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#45

GUIDANCE DOCUMENT
THREE PROTOCOLS FOR THE MEDICO-LEGAL DOCUMENTATION OF PSYCHOLOGICAL TORTURE

ELNA SØNDERGAARD, MARIE BRASHOLT AND PAU PÉREZ-SALES

DIGNITY
DANISH INSTITUTE AGAINST TORTURE

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INTRODUCTION

BY: ELNA SØNDERGAARD AND MARIE BRASHOLT

Torture and ill-treatment continue to be practiced in at least 140 countries worldwide[1], and the use of torture methods that leave no visible marks (psychological or stealth torture) is on the increase in various settings[2] and countries[3]. Examples of psychological torture methods are many and include among others prolonged solitary confinement, sleep deprivation, sensory deprivation, humiliations, and threats. Psychological torture may be used alone or together with other techniques to produce a cumulative effect. By way of example, we know that sleep deprivation is an ineffective method for obtaining valid information, information during a criminal investigation but a useful method for obtaining confessions because after only a short time deprived of sleep, the detainee is cognitively and emotionally exhausted and can easily confound his own thoughts with suggestions by the interrogator.

Psychological torture methods are characterized by having very severe psychological long-term effects. Despite the artificial distinction between physical and psychological torture methods, the label of 'psychological torture' remains apt given that "the brutality of psychological torture is very much based on what we know of human psychological function ['personal agency, values, emotions, hope, relationships, and trust'], on information and knowledge developed within the realm of psychology"[4]. The deleterious impact on the victim is, however, invisible. The difficulty in assessing the consequences of torture and their link to the torture experienced, defining it legally, and adjudicating cases is thus amplified when it comes to psychological torture.

Based on DIGNITY's and partners' experience, we can conclude that there exists a dearth of understanding and, in turn, appreciation of psychological, or non-physical, methods of torture, both among practitioners and in the legal system. Among practitioners, often, the documentation is limited to physical scars. This was confirmed at the international conference regarding Psychological Scars of Torture in Israel/Palestine held at DIGNITY, Copenhagen in 2015 and organised in cooperation with PCATI – Public Committee against Torture in Israel and REDRESS. The conference concluded that the collaboration between lawyers and health professionals could be strengthened. Formulating approaches to translating the medical knowledge about psychological methods of torture into the context of the legal definition of torture[5] and translating such knowledge into specific interdisciplinary tools applicable in a local context therefore became important.

Our knowledge and experience indicate that the likelihood of ensuring accountability for perpetrators depends upon the quality of the documentation of psychological scars. Therefore, we have targeted two professional groups, who are independent of the state, and who often meet and interview victims of torture, i.e., lawyers and health professionals. Better documentation, based on research-informed tools, would lead to collection of evidence that can be

1 Amnesty World Report (2018), available at Torture - Amnesty International (visited 21 March 2024).

2 The US' use of psychological torture methods in the "war on terror" is an example, see Physicians for Human Rights, Break Them Down, systematic use of psychological torture by US Forces (2005), available at irct.org/assets/uploads/Systematic%20use%20of%20psychological

3 Darius Rejali, Democracy and Torture (2000) and Pau Pérez-Sales, Psychological Torture: Definition, Evaluation and Measurement (2016).

4 Nora Sveaass, Destroying Minds: Psychological Pain and the Crime of Torture (2008) 11 New York City Law Review 303, p. 316.

5 As stipulated in Article 1 in UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984).

used within the judiciary system to seek access to justice and in local and international advocacy efforts to raise awareness of the severe consequences of psychological torture and of the use of such methods to avoid accountability.

We have developed three Protocols with the aim to improve documentation of sleep deprivation, solitary confinement and threats, and therefore to clarify the facts of the case so that stronger legal claims can subsequently be submitted to local, regional and international courts and complaints mechanisms. The Protocols supplement the United Nations Manual for the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment (1999, revised 2022) (Istanbul Protocol) that sets out standards for legal and medical documentation of cases of alleged torture, including of psychological torture.

The three Protocols have been developed following a methodology involving compilation and review of existing legal norms and standards; review of knowledge found in legal and health practice and research; and discussion in a group of international experts (see further in the individual protocols). Two of the Protocols (regarding sleep deprivation and threats) have to some extent been pilot-tested in collaboration with partners in Israel and Ukraine. We are cognisant of the significance of the specific social, cultural and political contexts in a local setting in which the methods are used and encourage the adaption of the Protocol to local needs.

