was possible (Brewin et al. 2017; Cloitre et al. 2019), and to incorporate fewer of the common symptoms of anxiety and depression. Yet neither system used by researchers, ICD or DSM, takes any account of the wider concerns about cultural validity – and in the case of torture survivors, the social and political functions of using disease categories to attempt to capture the immeasurable impacts of torture as a human rights violation – as ‘abnormalities’. By comparison with the attention to PTSD, and the uncritical application of the diagnosis, other common problems in survivors of torture that cause immense distress and adversely affect everyday functioning, such as chronic pain (Amris et al. 2019; Rasmussen 1990) and traumatic brain injury (Burnett & Peel 2001) are little investigated, discussed, or addressed in rehabilitation of torture survivors.

In summary, a reliance on Eurocentric nosologies for psychiatric disease categories is problematic on methodological and conceptual grounds, and for their assumptions of universality, making them inappropriate for assessing outcomes of holistic and multi-faceted rehabilitation for torture survivors from diverse cultural, linguistic, political and social contexts; and with diverse experiences of torture alongside other human rights violations.

Myth 6: Rehabilitation for torture survivors is equivalent to psychological ‘treatment’ of psychiatric ‘diseases’

Conceptualising the many difficulties experienced by torture survivors as PTSD and other individual ‘pathologies’ hugely simplifies the magnitude and breadth of the impacts of torture, the ‘ripples of harm’ (Patel, 2020) on individuals, families and communities, whilst pathologizing severe and enduring distress as a result of human rights violations, as if to be understood by psychiatric disease categories and locating the problem within the individual psyche. Such reductionist, narrow conceptualisations also construct, incorrectly, the tasks and success of rehabilitation to the reduction of symptoms of an assumed psychiatric disorder (‘evidence’) and as ‘treatment’ of a pathology, rather than recognising rehabilitation as a form of reparation and as addressing the wide ripples of harm of torture with corresponding ‘ripples of care’ (Patel, 2020). Rehabilitation, then, is not synonymous with psychological interventions - it encompasses a multitude of interventions and outcomes in relation to the medical, psychological, social, welfare, educational, vocational, legal, and humanitarian concerns and needs of torture survivors and their families.

In 2014 we published our first systematic review and meta-analysis on rehabilitation interventions for torture survivors (Patel et al. 2014); in 2019 we published a substantially larger update review and meta-analysis (Hamid et al. 2019). Both reviews started with a search for psychological, social and welfare interventions, all seen as interrelated aspects of rehabilitation, but we both found only psychological interventions among the eligible RCTs. Even common outcomes in studies of psychological interventions, such as quality of life, were only evaluated by a minority of studies. None of the studies addressed wider issues of health, impacts on families and communities, social participation or engagement, and only about half referred to the multiple serious problems faced by torture survivors. Unsurprisingly, dropout rates were high, and even where statistically significant gains were made
from the psychological interventions, participants’ post-‘treatment’ scores (disregarding concerns about validity of the questionnaires used for those participants) were still often in the clinically severe range. The implication was that even when survivors continued to live in conditions of ongoing threat and insecurity, where they had not been able to access justice, or to be reunited with their families, or to be assured asylum and safety; when they were homeless or had inadequate accommodation; where they were separated from family and friends and social networks; where they struggled to subsist and faced racist threats and attacks and so forth - their psychological symptoms could be effectively addressed in a vacuum, expecting benefit even if none of their social conditions changed.

In summary, how far this falls short of the rehabilitation aim “to restore, as far as possible, survivors’ independence; physical, mental, social and vocational ability; and full inclusion and participation in society” is all too clear. Psychological ‘treatment’ of ‘diseases’, such as PTSD, does not encompass holistic rehabilitation, and research which implies this decontextualises torture and the suffering it causes; narrowly defines the problem as psychological and locates the problem within the individual, whilst defining outcome (or lack of change) narrowly as symptom-reduction.

Implications for future research
Rehabilitation for torture survivors and their families and communities is broad, and ideally and necessarily contextualised, with a process of providing specialised, collaborative and coordinated interdisciplinary care. As such, our research endeavours need to move beyond the replication of studies testing psychological interventions alone, and beyond the myopic attention to reducing assumed disease symptoms. These studies have many methodological limitations, discussed by study/review authors, as well as limitations in how they have been interpreted in the field by researchers and practitioners (e.g., Montgomery and Patel, 2010; Jaranson and Quiroga, 2011; Carlsson et al., 2014; Patel et al., 2016; Patel, 2020). They require detailed consideration, beyond the scope of this chapter, but since their limitations significantly constrain what can be gleaned from the literature to inform rehabilitation practice with torture survivors, they are summarised here.

Conceptual limitations and implications
Conceptual limitations are often overlooked in research on rehabilitation with torture survivors, and these limitations can underpin many other weaknesses of the study and the conclusions which may be derived from them.

1. Rarely do studies start with a conceptualisation of rehabilitation for torture survivors (for a fuller discussion, see UN General Comment 3; Patel, 201; Sveaass, 2013), instead conflating rehabilitation with ‘psychological treatment’. Studies could elaborate on how their focus on psychological or other interventions is part of, or is related to, rehabilitation; and outline the limitations of the study, guarding against generalisations to or from other populations.

2. Studies rarely define participants specifically as torture survivors, and assume wide-ranging definitions. Some studies use definition-based checklists that compare participants’ experiences with those definitions, insofar as study participants are able to use the checklists, but do not report in a transparent way how many of their study population were torture survivors. Other studies make no reference to a definition, or do not distinguish torture
survivors from other refugees, asylum seekers, or internally displaced people in their study population. While some experiences may overlap, and study participants may share current conditions (e.g., living in a refugee camp, seeking asylum), the risks and restrictions they face, and their rights, may differ substantially. The legal and political context of torture survivors cannot be set aside in relation to research processes and outcomes, and average outcomes or generalisations for the entire study population may not be true of the subset of torture survivors, who may respond differently to rehabilitation interventions or be more likely to drop out. Providing information about how a study has defined who can be considered a torture survivor is essential information.

3. To compound the problem, reviews may combine results of these studies with those of studies with torture survivors alone. Again, this makes it impossible to generalise with any confidence from review findings. Avoiding combining such diverse studies is difficult but important, and at the very least, these limitations must be made transparent.

4. Study populations are often heterogeneous with respect to personal data, including baseline scores describing physical or psychological health status. Further, torture survivors may face additional socioeconomic stressors, lack of access to justice, absence of justice and of reparation, multiple losses and ongoing traumas, all potentially impacting on their psychological wellbeing and response to any psychological, social or other rehabilitation interventions. Such baseline differences can be hard to characterise and we have little understanding of how they might interact with content and process of interventions, but research study therapists are in a good position to generate hypotheses about such interactions that might be testable in meta-analyses that use individual data.

5. A further level of complexity arises from the context in which psychological interventions, often rather narrowly conceptualised, interact with other forms of rehabilitation (including social, legal, and educational interventions). Few studies note or reflect on the effectiveness of the psychological interventions in this context, or in the context of external events of significance for the torture survivor, for example, political changes in their country of origin, reprisals against and worrying or absent news of family members, and the vagaries of seeking asylum status. It is not helpful to attribute all gains or disappointing outcomes to the psychological intervention, without considering these factors in the study analysis, interpretation and discussion of study limitations.

6. It is common for the target of psychological intervention to be PTSD diagnosis (more specifically, symptom-reduction to sub-threshold levels), whether or not that is the predominant concern of participants, and sometimes eclipsing all other forms of distress, or sub-threshold psychological/psychosocial difficulties. Further, those studies that attribute PTSD entirely to the experience of torture implicitly equate symptom reduction with modifying the assumed main/only impacts of torture, whilst also obscuring other current sources of distress: legal proceedings, societal racism, marginalisation and ostracisation, insecure living conditions, poverty etc. Studies should broaden their focus on the widespread impacts of
torture and be transparent about their focus, and the limitations of their study with respect to underlying assumptions, and their neglect of other sources of suffering and distress impacting on torture survivors and on their engagement with psychological interventions.

**Theoretical limitations and implications**

In any research, interventions used need to provide a rationale for the choice of intervention, specifically for torture survivors, and details of any adaptations made and of the rationale. It is common in RCTs for the convictions of the research team and delivering clinicians to substitute for a theoretical rationale, but this fails the requirement of equipoise that is required for a good quality RCT (John, 2017; Sackett, 2000). The theoretical and evidence base for the particular intervention requires description in a detailed protocol that constitutes part of the public registration of that trial (Cybulski et al., 2016; DeAngelis et al., 2004).

1. Many studies make reference to torture, traumatic experience, and PTSD as rationale, with a basis in observational studies of torture survivor populations. They lack an explanation of why PTSD is prioritised, or singled out, by researchers and clinicians as the target of treatment, and they lack any exploration with torture survivors of what they perceive as their problems in need of intervention. As noted earlier, this practice decontextualises the nature and effects of torture, excluding the wider environment that can exacerbate or maintain distress, and presents suffering from torture as an individual, and usually only as a psychological, problem (Patel, 2011), in turn used to justify the choice of individual psychological interventions. Studies should provide a rationale for the interventions, noting their limitations, and justifying their treatment priorities in terms of how these fit into the wider aim of rehabilitation.

2. As described in Myth 5, the psychological interventions commonly considered for use by researchers and clinicians working with torture survivors are based on frameworks of understanding and models of psychological change developed in the West (and then ‘tested’ in low-income countries, conflict areas etc.), with a focus on reduced symptom counts in the target categories of distress (PTSD, depression, anxiety, etc.). The meaning of distress, health and wellbeing need to be elaborated beyond Eurocentric constructions, including (for instance) spiritual, familial and social health, and interactions between these and the context within which the individual is living: family, community, and legal and political context. Studies should broaden their focus on a range of rehabilitation interventions, and note the limitations and culture-boundedness of Eurocentric models of interventions used.

3. In an attempt to recognise the different cultural and political context in which these Eurocentric theoretical frameworks are applied, with all their embedded values and assumptions about gender, morality, and social relationships, some studies make ‘cultural adaptations’, assuming and reasserting a normative framework that is still Eurocentric, without defining in detail ‘culture’, whose culture and in what context (since cultures are not homogenous and bound by language or nationality), and what are these ‘adaptations’. Studies should make clear how such
‘adaptations’ are developed, by whom, and on what theoretical and empirical foundations; as well as detailing the underlying assumptions of the assumed norms, and related limitations of the study.

4. Beyond the effects of the contextual factors described on the impact of any psychological intervention, and the experience of participation in a study, the ‘ripples of harm’ of torture extend beyond the individual. Interventions are often provided in a setting in which multiple and intersecting systems and processes of power and oppression (e.g. sexism, racism, economic, homophobic) impress on study participants. Studies should note these contexts and consider an intersectional analysis to fully grasp what individual psychological intervention can and cannot do, and to interpret outcomes in that light, noting the related limitations of the study.

Epistemological limitations and implications

Often research on rehabilitation, including psychological research, neglects a discussion of epistemology and the implications for the research process. Epistemology, however, is hugely important, since all researchers hold assumptions about the world that guide their research agendas, practice and conclusions (Chamberlain, 2015). Epistemology inevitably influences theoretical orientations and chosen research methodologies, with underlying assumptions about what can be known (ontology), how and what is valued or devalued as knowledge, and the role of the researcher throughout the research process, during design, method, analysis, interpretation, discussion and reporting of research outcomes.

1. The largely positivist epistemology of torture survivor treatment studies ignores the roles of researchers and their influence on the research process. It also deems symptom counts to be more important and less subject to bias than, for instance, survivor-based experience and meaning-making as evidence, or evidence from experienced clinicians. This assumption is examined below. As with theoretical limitations, the epistemological stance of researchers in any study needs to be stated, in particular, with transparency on what is valued and devalued as evidence in the research.

2. Rehabilitation as an overall aim of intervention implies not just changes for the individual, but also changes in the individual’s environment, including their social environment. Meaning is central to these processes, and understanding what is rehabilitative and enabling for an individual, in what situations, goes far beyond symptom counts. The perspectives and experiences of survivors and practitioners thus afford invaluable insights into what helps, and what can be seen as ‘rehabilitative’. One implication for future research is that a wider range of research epistemologies beyond positivism, and a broader range of qualitative and quantitative methodologies, are used as they may yield a wider range of evidence with can inform practice, services and community programmes.

Methodological limitations and implications

There are many methodological challenges in designing treatment studies, particularly in interventions with torture survivors, but there is also a substantial literature exploring and testing how these challenges may best
be addressed within the constraints of any particular study, aiming for highest possible quality and usefulness of the research outcomes for the wider field and for populations targeted. Grant et al. (2018) offer detailed CONSORT guidelines extended for psychological and social interventions, particularly RCTs, and Montgomery and Patel (2011), Patel et al. (2016) and Baird et al. (2017) all explore the specific area of torture rehabilitation. Common methodological limitations of the predominantly quantitative studies on rehabilitation for torture survivors, and their implications, are outlined below.

**Sample**

1. Small samples are not only underpowered to show the changes or differences they claim, but are particularly liable to produce large effect sizes (Dechartres, 2013, 2014); these studies in turn contribute to questionable summary statistics in meta-analyses (Turner et al., 2013). Where samples are inevitably small, it would be better to use single case methods than group-based analyses.

2. Sampling processes are rarely adequately described: there are barriers and facilitators to arriving at the point where eligibility criteria are applied, and many of those earlier selection procedures depend on judgements made, often by individuals peripherally involved in the research processes (such as referrers to a service), on whom to approach, or how and where to distribute invitations to participate. A careful account of these procedures allows more nuanced and contextualised understanding of the results and recognition of the limits of generalisation.

3. Unlike standard clinical studies in high-income countries from the Global North, such as studies of interventions for depression, participants in studies with torture survivors may be recruited on the basis of their legal status (e.g. including/excluding asylum seekers), their nationality, or language (for practical reasons), or experiences of torture. Before intervention they are typically assigned a PTSD (or other) diagnosis or score, although they may not be required to exceed a threshold severity score on a PTSD questionnaire, or to reach caseness; often those who may be suffering severely but do not meet PTSD criteria are excluded. Generally, there is a lack of necessary detail reported on how participants were selected (and excluded) for studies, with most studies recruiting their sample based on severity of symptoms, psychiatric diagnoses or care-seeking behaviour. Attention to this detail, and limitations in study recruitment practices, should be explained by researchers.

4. As described in Myth 4, samples of studies reported are mostly heterogeneous and highly variable, including in their experiences of torture (if specified) and other traumatic experiences, environmental, socioeconomic and political stressors and injustices and support structures; in period of resettlement (if refugees or asylum seekers); and country, cultural, ethnic, linguistic and other backgrounds. This presents particular problems in the outcomes being unquestioningly generalised to all/other torture survivors. Additionally, the duration of distress, and any previous psychological interventions and their results, are rarely reported, yet references to chronicity of symptoms and ‘treatment-resistance’ are made in defining target populations. In the light of sample heterogeneity, complete description of the sample cannot be realised, but sup-
complementary information and data sharing make collection of more such information, of possible use to further analyses; they may also allow combination with other researchers’ samples. This is an area where more reference to the wider literature on psychological wellbeing would suggest variables that are rarely described, such as social support/isolation; disposable income/material deprivation; and physical health status.

5. While many studies are only able to recruit small samples, often because of inadequate resources, many also show high attrition rates which further reduce the power of the study, and that introduce questions about acceptability of the intervention. Study participants may stop attending services and ‘treatment’ offered for an infinite number of reasons, including many unrelated to the intervention or to those carrying it out, and it is very hard to obtain from those who drop out the reasons for doing so. Nevertheless, psychology as a discipline is poor at considering the risk of harm from interventions, from distress worsening as a result of interventions to undermining confidence in the possibility of any psychological/psychosocial improvement. Studies should note attrition rates, possible reasons why and explain what follow-up methods were used, and their limitations.

1. Modelled on medical research, RCTs using psychological interventions often rely on closely supervised interventions, which also depend on the vehicle of therapeutic relationship (Baier et al. 2020). The convention for RCTs, again following medical methodologies, is that treatment methods should be protocolised and manualised, and then scrutinised for adherence by participants and therapists, as should control conditions. If we do not truly know what was done in the intervention, and how it differs from the control condition, outcomes are uninterpretable or have huge margins of error around them. However, manualisation and adherence to a manual go against all principles of flexible, personalised, responsive and contextual therapeutic and rehabilitation interventions. With torture survivors, manualised interventions neglect the wider scope of rehabilitation, and narrow the focus to psychological interventions, viewing any positive changes as solely a result of those interventions (as opposed to the other factors and interventions which may impact on the survivor’s well-being). In RCTs, it is essential to describe interventions clearly, so that they...
can be replicated, reviewed, and built on. However, it is easy for inexperienced therapists in studies and researchers to either be highly protocol-driven, neglecting the specific needs of torture survivors, or to fall back on a non-directive counselling style or simplistic advice-giving, and this inevitably affects the outcomes of the interventions offered to survivors. Any interventions in studies on torture survivors should be designed for maximum effectiveness, in other words, maximum benefit for the participant/client. In studies using psychological interventions this likely demands adaptations and adjustments in the moment, and during the course of intervention, to address the needs of the participant/client – as such, the specific needs of the survivor should be prioritised over study protocols and researcher interests. Discussion of these pragmatic and ethical aspects, and limitations and evaluations of interventions offered (and by whom) must be included in study reports.

2. RCT trial therapists are commonly supervised during the course of the trial to ensure adherence to protocol and to keep interventions true to the theoretical basis of the intervention. Issues of the quality of supervisors (including qualifications, experience and competency) to encourage, guide, even to retrain or remove therapists with poor performance, are therefore extremely important, but rarely mentioned in studies. Again, this refers not only to conventional therapeutic competences but also familiarity, contextual knowledge and skills in work with the study population – torture survivors – particularly where local health workers or lay persons are trained as therapists, but their adjustments in the interventions may be insufficiently understood or even derogated by supervisors unfamiliar with local context and sociocultural norms. Studies should provide details on supervisors, their professional backgrounds and nature and level of experience with torture survivors, their practices and decisions during the study, noting limitations relevant to the evaluation of the study.

3. The choice of comparison group or groups in RCTs requires justification. The common waiting list (no treatment) control provides control for the passage of time, somewhat less important in chronic than in acute psychological difficulties, and for attention from researchers at a minimum on assessment occasions. It does not control for possibly therapeutic components, such as having therapist time and attention, the induction of hope, and in group interventions, meeting others with similar problems, although some waiting list control treatments do have elements of these. People can improve in waiting list conditions across a range of problems, more than people not included in the trial, which is a more realistic approximation of the usual option. In addition to what is provided as part of the waiting list control, participants may take initiatives in trying other rehabilitation interventions over this time, but they are rarely asked if they have done so.

Although most trials have a fixed number of sessions of specified length, those with a minimum and maximum number rarely describe how different therapists decide on the number, or how this is treated in analysis, since early discharge can be a result both of rapid improvement and of lack of improvement (Barkham et al., 2006). Further, particularly in groups, members may attend less than 100% of sessions,
and this may affect efficacy, but that question cannot be addressed without the data. Particularly in the light of high attrition, and the multiple possible reasons for attrition from intervention, positive evidence of acceptability of the intervention to the study population increases confidence in replication and generalisation, but is rarely provided in studies with torture survivors. Some trials analyse data only from those participants considered ‘completers’ by having attended a minimum percentage of sessions, but even that assumes equivalence of content across sessions that is unlikely to be true. Further, some interventions are given as part of a larger therapeutic or rehabilitation programme with the wider community from which participants are drawn, meaning that they could be attending other individual, group or community-based interventions at the same time as the psychological intervention of interest.

4. A minimum follow-up of 12 months for interventions offered to torture survivors in studies seems appropriate, ideally longer. This is often difficult in the light of resources for intervention; unstable living conditions, and other circumstances that can make follow-up assessment hard to complete. However, participants’ reflections on psychological interventions and on their wellbeing over the intervening time can offer valuable insights. There may also be other important changes in participants’ safety and security, legal status, or other living conditions, for better or worse, that are relevant when interpreting follow-up data. Studies should provide relevant detail on the choice of comparison groups, on how session lengths are decided and vary, on attrition rates and possible reasons, on follow-up assessments and relevant other contextual changes in the study participants’ lives which may impact on their wellbeing; and studies should note all related limitations of the methodology.

Assessment instruments
Assessment is a complex and fraught undertaking that in studies with torture survivors is too often separated from the theoretical basis of the study and from the specific and varied psychological difficulties of participants, and their cultural and social context. Some of the specific limitations of studies are outlined below.

1. Consistent with the psychiatric disorder classification system as the basis of intervention studies, almost all studies with torture survivors use psychiatric diagnosis-specific symptom assessment, quantifying usually by severity, frequency, or interference with daily life. In some studies, this may be complemented by a general health assessment, but these tend to preclude assessment of change in distress across broader domains, and ignores the numerous ripples of harm of torture and the desired and potential changes in social wellbeing, and wellbeing within families, groups and participants’ community or communities. As a theoretical basis, studies should situate their assessments within a sound understanding of torture and its wide-ranging impacts (beyond simplistic and reductionist notions of ‘symptoms’ and ‘disorder”).

2. Assessment instruments are developed and tested for psychometric quality in a particular culture, with norms of expression, expectations of disclosure (including to clinicians and to strangers such as researchers), and with particular theories...
about how emotions are or are not experienced and associated with one another and with somatic symptoms. They are also often designed to meet the requirements of a diagnostic system, so that, for instance, anxiety-related items are removed from depression questionnaires, and depression-related items from anxiety questionnaires, although many of the psychological difficulties co-occur and are inter-related. Used with people from cultures with diverse theories of distress, the content of typically Eurocentric instruments may poorly represent the construct (e.g., ‘depression’), assuming that there is conceptual equivalence and cultural validity. Even where there is agreement across different cultural groups on the concept and the particular difficulties or symptoms that are relevant, the associations between items may be very different in different cultures (and diverge from those in Eurocentric assessment instruments), threatening reliability and interpretation, particularly where these use factor scores derived in the original population. Where instruments are used, they should demonstrate cultural and other validity for the population under study.

3. Many studies comment in passing on the limited validity (including cultural validity) and reliability of instruments developed in one population and setting and used in very different ones, and some use standard or local translations, or on-the-spot interpreters to deliver those assessments. However, there is little to no discussion of the ethical implications of using lay interpreters/translators, or of translating instruments without formal cultural validation. Validity is not infrequently asserted by researchers and study authors without any supporting reference or other information, but validation is an ongoing enquiry into the performance of an instrument within any particular population and setting, not a fixed property of the instrument, as often implied. A common form of validation (in the normative culture within which the instrument is developed) is comparison with existing questionnaires for the same construct, and/or diagnostic categories, both of which are culturally-bound. Understandings of well-being can vary across cultures and communities, and particular presentations or difficulties may be misinterpreted by researchers, or simply ignored where the instruments used do not capture culturally-specific understandings of distress and well-being. Studies should not only ensure cultural validity (not merely translations) and other validity, they should note the limitations of the study, and address ethical considerations.

4. There is some heterogeneity in the outcome instruments used in studies with torture survivors, with variability in the content addressed. Consensus recommendations for assessment instruments would be a welcome initiative to reduce this heterogeneity and improve overall quality of evaluation. Meanwhile, as is common for psychological intervention, most outcomes are assessed by self-report, with all the problems identified above, or less often by diagnosis-based on self-report or clinician interview. Studies could make use of external indicators, such as attending training or employment, making or extending social ties, or making quantifiable steps towards some other aspirations of torture survivors. Changes in the intervention and control groups also need to be reported in terms of effect sizes and actual mean
change, and the variance of both, not only in terms of statistical significance of change. Some changes that meet required statistical criteria for change fall far short of a desirable clinical improvement, particularly when participants start with severe levels of symptoms as is often the case in RCTs with torture survivors. Additionally, selective reporting is a common bias in this field (Hamid et al., 2019) and all outcomes should be reported, whether they changed as predicted or not (Goldacre et al., 2019).

These problems are not easy to address. While external indicators of well-being can be added, and a broad range of outcomes agreed with the help of survivors themselves, the central problems remain: that self-report questionnaires are conceptually culturally-bound, and even where concepts seem to align, professionally and properly constructed translations (Sousa & Rojjanasrirat, 2011) are resource-demanding and not guaranteed to achieve equivalence with the original, let alone cultural validity. Solutions will only emerge from more open acknowledgement of these problems, and critical appraisal of novel initiatives.

**Bias**

In quantitative research within positivist epistemologies, bias is seen as diminishing the quality of the research and limiting the applicability of its findings.

1. Absence of blinding in RCTs is seen as potentially leading to bias, but blinding of therapists to psychological intervention conditions in RCTs is very rarely possible, and blinding of participants often unsatisfactory, depending on the nature of the comparator. The best proxies are to try to achieve equivalent participant expectations of benefit from treatment and control arms, assessed after assignment to condition; of course, it is hard to generate positive expectations of a totally inactive control; and to aim for equipoise, described above in relation to therapist allegiance. At the very least, studies should report on the details of the procedures used and the limitations of the study.

2. Many RCTs with torture survivors provide no information on sample size decisions or on power, and are likely to be underpowered; others underrecruit or suffer more attrition than expected. This is a serious problem that should elicit more caution in reviewers in relation to results of these studies. Researchers should provide information on sample size decisions and on power, noting the limitations of the study.

3. It is common for RCT analysis to drop participants who failed to complete assessments (or psychological intervention or control), but it is unlikely that data are missing at random, so important information is lost and the analysis compromised by this practice. There is a good literature on methods for dealing with missing data, which researchers may draw upon (e.g., Little & Kang, 2015), and information on missing data and methods used should be reported.

4. Therapist allegiance may go beyond enthusiasm for a particular therapy: in some studies, many trials may be published by one research group, or by a close network. Conflict of interest statements should be universal, even though at present studies with torture survivors often only provide information about financial interests in the intervention under test: some clinicians and research-
ers do have a direct financial stake in the particular version of therapy they seek to propagate, and others may derive indirect benefits. Transparency by researchers is both important for the evaluation of the research, and as an ethical practice (e.g. Munafò et al., 2017).

5. Most reviews of studies with refugee and/torture survivors only include studies in English, although they do not necessarily make this explicit (e.g. Weiss et al, 2016; Bunn et al., 2015), nor comment on the possible implications for their conclusions of excluding those in other languages, such as Spanish, French, or Arabic. This exacerbates the existing bias towards studies conceived, designed, led and published predominantly by Western researchers, from the Global North, even if conducted in a range of countries. To broaden our understanding of what is effective as rehabilitation for torture survivors in different social, political, cultural and economic contexts, a range of studies and rehabilitation work globally should be valued, where it is likely disseminated in a range of languages, in a range of places, beyond English-language, Global North-dominated academic journals.

Reporting

Comprehensive, transparent and ethical reporting is a cornerstone of quality research.

1. The quality of reporting of studies on all the aspects described above varies considerably. While word limits can constrain effective reporting, some authors willingly provide further and detailed information on request. Unfortunately, a culture of proprietorial interest in the authors’ own studies, and unwillingness to engage in critical debate, is worsened by competition for scarce funding. Poor reporting seriously weakens attempts to summarise the field, qualitatively or quantitatively, and slows progress towards better therapeutic practices for torture survivors. Guidelines on many aspects of methodology (Grant et al., 2018), and online resources, can be used by researchers to share protocols, detailed methods, full anonymised data, and to engage in discussions to enrich the next generation of research. Researchers are encouraged to improve the quality of their reporting on conceptual, theoretical, epistemological and methodological aspects and limitations of their studies.