We hope that the Protocols will assist in the discussions between professionals and other stakeholders and provide guidance on what can be documented and how to document torture. We present the Protocols here together with a more detailed description of how the protocols were developed as well as the core text from the three Protocols in a lay-out that we hope may serve as a practical tool during interviews.

The documents were first published individually in different volumes of Torture Journal (see references below), and we are grateful for the journal's permission to reprint them in this publication. Copyright remains with the authors and Torture Journal. However, we welcome local adaptations of the core text and kindly request that we are informed in case a locally adapted version is developed.

Collective efforts to document torture will always be an important endeavour. We would like to thank organisations and individuals who have contributed to the development of the content of this collection. In particular, we would like to thank PCATI in Israel and FORPOST in Ukraine for for excellent partnerships. We would also like to warmly thank individuals with whom we have had valuable discussions over the years, in particular Pau Pérez-Sales, Nora Sveaass and Ergün Cakal, as well as other members of the international group of experts on psychological torture, including Ahmed Benasr, Angela Burnett, Asger Kjærum, Brock Chisholm, Carla Ferstman, Chris Esdaile, Emily Rowe, James Lin, Nimisha Patel and Rupert Skilbeck.

Development of interdisciplinary protocols on medico-legal documentation of torture: Sleep deprivation[1]

Elna Søndergaard*, Rupert Skilbeck, Efrat Shir*****

Key points of interest

- Our experience indicates that the likelihood of ensuring accountability for perpetrators depends upon the quality of the documentation submitted to courts and investigative bodies.
- Formulating approaches to translating the medical and legal literature and knowledge about torture methods into specific interdisciplinary instruments or protocols applicable in a local context – based on which better documentation practices could be developed.
- Development of the Sleep Deprivation Protocol as the first testing of the research-based approach.

Abstract

Background: The use of psychological torture or torture methods that leave no visible marks (stealth torture) is on the increase in various contexts. However, the difficulties in the documentation of such methods should be recognized by lawyers and health professionals who may benefit from using research-based interdisciplinary instruments to improve their documentation for legal processes - in addition to the United Nations Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1999) (Istanbul Protocol). *Objective*: With the aim to develop additional instruments for the documentation of various psychological torture methods, this article explains the recommended methodology for such research-based interdisciplinary instruments and the process of developing the first example of this approach relating to sleep deprivation. *Development and pilot-testing of the Sleep Deprivation Protocol*: The pilot-testing of the Protocol by lawyers in the Public Committee Against Torture in Israel (PCATI) has already yielded positive results. *Conclusion*: Further advanced documentation instruments, using medical evidence in non-torture contexts and legal research, should be developed to effectively identify and record other psychological torture methods.

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[1] Søndergaard, E., Skilbeck, R., & Shir, E. (2019). Development of interdisciplinary protocols on medico-legal documentation of torture: Sleep deprivation. Torture Journal, 29(2), 23–27.

Keywords: Psychological torture, accountability, medico-legal documentation, interdisciplinary cooperation between lawyers and health professionals, sleep deprivation

Introduction

Torture and cruel, inhuman or degrading treatment or punishment ("ill-treatment") continue to be practiced widely worldwide, and the use of torture methods that leave no visible marks is on the increase in various contexts and countries (Rejali, 2007). Such methods can and will often lead to psychological long-term effects (Pérez-Sales, 2017). The apparatus of torture, its agents as well as the deleterious impact on the victim are rendered invisible. The difficulty in assessing the consequences, documenting it legally and medically, and adjudicating cases is thus amplified when it comes to psychological torture (Cakal, 2018). Examples of psychological torture methods (used alone or together with other techniques to produce a cumulative effect) include, among others, solitary confinement, sleep deprivation, sensory deprivation, sensory overstimulation, humiliations, and threats. Many of these techniques do not have specific definitions or parameters, and it will be up to lawyers in individual cases to explain how such treatment is unlawful, or how the impact on a particular individual may cross the severity threshold to make it torture.