2. Participants’ own views and perspectives on the research are rarely represented, even though some funders and ethics committees may require such consultation with the population targeted by the study. Participants can supplement our understanding and improve the quality of research by contributions at all points from conceptualisation and design to interpretation when the study is complete, but the research team need to invite and genuinely engage with and respect those contributions.

Ethical limitations and implications

Ethical considerations in any research with human participants are paramount, and these are particularly complex and weighty in research with torture survivors whose experiences of torture involve abuses of power and the breach of every conceivable ethical principle of humane conduct towards another human being.

1. Obtaining informed consent when par-
participants may be unfamiliar with the processes of Western research studies, and with the language in which it is conducted, is far more complex than implied by many studies with torture survivors. There is a far greater risk of implicit or explicit deception, coercion, implied benefit, or misleading by inadequate explanation of options and of the burden and possible disadvantages and risks of taking part in the research. It is, of course, hard to establish freedom of choice when the choice is between apparent help in the context of a research study or nothing, or when the apparent offer of help via research participation comes with implied benefits (economic, legal etc.). These and other ethical considerations are rarely discussed in detail in the literature and researchers could elaborate on the ethical considerations, specific to research with torture survivors, and consider how information can be effectively conveyed, to seek meaningful and valid consent, what opportunities can be provided to clarify and answer questions, and how fully informed consent is supported by such processes.

2. Power differentials between researchers, their funding and institutional bodies, and the study participants are a reality, and should be acknowledged by researchers. They have important implications for the cultural and gender appropriateness and acceptability of the interventions to the participants, participants’ expectations and adherence, and study implementation and dissemination.

3. Studies may risk compromising participants’ confidentiality, safety and security, particularly in research conducted in settings where torture survivors face ongoing threats to their own and their families’ safety. Yet, it is rare for studies to detail the measures taken to minimise these risks, and to consider unexpected risks to study participants, including in follow-up.

Conclusions

In providing some suggestions for better design, conduct, and reporting of studies, we have drawn on our experience of providing rehabilitation to torture survivors, conducting research and reviewing research on psychological interventions for torture survivors. Conducting quality research with torture survivors, particularly research on what is beneficial to survivors, as rehabilitation, is extremely difficult and fraught with ethical, conceptual, methodological and philosophical challenges – with which we must collectively engage – though first and foremost, we must focus on what rehabilitation as a form of reparation means and entails. At present, the quality of research in the field is very weak, and as such, the available research precludes convincing and firm conclusions and recommendations to be made for rehabilitation practice. This represents a serious risk of wasted research resources applicable in medicine (Glasziou & Chalmers 2018), as in research on the rehabilitation of torture survivors.

To move towards improved rehabilitation for torture survivors, we need to recognise rehabilitation as a complex, interdisciplinary set of practices and activities, not only psychological interventions; and we need to recognise rehabilitation as a human right to reparation. As such, we need to embed human rights principles in all research, and we cannot simply say ‘more research is needed’ – instead, we need to ask what is rehabilitation for torture survivors, what kind of research is really needed, valued, by whom and in which context, for whom and to what end? (Patel, 2020). Our focus should be
to ensure quality rehabilitation as a form of reparation for torture survivors, their families and communities, and this should always come before benefits to academia and to research teams.

References


Abstract
This article briefly reviews the evolution and evidence-base of Control-Focused Behavioral Treatment (CFBT), largely self-help-based treatment that involves no cognitive interventions, focuses solely on reducing avoidance behaviors through self-exposure to anxiety-evoking trauma cues, and, unlike other interventions, aims to enhance sense of control over traumatic stressors, rather than anxiety reduction. As such, it is radically different from other interventions in both theory and practice. Our studies have shown improvement rates of 80%-85% with a single treatment session in earthquake survivors. When administered in an average of 6 sessions in war and torture survivors, it achieved 82% reduction in posttraumatic stress symptoms (PTSD), leaving 97% of the cases nearly asymptomatic or with only mild PTSD symptoms. Meta-analytical comparisons suggest that such improvement rates are substantially higher than those achieved by other evidence-based treatments.

Introduction
Trauma events affecting large numbers of people, such as natural disasters, political violence, and torture lead to a serious mental health problem around the world. Effective dealing with this problem requires a mental healthcare model based on treatments that are theoretically sound, proven to be effective, brief, easy to train therapists in their delivery, practicable in different cultures, and suitable for dissemination through media other than professional therapists, such as lay people, self-help tools, and mass media. Current evidence-based trauma treatments do not meet more than two or three of these requirements. The last requirement is particularly important, considering that most survivors do not have access to specialized treatment services and resources are not available to disseminate treatment to large survivor populations around the world.

Among the currently available evidence-based treatments, Cognitive-Behavioral Treatment (CBT) and its variants are the most widely used interventions in care of trauma survivors. The usefulness of CBT in psychological trauma is limited for several reasons. First, it involves a combination of different interventions, the relative efficacies of which are uncertain. There is evidence to suggest that cognitive interventions (Cahill, Rauch, & Riggs et al., 2005; Foa, Hembree; Marks, Lovell, Noshirvani, & Livanou, M., 1998; Paunovic and Öst, 2001) or anxiety management techniques (Foa, Dancu, Hembree, Jaycox, & Meadows et al., 1999; Foa, Rothbaum, Riggs, & Murdock, 1991) do not confer additional improvement when used in combination with exposure, sug-
sugest that the latter is the critical element of the treatment. There is further evidence from our own studies (reviewed later in this article) showing that cognitive interventions are not an essential component of treatment. Second, CBT is aimed at anxiety reduction and thus not suitable for ongoing trauma situations where anxiety is a natural response to continuing realistic threats to safety. Third, there is no convincing evidence regarding its cross-cultural practicability. Most importantly, it is not suitable for dissemination as an entirely self-help treatment without the need for a therapist.

Cognizant of such limitations of CBT, we initiated a series of studies in the 1990s to develop Control-Focused Behavioral Treatment (CFBT) as an alternative intervention that meets all requirements for post-disaster usefulness noted above. The reader is referred to our 2011 book (Başoğlu and Şalcıoğlu, 2011) for a detailed presentation of its evolution, theoretical framework, and evidence base. In this article I present only a summary of this work and the findings from a yet unpublished study that examined the efficacy of CFBT in asylum-seekers in Turkey exposed to war and torture trauma.

Control-Focused Behavioral Treatment

CFBT is based on learning theory of anxiety, which posits that exposure to unpredictable and uncontrollable stressors is the primary mediating process in traumatic stress (Mineka and Zinbarg, 2006). Its development can be traced back to our work in the early 1990’s when we examined the parallels between animal responses to inescapable shocks and human responses to torture and presented a learning theory formulation of torture trauma (Başoğlu & Mineka, 1992). Over the years we conducted a series of studies to examine the role of unpredictable and uncontrollable stressors in human responses to war and torture trauma. These studies revealed ample evidence showing that loss of control over threats to safety or helplessness anxiety is indeed strongly associated with traumatic stress. Such evidence implied that traumatic stress can be reversed by interventions that enhance sense of control (or resilience against) traumatic stressors. It was indeed this hypothesis that eventually led to the development of CFBT. The treatment was first tested with earthquake survivors in two uncontrolled (Başoğlu, Livanou, & Şalcıoğlu, 2003; Başoğlu, Livanou, Şalcıoğlu, & Kalender, 2003) and two randomized controlled (Başoğlu, Şalcıoğlu, & Livanou, 2007; Başoğlu, Şalcıoğlu, Livanou, Kalender, & Acar, 2005) studies and found to be highly effective, even when delivered in a single session.

CFBT is a relatively simple intervention with a sole focus on anxiety-evoking trauma cues and behavioral avoidance. It is designed to enhance sense of control over distress, anxiety, or fear associated with traumatic stressors, including memories of trauma. This is achieved by encouraging the person not to avoid anxiety- or fear-evoking situations. Anxiety and avoidance are common features of traumatic stress and are particularly intense when there is a continuing (real or perceived) threat to safety. In the case of earthquakes, for example, the initial devastating shock is often followed by hundreds of aftershocks that pose further danger. Similarly, torture survivors may face (or perceive) risk of further arrest and torture. In such situations sleeping difficulty, extreme alertness, and startle reactions in response to sudden movements and sounds are quite common. Many survivors fear and avoid various situations that signal further threat. For example, earthquake survivors often avoid going into their houses or
other concrete buildings even when it is safe to do so, stay alone at home, sleep alone or in the dark, take a shower, get undressed when going to bed, or any other situation where they think they may be caught helpless during an earthquake. Torture survivors avoid military or police officers on the street, people in positions of authority, interviews that resemble interrogation, medical examinations involving instruments, or any other situation or activity that reminds them of their torture. Trauma survivors also avoid situations that bring back distressing memories of the original trauma. Such avoidance can generalize to a wide range of situations and activities, leading to significant disruption in social, work, and family functioning. Generalized fear and avoidance may lead to feelings of total helplessness, loss of control over life, and eventually hopelessness and depression (Başoğlu and Şalcıoğlu, 2011).

Briefly, CFBT involves the following procedures: 1) identify trauma cues or reminders that trigger anxiety, fear, or distress; 2) explain the treatment rationale (i.e., confront your anxiety, fear, or distress until you gain control over it); 3) give self-exposure instructions (i.e., do not avoid situations that evoke anxiety, fear, or distress); and 4) monitor progress. It is fundamentally different from CBT and other exposure-based treatments in its underlying theory, aims, presumed mechanisms of action, and treatment techniques and procedures. Most importantly, it is not based on habituation paradigm. The primary aim is to increase anxiety tolerance or sense of control over anxiety (hence resilience against anxiety), rather than anxiety reduction. Although anxiety diminishes with increased sense of control in most cases, improvement occurs even without substantial reduction in anxiety. This implies that patients are not required to conduct extensive exposure until complete habituation occurs. Exposure until anxiety tolerance or control develops is sufficient. A focus on resilience-building rather than anxiety reduction makes the treatment suitable for environments involving ongoing threats to safety, where anxiety reduction is neither possible nor desirable. Second, it focuses solely on avoidance (behavioral or cognitive) and distress induced by trauma cues and does not involve any other techniques or procedures commonly used with CBT, such as cognitive restructuring and imaginal exposure. This makes it relatively easier to administer and train therapists in its delivery. Third, the therapeutic benefits of CFBT arise mainly from self-exposure to anxiety cues in the person’s natural environment. In most cases the therapist’s role is limited to explanation of the treatment rationale, giving self-exposure instructions, and monitoring progress. As such, it is more suitable as a self-help intervention than other treatments. Finally, a behavioral focus without elaborate cognitive interventions makes it easier to administer in different cultural settings and with people of lower socio-educational status. This aspect of treatment confers a distinct advantage in work with refugees where treatment needs to be delivered through interpreters.

A study of Control-Focused Behavioral Treatment of war and torture survivors
As noted earlier, CFBT was first tested with earthquake survivors in the early 2000s and then with asylum-seekers in Istanbul in more recent years. The latter study was conducted to examine the minimum number of treatment sessions needed to achieve significant clinical improvement. It involved 80 asylum-seekers referred to the project by various refugee care agencies in Istanbul. Of these, 20 were lost to the study for various reasons (mostly unrelated to treatment response), so the results were based on 60 cases. The
study was conducted as part of routine care of asylum-seekers referred to the project. Among all referrals, cases with Posttraumatic Stress Disorder (PTSD) were consecutively included in the study. Only psychotic cases were excluded.

Of the 60 study completers, 47% were from Democratic Republic of Congo, 18% from other African countries, 27% from Iraq, and 8% from other Middle Eastern and Asian countries.

The most commonly reported trauma experiences were witnessing war atrocities, exposure to bombings, sexual violence including gang rape (37%), and torture (32%). In most tortured cases, torture had been perpetrated by non-state actors (e.g., rebel groups, paramilitaries, etc.). Fifty-seven percent of the cases were female, and the mean age was 25 (SD 10). Forty-seven percent were illiterate, or literate with no schooling, or had only primary school education. None of the study participants were on any medication for traumatic stress problems and no psychotropic drugs were used in treatment.

The study did not include a control group, but the non-specific effects of therapist contact and pre-treatment assessment were examined in a subset of 25 cases by using a single-case multiple baseline experimental design. This included two baseline assessments conducted three weeks apart with no treatment in the interim period. Treatment was initiated after the second baseline assessment. The mean scores of the Clinician-Administered PTSD Scale (CAPS) – a measure of PTSD symptoms (Blake, Weathers, Nagy, Kaloupek, Charney, & Keane, 1990) – showed no reduction at the second baseline, meaning that therapist contact had no effect on PTSD symptoms. This suggests that the improvement in PTSD symptoms at post-treatment can be attributed to the specific effects of treatment.

Because the main aim of this study was to examine the minimum number of treatment sessions required for significant clinical improvement, treatment duration was flexible and involved a maximum of 12 sessions. Treatment was terminated (and follow-up phase initiated) when a rating of ‘much / very much improved’ was obtained on Patient’s Global Improvement (PGI), a 1-7 scale used to assess overall clinical improvement (1 = very much improved, 2 = much improved, 3 = slightly improved, 4 = no change, 5 = slightly worse, 6 = much worse, 7 = very much worse). Our studies have shown that this is valid and reliable measure of overall clinical improvement. As it reflects patients’ own assessment of improvement, it is free from assessor bias. Depression was assessed by using Beck Depression Inventory (BDI; Beck, Rial, & Rickels, 1974). Treatment effects on PTSD and depression are shown in Figure 1 and Figure 2, respectively.

The results are shown together with the results of two randomized controlled studies of single-session CFBT in earthquake survivors (Başoğlu et al. 2005; Başoğlu et al, 2007) to demonstrate how the outcomes of a single treatment session compare with those of full-course CFBT. Study 1 (31 CFBT cases vs 28 waitlist controls) involved a single session of self-exposure instructions with no further therapist contact until post-treatment assessment at week 6, whereas Study 2 (16 CFBT cases vs 15 waitlist controls) involved one session of therapist-administered exposure to earthquake tremors in an earthquake simulator (45 minutes) followed by self-exposure instructions. Post-treatment assessment was conducted at week 6 in Study 1, at week 8 in Study 2 and at week 7 in Study 3. Figure 1 shows outcome separately for asylum-seekers with and without torture experience (difference non-significant). Figure 2, on the other hand shows outcome in pooled subgroups.
Figure 1 - Comparison of war and torture survivors with earthquake survivors in response to treatment (mean total CAPS score)

- Study 1: Earthquake survivors (n = 31)
- Study 2: Earthquake survivors (n = 16)
- Study 3: Tortured asylum-seekers (n = 19)
- Study 3: Asylum-seekers with war-related trauma (n = 41)

Figure 2: Comparison of war and torture survivors with earthquake survivors in response to treatment (mean Beck Depression Inventory score)

- Study 1: Earthquake survivors (n = 31)
- Study 2: Earthquake survivors (n = 16)
- Study 3: Asylum-seekers (n = 36)
(which also showed no significant difference). Also, depression was assessed in only 36 refugees due to unavailability of BDI in some languages.

In study 1 and Study 2 the waitlist control group cases were crossed over after post-treatment assessment to receive active treatment following the same study design. In both studies the two groups were pooled together to examine the long-term global improvement rates in larger samples. Global improvement rates in Study 1 were 80% at 3-month follow-up, 85% at 6-month follow-up, and 83% at 1-2-year follow-up. The respective figures were 72%, 80%, and 80% in Study 2. The improvement rates at 6-month follow-up in the two studies correspond to within-group effect sizes of 1.6 and 3.5, respectively (mean 2.55).

In study 3 the mean number of sessions required for much / very much improvement in the sample was 6, which corresponded to the 7th week in treatment. The maximum number of sessions required for improvement was 4 in 20% of the cases, and 6 in 55% of the cases. Of the 60 cases, 56 (93%) met the criterion of much / very much improved at some point during treatment, which corresponded to 82% reduction in PTSD symptoms (81% in tortured cases and 82% in non-tortured cases). Although four cases rated themselves as ‘slightly improved,’ their PTSD symptoms showed mean 71% improvement. The CAPS score at post-treatment was under 20 in 70% of the cases (indicating near-complete recovery), between 20 and 39 (mild / sub-threshold PTSD) in 27%, and between 40-59 (moderately severe PTSD) in only 2 (3%) cases. Thus, 97% of the cases were either nearly asymptomatic or had only mild PTSD symptoms at the end of treatment. This outcome measure based on CAPS score is used in clinical studies to assess the end-state functioning achieved by treatment. It correlates highly with recovery from the disabling effects of trauma on social, occupational, and family functioning.

The mean pre-treatment CAPS score among the asylum-seekers was 85, which indicates extremely severe PTSD, compared with 68 in Study 1 and 63 in Study 2, both of which fall into the category of severe PTSD. Despite such high levels of illness severity, the asylum-seekers showed greater improvement in both PTSD and depression than did earthquake survivors at post-treatment. This finding probably reflects the fact that the treatment was delivered to earthquake survivors in a single session, whereas the refugees received full-course CFBT. Note, however, that the improvement trends in the three groups converge at 6-month follow-up. This suggests that improvement with a single treatment session is slower but runs a steady course over 6 months, reaching the same level of improvement achieved by full-course treatment. This finding implies that CFBT can be administered on a largely self-help basis in war and torture survivors. Because Study 3 aimed at examining the optimum number of treatment sessions required for much / very much improvement, treatment had to be continued until such improvement occurred. It could have been discontinued earlier, as soon as the survivors showed sufficient reduction in avoidance behaviors (e.g., by 20%), thereby reaching a stage in treatment beyond which they might have been capable of conducting exposure on their own. Viewed together with the outcomes of a single-session CFBT in earthquake trauma, this possibility raises the prospect of a treatment even briefer than 6 sessions, possibly involving 1 to 3 sessions. Furthermore, CFBT could be helpful in reducing traumatic stress in some cases even when delivered on a solely self-help basis (e.g., through self-help tools). There is indeed preliminary evidence from a pilot study (Başoğlu,
Şalcıoğlu, & Livanou, 2009) with earthquake survivors showing that treatment delivered by a structured self-help manual can achieve a similar improvement rate as therapist-delivered treatment. This hypothesis is well worth testing in future research with war and torture survivors.

**Comparison of CFBT with other evidence-based treatments**

Although comparative studies of CFBT relative to other evidence-based treatments are not available, there is some indirect evidence to suggest that CFBT is superior to other treatments in efficacy. Figure 3 shows a comparison of CFBT (separately for earthquake and war/torture trauma) with other evidence-based treatments in terms of percentage of overall clinical improvement (or responder status). The improvement rate with CFBT in the first group is based on a total of 331 cases from our four treatment studies with earthquake survivors cited earlier, whereas the improvement rate in the second group is based on 60 treatment completers in Study 3.

Figure 3 shows that the global improvement rates in our studies are substantially higher than those reported in studies of other treatments. Data on the latter treatments were drawn from a meta-analytical study (Bradley, Greene, Russ, Dutra, & Westen, 2005) of 26 studies (total of 1,535 cases) published between 1980 and 2003. As meta-analyses of treatment studies rarely report global improvement rates, I was able to find only one such study for comparison of treatment outcomes. Considering that more recent meta-analyses, such as that of Cusack, Jonas, Forneris, Wines, Sonis, et al. (2016) based on 31 studies conducted between 1980 and 2014, have not found greater between-group effect sizes for these treatments (mean treatment effect sizes across all treatments in Bradley et al and Cusack et al studies 1.32 and 1.26, respectively), the effectiveness of these treatments do not seem to have increased over time with the

![Figure 3 - Comparison of trauma treatments: Percentage of overall improvement (treatment completers)](image-url)
inclusion of more recent studies. Thus, to the extent that the studies included in these meta-analytical analyses reflect current practice of these treatments, CFBT appears to have a distinct superiority over them.

Comparison of between-group effect sizes across treatments is another useful way of comparing different treatments in effectiveness. However, this was only possible using within-group effect size for comparison here, because the pooled sample of 331 cases from our four studies of earthquake survivors included two uncontrolled trials of CFBT (Başoğlu, Livanou, & Şalcıoğlu, 2003; Başoğlu, Livanou, Şalcıoğlu, & Kalender, 2003). Again, such data were available only in the Bradley et al study. Figure 4 shows a comparison of treatments in within-group effect sizes. Information of mindfulness-based treatments was obtained from a metanalytical study of Boyd, Lanius, & McKinnon (2018) involving treatments such as meditation-relaxation in child survivors of tsunami, mindfulness-based stress reduction, mindfulness-based cognitive therapy or mindfulness-based exposure therapy in war veterans, and mindfulness-based stress reduction in childhood sexual abuse.

All within-group effect sizes in Figure 4 were based on Intent-to-Treat analyses, except for the first one (4.87 in war and torture survivors), which is based on completers analysis. This effect size is therefore not comparable with those of other treatments. This information is nonetheless included in the figure to give the reader an idea about the magnitude of pre- to post-treatment change in PTSD symptoms (i.e., treatment efficacy) when survivors complete the treatment process. This finding reflects the substantial reduction in PTSD symptoms (81%-82%), while also explaining the high rate of global improvement (93%) as perceived by the study participants themselves. When the 20 non-completers are included in the analyses the effect size drops to 2.03, which is still substantially greater than the respective figures for other treatments. It is also worth noting here that an effect size of 2.48 in earthquake survivors is achieved by 1
or 2 sessions of CFBT (total session time of 1-2 hours), in comparison with an average of 15.6 total session time in other treatments.

A similar comparison of CFBT with other evidence-based treatments in asylum seekers or refugees was not possible because most studies do not report global improvement rates (or within-group effect sizes), as noted earlier. However, the results of some studies can be meaningful in this respect. A recent systematic review and meta-analysis (Turrini, Purgato, Acarturk, Anttila, Au, et al, 2019) of 26 studies involving a total of 1959 participants concluded that “while CBT was effective in decreasing PTSD and anxiety symptoms, EMDR was effective in terms of depressive symptoms only, and NET failed to show a significant effect.” The reported post-treatment between-group effect sizes were 0.71 (1.08 at follow-up) for PTSD symptoms, 1.02 (1.08 at follow-up) for depression, and 1.05 (1.28 at follow-up) for anxiety symptoms. Furthermore, only four studies assessed functioning and quality of life and found no difference between treatments and control conditions (effect size 0.17 for functional disability and 0.23 for quality of life at follow-up). These findings suggest that the so-called trauma-focused treatments do not perform better in asylum-seekers or refugees than in other trauma populations. Although such treatment effects can be statistically significant or effect sizes can be construed as large, there is still substantial room for improvement. Relatively low improvement rates around 50% points to only partial improvement and substantial residual psychopathology implying a serious risk of loss of treatment gains in the long-term.

It is worth illustrating the nature of this problem by examining the results of two studies of Narrative Exposure Therapy (NET), a variant of cognitive-behavioral treatment that has gained popularity in treatment of war and torture survivors in recent years. In a controlled study of NET versus Treatment As Usual in asylum-seekers and refugees in Norway, Stenmark, Catani, Neuner, Elbert, and Holen (2013) reported highly significant treatment effects on PTSD and depression symptoms in the asylum-seeker group with between-group effect sizes of 0.58 and 0.59, respectively. Consistent with such relatively modest effect sizes, 54.5% of the active treatment cases among treatment completers still met the diagnosis of PTSD at 1-month follow-up. Similarly, of the 27 cases with Major Depression before treatment, 16 (59%) still met the diagnosis at the same assessment point. In another study of NET (Hansen, Hansen-Nord, Smeir, Engelkes-Heby, & Modvig, 2017) of 110 asylum-seekers and refugees conducted by the Danish Institute Against Torture (DIGNITY) in various North African and Middle Eastern countries, treatment reduced PTSD, anxiety, and depression scores only by 43.7%, 42%, and 28.7%, respectively, with similarly low improvement rates in pain (34.6%) and disability (39%). The authors concluded that these results “strongly suggest that short-term NET therapy can significantly reduce the mental health symptom load of survivors of war and torture.” Some of these results might be statistically significant but the extent of clinical improvement observed unfortunately leaves much to be desired. Clearly, there is still much room for improvement in the efficacy of treatments commonly used with war and torture survivors.

Concluding comments
Our findings show that war or torture trauma, however severe its psychological effects might be, is as responsive to an effective treatment as earthquake trauma. Furthermore, substantial recovery in the asylum-seekers occurred despite their adverse life circumstances in
Turkey. Some were homeless and had no money to buy food. This shows that additional life stressors do not necessarily block response to a potentially effective treatment. Lack of compliance with treatment is the single most important cause of treatment failure with CFBT and difficult life circumstances can affect treatment outcome only to the extent they make treatment attendance or conduct of homework self-exposure exercises difficult. We were able to overcome such difficulties with minimal support (e.g., providing travel money for treatment attendance) during the course of treatment.

While the fact that our study with asylum seekers did not include a control group could be viewed as a limitation, this does not necessarily invalidate the results for several reasons. First, lack of significant recovery between two baseline assessments in a subset of 25 cases suggests that the improvement observed at posttreatment does not reflect the effect of non-specific factors, as noted earlier. Second, the results need to be viewed together with those of Study 1 and Study 2, which had already demonstrated the effectiveness of CFBT using a controlled design. Third, the remarkable extent of improvement in asylum seekers (81%-82% reduction in PTSD symptoms, 93% of cases much / very much improved and 97% nearly asymptomatic or with only mild PTSD symptoms at the end of treatment, and a within-group treatment effect size of 4.85 among treatment completers), which is far greater than those reported with other treatments in the general trauma literature, is highly unlikely to reflect the effect of non-specific factors.

Over the last three decades I have argued for the need for an evidence-based approach to rehabilitation of survivors of torture. Such approach involves treatment research. I remember the strong negative reactions I had received from some circles in the human rights and torture rehabilitation communities in response to a 1988 editorial (Başoğlu and Marks, 1988) pointing to the need for research in the field. Scientific research with survivors of torture was perceived almost as a blasphemy by some. In further publications (Başoğlu, 2006; Başoğlu and Şalcıoğlu, 2011) in subsequent years I had pointed to the need for outcome evaluation studies to demonstrate the usefulness of torture rehabilitation programs. My 2006 British Medical Journal editorial (Başoğlu, 2006) triggered strong responses from many colleagues from around the world, leading to a heated debate (published online by the British Medical Journal, 2006) on issues such as whether there can be a “quick fix” or “standard therapy” for torture survivors (e.g., see Jaranson, 2007). In writing this article I could not help thinking that we have come a long way since then. Indeed, since the early 2000s some randomized controlled studies involving war and torture survivors have appeared in the literature, some conducted by torture rehabilitation centers, suggesting promising progress in this respect. These studies examined the effectiveness of various treatments, including CBT, EMDR, NET, and Interpersonal Psychotherapy, among others.

Having said this, I will once again have to play my usual Devil’s Advocate role and argue that there is still a long way to go. Most importantly, none of the above treatments are based on sound and empirically validated theory. It is therefore not surprising that they have only partial effects. In addition, how they exert their therapeutic effects and whether they have different mechanisms of action are important questions that have not received sufficient attention. Our research over the years has arguably shed some light on mechanisms of traumatic stress and improvement (the reader is referred to Başoğlu and Şalcıoğlu, 2011 for
a detailed review of evidence). Nevertheless, a general tendency in the field of psychological trauma to give more weight to cognitive approaches in treatment still perseveres. That being the case, proponents of CBT or its many variants need to address some important questions raised by our studies. If cognitive and other anxiety-reducing interventions are essential in treatment, how can an intervention focusing solely on avoidance behaviors, using only live exposure, and aiming for enhancement of sense of control rather than anxiety reduction achieve such remarkable improvement, even when delivered in a single session in some trauma survivors? What do these findings imply for other psychotherapies, particularly for CBT and its variants, that involve systematic cognitive interventions? Furthermore, are these treatments suitable for cost-effective dissemination on a self-help basis to large survivor populations around the world without access to effective psychological care? I realize that these can be discomforting questions for some, particularly those firmly entrenched in the idea that torture is a difficult trauma to treat and therefore requires lengthy psychological rehabilitation programs. Nevertheless, these questions will inevitably need to be properly considered and addressed to open the way to further progress in the field.

On a final note, I will take the opportunity to correct a common misconception that I have been advocating CBT for use in torture survivors throughout my career. First, I should note that my orientation in psychotherapy has been behavioral, not cognitive-behavioral, since the early 1970s. In the 1990s and early 2000s, I did some case studies of CBT in torture survivors (Başoğlu and Aker, 1996; Başoğlu, Ekblad, Bäärnhielm, & Livanou 2004) but having realized the limitations of both cognitive and traditional (habitation-based) behavior therapy, I abandoned them in the early 2000s and developed CFBT. In our early articles on treatment of earthquake trauma cited in this article, we referred to the intervention as “modified behavioral treatment.” After having deliberated for some years over the question whether it is a modified version of traditional behavioral treatment (BT) or a novel intervention in its own right (hence deserving a new name), we decided to call it CFBT for the first time in our 2011 book (Başoğlu and Şalcıoğlu, 2011). This decision was based on the consideration that CFBT is radically different both in its theoretical framework and clinical practice from either BT or CBT, as discussed earlier. It is therefore important not to confuse CFBT with the latter treatments.

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From rehabilitation to prevention: The need to move one step further

Tony Reeler

Abstract
In the 30 years in which Torture has been the flagship publication on organised violence and torture the world no longer can be oblivious to the prevalence or consequences of torture. The existence of documented torture provides the hardest indicator of the absence of human rights in any given country, but does this demonstration still evoke the same sense of shock or same as it did thirty years ago? This is an important question to address currently with so much evidence suggesting that democracy worldwide may be in decline and that authoritarianism is on the increase. This article looks briefly at the current situation, the role of the antitorture movement and the Torture journal.

What has been the impact of the antitorture movement?
In the thirty years since the IRCT launched Torture, we have learned a considerable amount about torture. From the early, essentially newsletter format to the current referred and formal journal, we have gone from a small base of people working against torture to a large international community. We have gone from a publication to support workers to a journal of scientific merit. We have moved from the preoccupation with the forensic documentation of torture – so necessary to make people aware – to the careful empirical work on how we can rehabilitate the survivors.

There is no doubt that Torture has hugely succeeded in breaking the silence around organised violence and torture, and we should celebrate this anniversary with much appreciation. However, anniversaries are also times for reflection and celebration and ask some of the hard questions. The most complex questions are about impact as they are always.

Thirty years ago, the old world was breaking down, and we began to talk about the Third Wave of democracy as Samuel Huntington (1991) termed it. The IRCT grew at an enormous rate during the 1990s, commensurate with the changes that were happening worldwide. Since torture was such a hard indicator of authoritarian rule, it was not surprising perhaps that the movement felt that exposing it would be an important lever in moving countries into fuller democracy. UNCAT and the Rome Statute seemed such major victories.

For the antitorture movement, empirical documentation became critical in holding governments to account, and torture became a crucial factor in testing governments’ claims to be democratic. We had two aims behind the journal: rehabilitation and prevention. It is fair to say that Torture has been hugely successful in facilitating the former but much less successful in the latter, and it is to the latter that I want to address my thoughts. This is not to minimise the power of all the forensic work,
or the huge contributions to our understanding about trauma disorders and treatment of trauma.

A sage professor on community medicine pointed out that the big problems in health lie outside the control of health professionals. He talked about child malnutrition and concomitant diarrhoeal disease, where poverty was the major underlying factor. Removing poverty was not a medical problem but needed a major socio-political (and economic) effort. I think that much the same problem exists for torture. Like public health specialists, we can show the symptoms and point to the disease, and we can cure the symptoms, but the disease is beyond our power. Our advocacy is based on empirical evidence thirty years later, but are we any closer to curing the disease?

1991 was the beginning of a honeymoon for democracy and stopping torture, but the honeymoon was soon over. By 2002, Thomas Carothers (2002) and other political scientists, such as Steven Levitsky and Lucian Way (Levitsky & Way, 2002) were pointing this out as well, arguing for the rise of “competitive authoritarianism”. The point was that countries in which authoritarian governments wished to keep power learned very quickly how to meet the minimum bar to avoid international opprobrium, including torture. Zimbabwe was a classic example of this, and I will use Zimbabwe as a case illustration.

There were other factors that impeded the struggle for the prevention of torture. The most important of these was the “war against terror” that followed the attack on the United States by Al Quaeda, and the establishment of a worldwide campaign to eliminate terrorists by the US. The antitorture movement was hugely undermined by the demonstration of the world titleholder for democracy, and the largest military power in the world, blatantly indulging in abductions, arbitrary imprisonment, and torture. This undermined the moral basis of the antitorture movement in so many ways, not the least for the authoritarian states who pointed out that “do as I say, and not as I do” was an insufficient criticism of countries that practise torture. We heard about a “democratic rollback” (Diamond, 2008), and two decades later, respected political scientists are concerned whether the established democracies will even survive (Fukayama, 2014; Grayling, 2018). The ground is shifting under the feet of the antitorture movement so quickly and far quicker than the idealism that launched Torture could imagine.

In 1991, Zimbabwe, prompted by the changes to the international order, gave up on the one-party, Marxist-Leninist project, opened up the civil space, allowing the Amani Trust to come into being and publicly start to work on torture. It started with looking at the Liberation War victims, work published in Torture (Reeler, 1994; Reeler, 1995; Reeler & Mbape, 1998; Reeler et al., 2001), but this all changed in 2000 when the first serious challenge to the government’s hold came. Torture returned with a vengeance and subsequently on a mass scale. Both prior to independence in 1980 and subsequently in 2002, 2005 and 2008, Zimbabwe has seen torture on a scale that fits the bill of crimes against humanity.

This is no hidden problem, for Zimbabwe must be amongst the world’s best-documented human rights crises. There are now more than five hundred individual reports on organised violence and torture, the vast majority from 2000 onwards. The methods learned from IRCT trainings, and the literature provided in Torture mean that all these reports are solidly grounded in medical and psychological examination and legal affidavits. The data has been used to sue the Zimbabwe government in national courts and be taken to the UN Human Rights Commission, the African
Commission on Human and People’s Rights, and even to the Southern African Development Community (SADC) Tribunal before it was disbanded. Attempts have been made to get the human rights abuses on the agenda of the UN Security Council but failed due to vetoes of China and Russia.

So, torture, abductions, disappearances, ad extra-judicial killing continue to this very day and even appear to be getting worse. Human rights defenders face increasing risks, whilst the government has learned that the international will to deal with torture is largely absent, bar rhetorical criticism and the imposition of targeted sanctions. After 30 years of hard work, it does seem that we are back where we started, and torture has faded into the background against so many other pressing problems for the international community.

My point here is that we have lost the moral high ground in the fight against torture. If the established democracies are willing to countenance renditions, arbitrary detention, and torture, then the way is open for authoritarian states to do the same and the UN to become less and less effective. We have not lost the rehabilitation battle; Torture is an excellent testimony to this; hundreds of thousands of victims have become survivors over the past 30 years. However, we are not winning the political battle. We are reduced to the public health solution. Ensure the little children are rehydrated, and give them antibiotics for diarrhoea, but we are ineffective against poverty.

Perhaps we must remember how we began in the IRCT and the launch of Torture and return to the activist commitment that characterised those early years. Accept the technical importance of documenting torture and rehabilitating the victims, but this needs to lead into a more powerful advocacy for prevention. We can be optimistic in this: look how one little girl from Sweden has galvanised the world around climate change and how the youth have rallied in their hundreds of thousands around the world. Margaret Mead once commented that we should never doubt what a small number of people can achieve, but it was the only way things ever changed. The IRCT may be small, but we need to turn the knowledge from 31 volumes of Torture into the basis for advocacy on a scale not seen before. It can be done.

However, how to address the analogy with public health?

As pointed out, the conditions that favour torture lie in the political domain and a political domain that is increasingly dismissive of human rights: just as with poverty, there are forces that work towards maintaining antidemocratic governance and undermining the gains in global human rights. One small example illustrates this, the creation of the UN Special Rapporteur on the negative impact of unilateral coercive measures on the enjoyment of human rights. In the vote for establishing this mandate in the UN Human Rights Council. 26 of the 31 countries voting in favour were rated as either Partly Free (15) or Not Free (11) according to Freedom House. Of the 14 countries voting against the mandate, eleven were rated as Free. Thus, one of the very few peaceful means for dealing with countries that practice torture is undermined.

However, in theory (and sometimes in practice), the overarching body that provides global oversight of human rights, the United Nations, should be the place to start. The UN Security Council and the International Criminal Court are essential to this, but the former often trumps the latter. Take again the example of Zimbabwe and the plausible allegations that crimes against humanity have occurred on at least four occasions, and twice there have been attempts to have these discussed at the Secu-
rity Council, both blocked by the vetoes of Russia and China. Moreover, Zimbabwe has signed but not ratified the Rome Statute nor the UN Convention Against Torture, so the only route was to the Security Council.

Like the Covid pandemic and the dangers of climate change, issues that require global, not national action, so it is with organised violence and torture. When the three most powerful countries in the world – China, Russia, and the United States – all refuse to be bound by the Rome Statute and have the power of veto in the Security Council, then the oversight function of the UN is weakened, and human rights are violated by narrow political interest. This is where the battle to eradicate torture must focus and removing the power of the mighty over the weak. Unless we win this battle, we will continue to treat the symptoms and not the disease.

It does therefore seem that our advocacy must be upscaled dramatically in coming years, and *Torture* can be the flagship in this struggle. Perhaps the regular inclusion of a *Torture Barometer* can be useful addition to the journal, much along the lines of the metrics provided by Freedom House or Transparency International. It might provide a way of linking the empirical to the political, and a way to shame the countries that are actively undermining all the gains of the past two decades.

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The Covid-19 pandemic has accelerated the inevitable and essential debate on the civilizational model that humanity is undergoing. It is a set of world-systems that hegemonizes at a planetary level an indisputable transit towards self-destruction, not only of human life but also of all forms of life and the biosphere. Social scientists concerned about this issue have agreed that it is a global problem with characteristics of social tragedy, which calls upon States to assume an urgent change of course if we want to save the planet. This crisis places the “economy-health” relationship at the centre of the critique since the accelerated accumulation of capital has led the workforce to an undermined position due to the precarious conditions of their material and spiritual life, and above all, of their health. The countries of the Global South are the most affected by this crisis, where inequalities, not only of social class but also ethnic, gender, generation, territorial and environmental, are exacerbated.

What is critical is what the Ecuadorian epistemologist Jaime Breilh (2013) calls the “society-nature metabolism”; this concept refers to the fundamental balances that allow the harmonious flow of life, the conservation of ecosystems, the protection of the planet and its resources. The depredation of the biosphere and the overexploitation of the subaltern classes make neoliberalism what the Cameroonian philosopher Achille Mbembe (2020) calls “necro-neoliberalism”; this concept denounces the thanatic power of the dominant economic system, its annihilating force and its contempt for human life. This idea is enriched, among others, by Naomi Klein’s (2014) “shock theory” and by Sayak Valencia’s (2010) idea of “gore capitalism”. Both perspectives point to the description of mechanisms of wealth production that are based on the application of dehumanized forms of social violence, of the subjection of the human person. A necroeconomy that is at the same time a psycho-biopolitics in the sense given by Byung-Chul Han (2016) and Maurizio Lazzarato (2013); the latter adds an exciting reflection on another dominant characteristic of this capitalism of death in his recent text, “Capital hates everyone”: the irruption of neo-fascism, of fascism with a friendly, mystifying and enveloping face, which favours its incrustation in everyday life (Lazzarato, 2020).

The practice of torture today cannot be read outside this socio-historical, political, economic and cultural context; it is an instrumental part of the civilizing pattern. It fulfils extreme functions in the battle for the conservation of power in the centres of concentration of financial capital. The Chilean experience of these last two years is a good laboratory of thanato-politics and necro-economics; we are experiencing the confluence of two dra-
matic events: the social crisis, which debuted on October 18, 2019, and the COVID-19 pandemic, with the first case registered on March 3, 2020.

The popular uprising, a process still in full swing, was the culmination of a series of massive social mobilizations generated from the so-called “penguin revolution”. High school students put the issue of public education on the table. From then on, a series of marches took place that brought together millions of people throughout the country, denouncing various social problems: the privatization of education; the public health crisis; the sexual and reproductive rights of women and gender-diverse people; the self-determination and territorial demands of indigenous peoples; social security, undignified pensions and the end of pension fund associations, etc.

October’s misnamed “social outburst” was nothing more than the result of the progressive confluence of claims against the injustices, inequalities, and inequities generated by neoliberalism in our country. Messages written on the walls, such as “It wasn’t depression, it was capitalism”, show a popular imaginary capable of inscribing personal suffering in the complex scenario of social determinations. New social actors emerge with the social movements they have brought to the streets of the country; young people, women, indigenous people, housing debtors, sexually and gender diverse people, the elderly, along with workers and civil servants. The first success of this movement has been the launching of a constituent process with a view to overcoming the illegitimate political constitution imposed by the dictatorship; a process underway and presided over by a representative of the Mapuche people, whose mission is to design and propose to Chilean citizens a new fundamental charter, based on the doctrine of human rights. A multivariate process and at the same time capable of converging in great demand: the end of the current system of domination.

We understand the Covid-19 pandemic as being structurally linked to the social crisis. It is a specific expression of the contradictions generated by the neoliberal economy. The management of the pandemic in our country is immersed in a necropolitics that has put the population at serious risk by privileging the protection of economic macro-indicators over the population’s health needs. The hegemony of an economic policy for the pandemic has had deleterious effects on the population, expressed in the emergence of vulnerable groups, physical and mental illnesses, the collapse of the public system, high mortality, increased social inequalities and poverty, etc.

All of this has been added to the social crisis that precedes it; the very tannin of this psycho-biopolitics comes from how the State has confronted both the social mobilizations and the effects of the virus on the health/illness process. The political repression and the massive and systematic violations of human rights had resulted in a devastating reality, denounced by national and international human rights organisations. More than 11,000 people were detained; 2,500 imprisoned; more than 400 were mutilated due to ocular trauma; an undetermined number of people tortured; close to 30 deaths in different circumstances; states of emergency and military patrols in the streets and towns; intimidation and persecution. Tragic repetition of the practices of State terrorism, not unknown to the generations that lived during the dictatorship. Moreover, there has been the same climate of impunity for these crimes: of 3,072 complaints filed by the National Institute of Human Rights, only four have led to convictions as of October of this year.

The experiences of extreme traumatization and re-traumatization behind these figures
reveal another bloody reality: the absence of comprehensive reparation policies for victims, disregarding the international commitments signed by the Chilean State. At the same time, it incorporates into society a new generation of victims of social trauma, which is added to the hundreds of thousands of people harmed by the military dictatorship. We are referring both to the first generation, which is in the *exitus letalis* stage and to the second and third, in which a relatively new phenomenon materializes as a public health problem: transgenerational harm/trauma.

The Programa de Reparación y Atención Integral en Salus [State’s Programme for Reparation and Comprehensive Health Care] (PRAIS) currently has about 900,000 users, all of them directly affected and descendants of people who were tortured or affected by attempts on their lives. Being PRAIS a vanguard experience in the region, the integral reparation is a pending debt; in terms of health, it has many insufficiencies, and its possibilities of success collide irremediably with the failure in the integrality of the reparation processes, especially in the battle against impunity, the longing for truth and justice, the recovery of the historical memory and a culture of human rights, the demand for a dignified economic reparation, etc. The superposition of the new violent acts of this social crisis shows an essential characteristic of the social trauma: its historical *continuum*, its recurrent and cyclical character, whose origins are not on September 11, 1973. They were inaugurated in the colony and were constantly repeated throughout the formative period of the Nation-State, transformed into a structural strategy of domination with the neoliberal project. This has transformed Chile into a world laboratory of experimentation of capitalist modernisation. This is recognised by Chilean historians and social scientists such as Gabriel Salazar (2006), Patricio Manns (2001), Sergio Grez (2007) and others.

Thus, the battle against torture in Chile is entirely situated in the constituent process, since it is imperative to resonate with the global debate for a new project of human society, based on the values and principles of human rights, on social justice, on balance between diversity and equality, between redistribution and recognition, on an ethic for life and nature.

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Abstract
In this short essay, the focus is on social and political aspects of forced migration. It is argued that policies designed to restrict access to developed countries have, rather like the American “prohibition”, produced a thriving criminal market for smugglers, in this case of people. Making travel more difficult increases both their profits and the sophistication of their methods. Provision of targeted, properly controlled, support for refugees in countries neighbouring conflict zones might help to reduce the pressure on travel to Europe and could be both more successful and more humanitarian. For those who do reach developed countries, there is scope to improve the legal decision-making process. Psychological input should include scientific investigation of legal assumptions, and the provision of relevant expert literature reviews, for example concerning modern knowledge of memory. Trust is the first casualty of repressive violence, and mistrust among opposition groups is probably one of the key mechanisms of its success. We need to make sure that we do not provide further grounds for this sort of reaction. Although there is no brave or new world ahead, we must continue to confront ignorance and prejudice, as we seek to avoid more humanitarian disasters.

It is now just over thirty years since we published a potential framework for understanding how survivors of organised state violence react to complex and severe trauma (Turner & Gorst-Unsworth, 1990). We argued that no single psychological process underpins the reactions to this experience, and therefore, there can be no unitary torture syndrome, but rather a series of understandable psychological pathways activated to varying degrees by different experiences, leading to diversity of emotional response, with implications for recovery and treatment. We also asked family doctors about health needs of refugees (Ramsay & Turner, 1993), and it is wonderful to see how the evidence on treatment options has developed since then, especially in recent years.

In this paper, looking back over the last thirty years, in celebration of the anniversary of Torture journal, I will focus on political, legal and forensic aspects of forced migration.

History of forced migration, people-smuggling and asylum in the UK and EU
Sadly, although knowledge about how best to understand and support torture survivors has improved, the political context in the western countries that receive refugees and forced migrants has generally deteriorated. The very recent case of Ukrainian (European) refugees, if anything, serves to illustrate the stark contrast with attempted migrations into Europe. There have been increasingly restrictive policies limiting access to the UK and Europe.
in general. As Pérez-Sales (2018) points out, these problems are not restricted to Europe. The borders between Guatemala, Mexico and the United States had become dangerous, with many people disappearing there. However, the focus of the present paper will be on the UK and Europe.

When I began to work in this field, in the mid-1980s, using data from the Home Office (the responsible part of the UK government), the numbers of asylum seekers arriving in the UK were relatively low, ranging from 2,352 in 1980 to 5,263 in 1988 (Home Office, 1990). During this period, there was a tightening of visa rules, and, in 1987, a law was passed to penalise international airlines if they transported people to the UK without valid papers. In effect, key immigration controls had been outsourced to the airlines at the point of departure, with a financial penalty if they got it wrong.

These changes largely prevented people from arriving legally in the UK to claim asylum. The legislation was not supported by evidence of increasing abuse of the asylum system. In fact, during the decade 1979 to 1989, the proportion of unfavourable asylum decisions (denial of refugee status or exceptional leave to remain) tended to reduce (Home Office, 1990).

The number of people seeking asylum in the UK increased substantially from 1989. Although varying since then, it has continued at a higher level (although nothing like the numbers in some countries). The big change that I observed at the time concerned the increasing use of paid ‘agents’ (people-smugglers). An activity, which hitherto had often been motivated by an altruistic wish to help people escape violence, increasingly became a viable commercial project.

This increase represents the great failure of the policy of restricting access. Politicians, since then, trying to maintain control over forced migrants, have adopted even more restrictive policies. This has been done to make the border crossing points even more difficult for refugees and provide even more scope for people smugglers to increase their profits.

Rather like the American experience of alcohol “prohibition”, the more nations adopt such policies, the more they build the (commercial) business case for smugglers (in this case, people rather than alcohol smugglers). This is an untenable position. There will inevitably be increasingly sophisticated criminal activity if we continue like this, with refugees facing ever more dangerous journeys.

This development was not restricted to the UK. By the early 2010s, increasing numbers of smuggled refugees crossed the Mediterranean in small boats. In October 2013, a boat travelling from Libya to Italy sank near the Italian island of Lampedusa with a death toll of at least 359 people. The initial Italian response was to establish a humanitarian military response (Mare Nostrum), with ships sailing close to Libya to pick up refugees in distress or dangerous craft, before they set off across the Mediterranean.

It was then argued that providing support off the Libyan coast simply encouraged more people to travel that way, resembling the much-criticised Australian debates over ‘irregular’ asylum seekers. In 2014, this humanitarian policy ended, being replaced by a border control response, off the European rather than the Libyan coast, in the form of Frontex’s Operation Triton (Turner, 2015). This meant that migrants (mainly Syrians) had to experience the dangers of the full Mediterranean passage once again, with an increase in their death toll. UNHCR (2015) estimates that in April 2015, 1,308 refugees and migrants drowned or went missing in a single month.

In March 2016, the European Union made a deal with Turkey, paying six million euros
and making political concessions in return for Turkey’s agreement to restrict refugees travelling to Greece (Terry, 2021). The value of asylum seekers on the EU border had therefore been monetised, in my view, a very dangerous precedent.

**Politics of displacement and refuge**

More recently, asylum seekers have even been recognised to have political value. At the border between the EU and Belarus, refugees found themselves in desperate conditions (UN News, 2021) in a state of limbo between countries, with Belarus “weaponising migrants in retaliation for sanctions” (Moreau, cited in UN News, 2021). At least eight people had already died at the border. Others who had entered Poland had been apprehended and illegally pushed back across the border to Belarus. “Pushbacks that deny access to territory and asylum violate human rights in breach of international law” (Moreau, cited in UN News, 2021). In January 2022, around 500 were still living in temporary accommodation near the border (Belta, 2022).

Over the last year or so, there has been an increase in the smuggling of refugees across the Channel between France and the UK. Recent news stories have suggested that the UK Government has considered pushing back migrants towards France, for example, using border force officers on jet skis. There have even been moves to allow these officers immunity from prosecution if there should be harm or death as a result (Syal, 2021).

It is hard to see where this will end. Will we start to see increasing violence as smugglers react to these changed circumstances? Will nations compete to push away refugees further and further from their borders? It is important to portray this for what it is, a denial of access to European justice. The courts can still decide that someone is or is not a refugee. Erecting border barriers is a means of preventing refugees from having their status considered.

The media describe refugee migration in increasingly hostile terms, whereas, as clinicians, we are sure that many of the refugees we meet are not being treated fairly. There is a disconnect between these different experiences.

So, what could be done at a political level? One of the first areas for improvement must surely relate to planning military action (and inaction) in countries such as Iraq, Syria, and Afghanistan. I am not in any sense advocating in favour of warfare, but rather suggesting that built into any intervention, any decision, there should be consideration of the humanitarian needs and political impact of internally displaced people, refugees, and other forced migrants. These should not come as a surprise after the event, nor should their cost, as so often appears to be the case.

There is also substantial scope to improve the condition of migrants in developing countries neighbouring conflict zones. Crawley and Skleparis (2018) found that many migrants do not leave their country of origin with the plan of arriving in Europe. Instead, these decisions are often made in steps. Having fled from their home countries, they decide to leave the countries where they first settle because of discrimination and lack of access to human rights or local citizenship. Improving their economic and political standing in these neighbouring countries, facilitated by international action, is likely to help refugees living there and reduce the pressure for onward transit to Europe.

There is a potential economic case to be made for this, although I set this out with some caution, in recognition of the sad truth that aid often does not reach its intended recipients. Betts & Collier (2017) note that the world spends approximately $75bn a year on the 10% of refugees who have moved to devel-
oped regions, but only around $5bn a year on the remaining 90% in developing regions. If an effective policy of constructive engagement with these countries were developed, conditions for refugees there could be improved. If this reduced the impetus for refugees to leave and move on, money would be freed up in developed countries, which could be diverted to support even better standards of care in neighbouring countries, a virtuous circle.

If greater aid to neighbouring countries, specifically for their support of forced migrants, and towards a policy of reducing the drivers for people to attempt the often-dangerous journey to Europe, could be delivered effectively, this should also facilitate a shift away from the punitive rule of prohibition. It would not reduce human rights or individual choice, but would surely benefit many more people, especially if UNHCR moves beyond the concept of detention in refugee camps (UNHCR, 2014) and encourages greater integration into neighbouring host countries, where the economic potential of refugees can be fully developed (Betts & Collier, 2017).

Applying the refugee convention, the legal perspective
The limitations of the processes that apply when people seek to have their refugee status accepted have been the focus of my interest over recent years, generally in collaboration with my colleague, Jane Herlihy. The Refugee Convention, established specifically to assist displaced peoples inside Europe at the end of WWII and later extended, allows too much scope for subjective interpretation. Part of the problem arises because of a political desire to create a false dichotomy between refugees and other migrants. In contrast, the truth is that migrants have often experienced a complex mixture of economic, political, and social factors driving their decision to migrate (Crawley and Skleparis, 2018). There is no such simple differentiation to be made.

The general flaws in the legal system have been demonstrated most clearly in a US study. Researchers were granted access to regional and national asylum data and and, alarmingly, found vast differences in decisions over similar cases (Ramji-Nogales et al., 2007). For Chinese asylum seekers (to take just one example), the grant rates between officers in the same region varied between 0% and 68%, and a similarly wide variation was found among judges. This was not just down to the preference of individual decision-makers; quality of representation also had a profound effect on the decision. Those who were unrepresented had a 16% chance of success; those routinely represented had a 46% chance; those represented by a specialist clinic had an 89% chance; those represented pro bono by a large law firm had a 96% chance. This evidence, published under the graphic title of ‘Refugee Roulette’, plainly suggests that this cannot be a fair or just law in practice.

Cameron (2018), an academic lawyer with experience working with refugees, has cogently argued in favour of exploring different ways of applying the international conventions. In her book (chapter 8), she illustrates a point with the example that as a child at a fair, she put her hand into a bag and by chance picked the one red jellybean among 99 black ones, winning a prize. If her safety turned on the validity of this assertion, simply arguing statistical improbability would surely be an insufficient basis for a decision. Uncommon events do occur, and this is more likely to be the case in someone with an unusual history, such as presenting as a refugee in a western country. Surely any decision would need to demonstrate weighing the validity for or against the alternative hypotheses, and consideration of the whole of the evidence.
If she found herself in front of a refugee decision-maker, it is possible at present for him or her to determine that finding a red jellybean was so improbable that she must be lying about it. Traditionally, in a refugee determination, this might become a solid building block on the way to a decision, the start of a chain of inductive inference. If a finding of fact were made that she did not find the red jellybean, it would follow that she could not have won the prize, and therefore that this could not have affected her future life in some other way. However, argues Cameron, surely what is needed is a probabilistic finding, perhaps that this picking of a red jellybean possibly occurred but was thought to be unlikely. Later in the process, looking at the whole of the material, noting perhaps that Cameron is a respected academic lawyer, that there is no reason for her to lie about this, and so on, the more reasonable conclusion is that she is probably telling the truth about an event which happened to be unlikely. There is, therefore, no reason to conclude that its sequelae did not occur.

Cameron suggests that “refugee narratives are survivor narratives and therefore littered with red jellybeans.” These are the often-unlikely events that do, in fact occur. Basing her argument on case law, she concludes that a decision-maker need not be perfectly certain and does not need to make spurious findings of fact like this. They need to set out best explanations, expressing their level of confidence in each statement they make. This is to adopt a risk assessment approach, much more like the models used by clinicians.

After all, how can a decision-maker really make a particular finding of fact, thereby expressing no doubt at all, that an assault (say) did not occur? The potential error is compounded, in the chain of inductive inference, when the decision-maker, having found this as a certain fact, can then assert, equally firmly, that a diagnosis of PTSD must be rejected because there was no assault to cause it, even if its characteristic symptoms were found.

This is the danger arising from making firm findings of fact from each building block of evidence as it presents. Suppose instead, the decision-maker had concluded, for example, that the assault was unlikely. This probabilistic decision could perhaps be revised upwards to some extent in the presence of evidence suggesting the clinical features of PTSD, together with any other independent evidence. Rather than being in opposition, these elements can each contribute to the determination. There is still a need for judgment, but this approach would probably correct some of the worst decisions.

I recall one written judgment in which a judge spent more time considering my report, and my credibility than he spent on the asylum seeker’s credibility. I had requested that the primary care records should be obtained but my instructing solicitor had been unable to obtain them. It was very interesting to read the judge’s finding of “fact” that I had not asked for these records, presumably therefore concluding that I was lying. I had not been asked to attend court in this case, but if I had, I could have provided the documentary proof of my request, including a signed acknowledgement of this by the solicitor. I can therefore say from my own experience that this approach to decision-making is seriously flawed. Having falsely concluded that I lacked credibility, it was easy for him to downgrade the rest of my evidence.

Cameron herself concludes chapter eight by stating, “In a refugee hearing, we know that we are often going to get it wrong. There is no need, and no excuse, for claiming to know more than we do. In the context of ‘radical uncertainty,’ the ‘illusion of certainty is not merely unwise and unnecessary; it is unethical. It needlessly adds the worst kind of insult...
to the worst kind of injury, and the law should reject it simply out of decency."

**Applying the refugee convention, the psychological evidence**

We have examined written refugee determinations and investigated the reasons given by immigration judges for their decisions (Herlihy, Gleeson and Turner, 2010). Their reasons were not always in line with current scientific evidence. They could be investigated further in some cases, checking the validity of the ‘common sense’ assumptions that judges were making.

For example, the proposition that discrepancies indicate fabrication betrays a lack of understanding of current scientific evidence about memory in general and, as we have shown, particularly about discrepancies after trauma (Herlihy, Scragg & Turner, 2002; Herlihy & Turner, 2006; Herlihy & Turner, 2007; Herlihy, Jobson & Turner, 2012; Hungarian Helsinki Committee, 2013 & 2015). Worryingly, those with both more symptoms of PTSD, and longer delays between research interviews, showed more evidence of inconsistency. This suggests that using discrepancy as a marker of fabrication would penalise those most traumatised and perhaps most in need of international protection.

We have previously demonstrated that avoidance symptoms are more common after sexual than physical torture (Ramsay, Gorst-Unsworth & Turner, 1993; Van Velsen, Gorst-Unsworth & Turner, 1996). This work was taken further by studying refugees and their accounts of Home Office interviews (Bögner, Herlihy & Brewin, 2007; Bögner, Brewin & Herlihy, 2010). Those with a history of sexual violence reported greater overall PTSD severity and avoidance symptoms, greater feelings of shame and more dissociation symptoms. They reported greater difficulty in disclosure of personal information during Home Office interviews. Once again, this points to the possibility that those with a genuine history of sexual violence would more likely be rejected in the process of determination.

In a presentation to a large group of immigration judges, I asked them to reflect quietly for a few seconds and to try and bring back into memory the event in their life about which they felt the most ashamed. I then asked them to imagine turning to the person next to them and fully and accurately disclosing this event. It could be argued that some of the reasons for the delay, or partial disclosure, in reporting experiences such as sexual assault should require no more than careful thought. However, scientific evidence is always much more robust.

In the centre we established (the Centre for the Study of Emotion and Law), over-general autobiographical memory, previously found in non-refugee populations with PTSD and depression, was also identified in refugees (Graham, Herlihy & Brewin, 2014). Fewer specific memories could easily act against the asylum seeker if the decision-maker considered that this was a feature of fabricating an event that had not occurred. Another analogue study revealed some interesting implications of appearance or demeanour during an account of traumatic experiences, conclusions that confirm that this is an unreliable method of determining credibility (Rogers, Fox & Herlihy, 2015). A study of how experienced lawyers assessed whether to seek a medico-legal report revealed limitations in their understanding of emotional presentations (Wilson-Shaw, Pistrang & Herlihy, 2012). There have also been studies of memory in adolescents seeking asylum (Given-Wilson, Hodes & Herlihy, 2017).

This body of work shows that some apparently reasonable pieces of evidence, often used in considering the validity of an asylum
application, are unreliable. Even more worrying, this is not a random effect; there is often a systematic bias against the asylum claimant most likely to be a refugee.

Conclusions
Unless the system positively facilitates disclosure of a refugee’s experience, permits later disclosure where this was not (psychologically or practically) possible initially, accepts that those most traumatised may have the greatest difficulties in disclosing their experiences, and a range of other necessary steps, it cannot be deemed fair and just.

Indeed, it is not easy to see why we should expect an asylum seeker to disclose any of this information to an official, even to a doctor, when both state officials and doctors may have been implicated in their prior detention and torture.

This raises a more general issue concerning the significance of trust. Arguably, engendering mistrust in community groups is the primary mechanism by which repression is achieved (Turner, 1996). One of the necessary conditions for effective resistance is the capacity for members of the political opposition to trust each other, for example, with secrets and with safety from betrayal. Knowing that a comrade has been arrested, and might betray, might even have betrayed, therefore can disrupt mutual trust and opposition activity.

Simply knowing of someone in a circle of friends who has been detained and tortured can be sufficient to lead people, in fear, to hide their private political opinions. It is probably the resulting widespread impact of social mistrust and fragmentation, more than the direct impact on individuals, that repressive regimes generally seek to utilise. That is why it often seems to matter less what you know, or who you are than what or who you symbolise in your community. This is at the heart of repression.

When people start to trust each other again, significant change is possible. One has only to look at the fall of the Berlin wall. For refugees in host countries, rebuilding the capacity to trust is often crucial if long term alienation is to be avoided. This must start with a trustworthy and timely process for determining status.

Failing changes to the legal process, the best way to achieve better standards in case determination is by greater transparency, with decision-makers obliged to audit and defend differences in their determination rates and share this information with international agencies like UNHCR.

However, clinicians and researchers must also engage with this process and move beyond individual asylum reports. We need to develop better models for understanding the general bases for decisions and provide scientific evidence to confirm or refute ‘common sense’ legal decisions. Like the country expert, we need to engage in developing and presenting general psychological information and not simply rely on individual assessments.

Sadly, if history is any guide to the future, I should not hold my breath waiting for a major change in direction. Indeed, as I write, there are plans to criminalise refugees arriving in the UK without a visa or immigration leave, as well as those deemed to facilitate their arrival - potentially including rescue ships or lifeboat crews (JCHR, 2021).

I can see no brave or new world ahead.

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The Future is Here: Mind Control and Torture in the Digital Era

Pau Pérez-Sales

Abstract
Torture, understood as a relationship of domination in which one person breaks the will and impedes the self-determination of another human being, taking control of all aspects of the victims’ life and trying to change the core elements of their identity to the perpetrator’s interests (Pérez-Sales, 2017), will increasingly come to be linked to new technologies, artificial intelligence, the use of media and internet, and to new forms of lethal and non-lethal weapons. The author reviews the implications of modern technology for the contemporary fight against torture and some of the emerging civil society initiatives that aim to face them.

Keywords: Torture, Non-Lethal weapons, Neuro-warfare, Nanotechnologies, Mind control. Surveillance Methods, Neuro-ethics, Cognitive Liberty.

Working with torture survivors: are there two parallel worlds?
When we discuss contemporary torture, it seems as if there are two parallel worlds. One is constituted by, let’s say, “real torture”, that of blows and beatings, of the dark ominous places of detention. And the other, that reflected in mostly speculative reports, is of the MK-Ultra, the laboratories of human experimentation, brainwashing and the dark world of military research institutions. Both worlds seem disconnected. When a field worker doctor or psychologist in a torture treatment centre in a MENA country is told about CIA or China mind control programmes, or about documenting threats or sleep deprivation as subtle forms of torture (Pérez-Sales, 2020, 2021), that person may read those reports with a certain curiosity. But as a reality, such programmes appear light years away from his daily practice of bruises, insomnia and flashbacks.

Until suddenly Guantanamo prison is among the main news on TV, and the two worlds, apparently disconnected come together. And we realise that thousands of people, ordinary citizens, have been, and are being, subjected for years to torture methods designed by Nazi psychologists and doctors, the foundation for ideas and programmes that sound like outdated Cold War relics, but which are nonetheless real: MK-Ultra, Albert Biederman, Brainwashing, Kubark Manual, and the like. In fact, centres like Guantanamo exist and have always existed. La Libertad prison in Montevideo, during the Uruguayan dictatorship, was a place of experimentation in psychological torture in the 1980s. There were similar centres in Brasilia and Buenos Aires, where mind control experiments on human beings were done with British, French or North American instructors. In the 1990s, experiments on different forms of identity destruction were carried out in Turkey in the Kartal Special Type
Prison (among others), which later gave rise to the well-known F-Type prisons. The Evin prison in Tehran has had, for more than 20 years, and still in use, a module for experimentation with forms of psychological torture. Similar modules have been described in other countries. It seems nobody wants to be left behind in this race for mind control.

**Torture Methods: Changing the Outlook**

Psychological torture, in the past, was based on destruction: destruction of the body through pain, and destruction of the mind through psychological methods of attacking self and identity.

Those methods proved to be of little practical use, except as punishment, and were not considered cost-effective by the State perpetrators. Whatever limited success such methods achieved often came at the expense of a negative social image, international isolation and a high political cost for the governments that used them. Moreover, such methods corresponded poorly with the logic of the free market and the monetisation of all aspects of society that can be made potential subjects of business in a globalised world in which markets supplant States as social regulators.

Thus, the torture of the future will be forms of social control that are also niche markets. The destruction of body and mind will still be part of contemporary torture; but the focus of torture methods will increasingly be based on the logics of late capitalist societies.

**Mind control: more than a myth?**

The technological society is advancing exponentially. In 1969, the US military research agency ARPA created the first rudimentary internet. The first PC came onto the market in 1981, based on the MS-DOS system. Barely 40 years later, quantum transmission systems are becoming available and any desktop computer is capable of handling gigabytes of information in seconds. Advances in the battle for mind control have followed the same exponential growth. What only ten years ago was part of a conspiratorial universe, is today a technological reality; sometimes in animal testing models, but very often already in human experimentation or applied in small scale environments. In a very short time, there will be attempts to scale it up, and a new battle will ensue as civil society and human right groups challenge the assault on individual liberty. Globally, this new field, which has undergone extraordinary expansion since the 1970s, has been labelled neuro-warfare (Krishnan, 2016). Part of it is Internet and Communications Ill-Treatment and Torture (ICIT) (Pérez-Sales & Serra, 2020).

Torture, understood as a relationship of domination in which one person breaks the will and impedes the self-determination of another human being, taking control of all aspects of the victims’ life and trying to change the core elements of their identity to the perpetrator’s interests (Pérez-Sales, 2017) will increasingly come to be linked to the new technologies if this neuro-warfare, artificial intelligence, the use of media and internet, and to new forms of lethal and non-lethal weapons.

**Controlling the Body: Beyond Pain**

Table 1 collects a brief summary of available contemporary weapons already in use, or in experimental stage with potential use, as torture devices (National Research Council, 2003; Wright, 2002). Some of them are well-known and debated, like electro-shock implements (Dermengiu et al., 2008; Institute for Security Studies, 2016), sound weapons (Davison, 2009a; Volcler, 2013) or chemical riot control agents (Scheep et al., 2015).

Other are less well-known, like thermal lasers, radiofrequency or directed energy
New Non-Lethal Weapons with potential use as torture devices

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemical weapons</td>
<td>. Incapacitating agents (e.g. CS, CN, CR, OC) used as gases or sprays</td>
</tr>
<tr>
<td></td>
<td>. Chemicals that target neurotransmission receptors aiming to produce anxiety, submissiveness or fatigue</td>
</tr>
<tr>
<td></td>
<td>. Chemicals that act as malodorant or produce nausea or vomiting</td>
</tr>
<tr>
<td></td>
<td>. Chemicals that produce temporary neurotoxic paralysis.</td>
</tr>
<tr>
<td>Electro-shock devices</td>
<td>. All kind of guns, projectile, batons or belts.</td>
</tr>
<tr>
<td>Acoustic devices</td>
<td>. White sound that produces irritability, insomnia and anxiety</td>
</tr>
<tr>
<td></td>
<td>. Low frequency sound that causes headaches, disorientation and nausea.</td>
</tr>
<tr>
<td></td>
<td>. Sound isolation devices – sound deprivation</td>
</tr>
<tr>
<td></td>
<td>. Sound saturation devices</td>
</tr>
<tr>
<td>Light devices</td>
<td>. Strobe lights, dazzling lasers, flash binding lights that cause disorientation and temporal blindness</td>
</tr>
<tr>
<td>Microwave generators</td>
<td>. Increase water body temperature creating general or focused burning sensations</td>
</tr>
</tbody>
</table>

 devices (Joint Non-Lethal Weapons Directorate, 2011; Risling, 2006; United States Air Force Research Laboratory, 2002).

One of the less known expanding areas of technological development in recent years is that of so-called Directed Energy Weapons (DEW). These are based on the use of different forms of distant energy emission devices (laser, microwave or other) directed against individuals or focused towards specific areas within the human body (Davison, 2009b). As an instrument of coercion and torture, they are invisible. In the short term, they cause thermal pain that can be unbearable and in the medium and long-term they can potentially cause lesions in the skin or internal organs.

Nanotechnology and Torture

Nanotechnology is the modern and rapidly expanding field of medicine that applies the use of nanoparticles (particles with a size of less than 100 nanometres [nm]) for preventive, therapeutic and diagnostic purposes. Nanotechnologies have applications in the fight against degenerative neurological processes, cancer and infectious processes where targeted actions are sought at specific points in the human body. But in parallel, for the last 20 years, the military industry has also been researching its potential application (Altmann, 2004). Nanomedicine as a non-invasive strategy for drug delivery across the blood brain barrier has enormous potential and enormous dangers, and has yet to be specifically regulated by international treaty. Nanoparticles do not necessarily require an injection site and can be absorbed via the skin or nasal passages. Just as an example of its potential applications, there are programmes that already allow for the tracking of the movements of animals, a
technology quite close to conspiracy-minded ideas of many antivaccine groups.

Chemical weapons are thought of as products that can be deployed on a large scale in war contexts, such as the case of Agent Orange gas in Vietnam (Verwey, 1977) or White Phosphorus Bombs used in Gaza or Syria (Crowley, 2016; Dando, 2015). This being true, less well-known is the development of chemicals linked to nanotechnologies. A recent review has found a wide array of research into aerosol-delivered toxins and neuro-regulators (Nixdorff et al., 2018). The use of oxytocin and other empathic substances and their potential applications in psychiatry and mental health are well known (Lane et al., 2013; Leppanen et al., 2018).

Neural implants

A neural implant is a device placed inside the body that interacts with neurons. It has multiple applications in medicine, especially related to neurostimulation in motor and sensory disorders, but also epilepsy, and depressive and obsessive-compulsive disorders (Costa e Silva & Steffen, 2017). This a rapidly progressing research area in which biochips and implants are built in new and better materials that produce no tissue rejection, with systems that do not require external sources of energy, incorporating nanotechnologies to diminish size and with more powerful software to control and interact with them (Dabbour et al., 2021; Salari et al., 2022; Wan et al., 2021) while, again, there is no international regulation of its use (McGee & Maguire, 2007). The most important concern regarding the use of these devices – decades away, for now - is represented by the possibility of controlling an individual’s mental functions via wireless waves interacting with the brain. From the perspective of torture, it has been claimed that they could be used in the future to manipulate memory and emotions and to induce hallucinations and psychotic-like symptoms, among many other harmful effects.

Unveiling the brain: Accessing thoughts and feelings

If anything resembles a future in which it is possible to control the human mind, it is through the hundreds of civil and military research projects on Mind-Brain interfaces and Remote Neural Monitoring. Under the coverage of medical projects, new generations of ever more powerful cortical modems are marketed and already in use in pilot experimental subjects. In its basic form, they allow to control orthopaedic systems with the mind, but in its more advance modalities, such cortical modems allow the user to ‘inject’ images or sounds directly into the visual or auditory cortex\(^1\) allowing blind people to recover their sight or the brain damaged to restore their ability to recall memories\(^3\), among other uses.

Reversing the idea, different labs in Europe, Japan and the US have also developed Brain Computer Interfaces that allow patients to communicate with researchers and control external devices simply by imagining the actions of different body parts (Bates, 2021), a technology that will have many potential benefits for patients suffering neurological disorders. There are now in the market different portable devices that monitor electric brain activity\(^4\) and electromyography signals\(^6\) for no-touch game interfaces, emotional train-

\(^1\) https://www.darpa.mil/news-events/2015-01-19
\(^2\) https://www.sbir.gov/node/736761
\(^4\) https://www.bitbrain.com/neurotechnology-products
\(^5\) https://www.mindtecstore.com/NeuroSky-Brainwave-Starter-Kit-EEG-Headset
\(^6\) https://store.neurosky.com/
Different Thought-to-Text devices are already available (Willett et al., 2021) and ready to be marketed.

**Big Data, Security and Surveillance in Law Enforcement**

This decade will undoubtedly be remembered as the decade of *Big Data*. The existence of super-computers with the capacity to process millions of data bytes in milliseconds and to integrate and analyse almost instantaneously databases from very diverse sources has opened the door not only to an unprecedented advertising invasion, but also to the integration of databases on human beings that include biometric data, activities, movements, expenditures and opinions, among many other elements. Always in the name of security and the fight against terrorism, and pushed by the new Cold War jargon, governments approve the existence of restricted databases over which there are few to any means of transparency or control. Such databases, in the form of anti-terrorist files of persons ‘under special surveillance’, have always existed. The difference is that the current databases aim to include all citizens, and they are transnational in nature. The citizen is confronted with the need and duty to rely on the good faith of institutions and governments. Most of these data are in the hands of private companies and police and military agencies that often act with little political oversight. There are many risks linked to the routine use of Big Data by law enforcement agencies, especially regarding discrimination and abuse (Guthrie, 2017). Policies for full transparency have been proposed, including regular meetings between local police, community representatives, elected leaders, technology experts, and civil liberties groups engaged in public and open information sessions (Guthrie, 2017). Furthermore, Big Data is used to decide political strategies and design communication campaigns (Stroud & McGregor, 2019). Debates in the field of human rights about the limits of the use of Big Data paint a picture of increasingly urgent ethical awareness and action (Davis & Patterson, 2012).

*Interception and control of communications* is the other side of the coin of social surveillance. It seemed technologically impossible to monitor and track millions of telephones and Internet communications around the world until Edward Snowden and others unveiled Echelon, the main among other similar global surveillance networks. Echelon, with an estimated of 300,000 employees in 120 stations around the world, according to official figures, monitors more than three billion communications every day, 90% of Internet traffic. The information captured by Echelon feeds different Big Data databases (Lyon & Murakami, 2021).

**Transhumanism: Upload Brains to Computers**

This decade has also been labelled the decade of the brain. The United States launched the Advancing Innovative Neuro-technologies (BRAIN) Initiative to develop and apply new tools and technologies to the mapping and study of neural circuits, and the understanding of the neural and computational basis of behaviours, perceptions, thoughts and emotion (Jorgenson et al., 2015; Koroshetz

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et al., 2018). New neuro-technologies fuelled by the BRAIN Initiative now allow investigators to map, monitor and modulate complex neural circuits, enabling the pursuit of research questions previously considered unapproachable (Hsu et al., 2020).

One of the most exciting (and frightening) careers in contemporary science, mostly in the private sector, is the pursuit of methods for transferring the entire information of a human brain into a computer. There are several companies working towards this goal, with Neurolink, the company owned by Elon Musk, being the best-known in newspapers and the media. According to company estimates, rudimentary systems of brain uploading will be available in about ten years. Neuro-ethicists debate whether, by the time this is achieved, it will transfer more than just a set of neural networks and information, or also transfer that person’s consciousness, which some speculate would amount to, somehow, achieving the immortality of a person in a machine body. This possibility has spawned several think-tanks of philosophical reflection that try to promote the debate on where contemporary civilisation and the human species should evolve. An example of this was made in a proposition by the Global Future 2045’s 2013 Congress which stated the goal “Towards a New Strategy for Human Evolution” in an open letter to United Nations General Secretary Ban Ki-Moon, and was debated at Oxford’s Future of Humanity Institute and other institutions (Benedikter et al., 2016). Furthermore, some philosophers are developing models that speak of a coexistence of a classic labour-based capitalism with what is called new cognitive capitalism, in which persons will have economic value for their brain and thinking and the economical applications of the data it generates (Lushetich, 2021).

Linked to it is transhumanism, a branch of science devoted to enhance (or abate) human beings by employing already existing and future technologies: artificial intelligence, robotics, cognitive science, information technology, nanotechnology, biotechnology and others reviewed here (Hofkirchner & Kreowski, 2021). While most of the field is futuristic projections, closer to science-fiction than reality, different projects of the so-called super-soldiers are already funded by DARPA military projects as announced on their website. Big Data is also used to create intelligent systems that can support military decisions (Labbe, 2019).

**Facing the Challenge: Initiatives to defend human rights in the 21st Century.**

**Research, Documentation and Advocacy Initiatives**

Fortunately, there are some initiatives for these new struggles of the human rights tradition that are central to the fight against torture. Amnesty Tech is a global collective of advocates, hackers, researchers and technologists that aims to “bolster social movements in an age of surveillance, challenge the systemic threat to our rights posed by the surveillance-based business model of the Big Tech companies, ensure accountability in the design and use of new and frontier technologies and encourage innovative uses of technology to help support fundamental rights”9. Besides publishing reports, they undertake strategic litigation cases. Human Rights Watch has created a specific research line on Technology and Rights with a team of full-time researchers that has produced both Global and Coun-

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try-Specific technical reports. Just to mention some relevant initiatives, the University of Essex created the Human Rights, Big Data and Technology Research Group that has developed good practice guidelines for the digital age. The Georgetown Law Library created in 2014 a special repository on legal initiatives and regulations related to cyberspace and digital rights. The United Nations Educational, Scientific and Cultural Organisation (UNESCO) has issued a set of Recommendation on the Ethics of Artificial Intelligence.

Neuro-Ethics and Cognitive Liberty
Most of these initiatives are related to privacy concerns. Less developed is human rights research and activism related to neuroscience.

A pioneering movement linked to what was called Cognitive Liberty started more than two decades ago (Boire, 2000) as a reaction to military research on the use of FMRI and other medical devices in lie detection in the interrogation of suspects (Balmer, 2018; Poldrack, 2008). Perhaps the movement was too visionary for the time and thus did not achieve the necessary backing from civil society organisations.

There are different civil society research groups working on the ethical challenges and regulations of new neuro-technologies and neuro-warfare (Carle, 2021; Herrera-Ferrá, 2021; Judy Illes & Hossain, 2017; Salles, 2021; Yuste et al., 2021). There is a pioneering initiative of a group of neuroscientists from different countries led by the Chilean professor Rafael Yuste, Director of the Neurotechnology Centre at Columbia University, which has articulated a transdisciplinary platform that lobbies for the adoption by the United Nations General Assembly of a new charter of cognitive rights and respect for the integrity of the conscience as a fundamental and inalienable value of human beings (Goering et al., 2021; Ienca, 2021; J. Illes & Hevia, 2021; Illes & Hossain, 2017; Yuste et al., 2021). Chile, by the way, will be the first country to adopt specific national legislation on cognitive rights (Zúñiga-Fajuri et al., 2021).

In summary
Brain implants and remote Mind-Brain interfaces; the expansion of nanotechnologies as weapons targeting not only the body but also the brain; the development of biomarkers and massive surveillance methods; the implementation of methods to monitor emotions and thoughts in the interrogation of suspects; the development of Internet-based technologies for the manipulation of opinion and social control: these, among many others, are technological developments with potential use in cruel and inhuman treatment and torture, the manipulation and social and control of societies and individuals.

The world of civil science and human rights advocacy has always advanced with a minimum of 10 years delay in regards to the advances made by military science. Ten years may not have been that long in the past, but it may definitely be too long in the future.

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10 https://www.hrw.org/topic/technology-and-rights
11 Their team, by the way, was among the list of persons with their telephones infected by Pegasus malware https://www.hrw.org/news/2022/01/26/human-rights-watch-among-pegasus-spyware-targets
14 https://guides.li.georgetown.edu/c.php?g=363530&p=4783483
15 https://unesdoc.unesco.org/ark:/48223/pf0000377897
And so what?

Many of these developments in the field of the interaction between technology, medicine and other branches of society have undoubted potential to help humanity. But they also have enormous potential risks when ethics are subsumed to serving business interests or military or political purposes. Even more when, in relation to all these developments, deregulation in the field of human rights, is complete.

Faced with this reality, it is easy to be tempting to consider that these are conspiracy fantasies and that there is too much work to be done in our daily lives with victims of “real torture” to worry about the evolution of ill-treatment and torture. This is partly true. Without falling into apocalyptic discourses nor into naïve confidence in human kindness, this are areas to which doctors, lawyers and human rights defenders must pay attention. If we want to understand the future of torture in the years to come, those who fight against it need to evolve as rapidly as those who help to perpetrate it.

References


Salari, V., Rodrigues, S., Saglamyurek, E., Simon,


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

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

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

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

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

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

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

**Deadline for submissions**
31th December 2022

**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/2eefc4b785f87c7c3028a1c-59ccd06ed.pdf
- **Read more about the Torture Journal here**: https://irct.org/global-resources/torture-journal
- **For general submission guidelines, please see the Torture Journal website. Papers will be selected on their relevance to the field, applicability, methodological rigor, and level of innovation.**

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Integrating livelihoods in rehabilitation of torture survivors

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

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

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

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

a. Defining livelihoods and its relationship with the concept of development in the context of the work with torture survivors. Going beyond a definition centered in material outcomes and working with the idea of life projects and finding meaning as part of the work with torture survivors.

b. Survivor participation in design and implementation of livelihoods programs

c. Innovative experiences in livelihoods programs: evolving from a business perspective to livelihoods programmes for social change.

d. Transcending the individual or family perspective: from cooperatives to collective forms of organisation in livelihoods programmes.

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

Deadline for submissions
31st December 2022

Submission guidelines and links

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• Author guidelines can be found here: https://irct.org/uploads/media/2eefc4b785f87c7c3028a1c59ccd06ed.pdf
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The Torture Journal is published by the International Rehabilitation Council for Torture Victims which is an independent, international organisation that promotes and supports the rehabilitation of torture victims and the prevention of torture through its over 150 member centres around the world. The objective of the organisation is to support and promote the provision of specialised treatment and rehabilitation services for victims of torture.

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