The forthcoming review of the Istanbul Protocol, which sets out minimum standards for legal and medical investigations of cases of alleged torture, aims to provide guidelines for national authorities to ensure the collection of evidence so that perpetrators can be held accountable for their actions. One of the standards stipulates that both a physical and a psychological assessment of the victim of torture should be undertaken (OHCHR, 2004, Chapter VI). The Istanbul Protocol provides useful guidance for health professionals and lawyers – for example regarding legal standards, interviewing techniques and general knowledge about the consequences of torture. However, the assumption is that attitude and skills with regards to documentation of psychological torture would improve further by additional research and the development of specific questions that take into consideration the complexities of the matter and existing legal and medical research.

Information collected by PCATI shows that the Israeli authorities commonly use complex techniques based on directly attacking the conscious self of victims causing pain without obvious marks (PCATI, 2016 and 2019). The Israeli Security Agency (ISA) apply sophisticated means of torture in interrogations to gain information and confessions from those interrogated, most commonly Palestinians from the West Bank, without leaving obvious evidence of physical torture behind. In practice, psychological torture, as well as the long-term psychological effects of all methods of torture, are often overshadowed by medical-legal evidence of physical torture, which is given prominence by the adjudicating bodies. As in other contexts, the scars inflicted on the mind, sense of identity and personality of the victims are often persistent and more harmful than those inflicted on the body according to PCATI's experience. Data from the past five years indicates that sleep deprivation is used in nearly 70% of PCATI's cases involving Palestinian detainees interrogated by the ISA (PCATI, 2019). Despite the common use of the method, its impact on the victims had not previously been systematically addressed.

Objective

With the aim to develop instruments for the documentation of various psychological torture methods, this article explains our methodology for research-based interdisciplinary instruments and the process of developing the first example of this approach relating to the documentation of sleep deprivation.

Development of the Sleep Deprivation Protocol

A conference held in Copenhagen in November 2015 highlighted the need among lawyers and health professionals for new tools to improve documentation of psychological torture. As a result, in 2016, DIGNITY – Danish Institute Against Torture, REDRESS and PCATI began a joint project perceived as a vehicle to establish a common understanding between health and legal professionals as to the reasons for the use of psychological torture, its impact, and how to improve the interdisciplinary documentation of such acts. The project aims at developing best practices on documentation of psychological torture; establishing evidence in individual court cases; strengthening jurisprudence and caselaw about psychological torture; and influencing policy debates while promoting better acknowledgement of psychological torture among key stakeholders.

Strategically, it was decided to focus on the target group of lawyers and health professionals who are independent of the state and who often meet and interview victims of torture. Better documentation on their behalf, based on research-informed tools, would lead to the collection of evidence that could be used within the judicial system and in local and international advocacy efforts to raise awareness of the severe consequences of psychological torture and of the temptation among national authorities to use such methods to avoid accountability.

DIGNITY, REDRESS and PCATI set up a project group and an international expert group[1] who met in London in 2017 and Copenhagen in 2018 to discuss existing medical and legal knowledge with regard to psychological torture methods and the limitations of and common challenges in its documentation. It was agreed to adopt the following methodology for the development of research-based protocols to document psychological torture methods:

1) Review of existing legal and health knowledge regarding the specific method of torture, both in clinical and non-torture contexts;
2) Drafting of an interdisciplinary research-informed protocol with specific questions;
3) Discussion within the group of international experts;
4) Adjustment of the protocol to a specific local context if required, pilot-testing; and
5) Evaluation.

Each protocol would include specific questions to be asked during an interview with a victim of torture. This approach should address lawyers' requests for more clarity on how to understand the concept of pain and suffering and research-oriented evidence of harms resulting from psychological torture in order to guide the adjudicator when

[1] The group includes the following experts and organisations in addition to the authors of this article: Nora Sveaass, Nimisha Patel, Brock Chisholm, Pau Pérez-Sales, Ahmed Benasr, REDRESS (Alejandra Vicente), Freedom from Torture (Angela Burnett and Emily Rowe), IRCT (Asger Kjærum and James Lin), PCATI (Efrat Bergman-Sapir), and University of Essex (Carla Ferstman).

interpreting the definition of torture in the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the scope of cruel or inhuman and degrading treatment.

The group decided to begin the process with one specific method for in-depth consideration: sleep deprivation, as it is a prevalent method used in interrogation in Israel and elsewhere. The content of the Protocol was developed following the methodology previously mentioned, and bearing in mind that sleep deprivation is often used to obtain information or a confession, albeit unreliable, during an interrogation (Cakal, 2019). The Protocol includes explanations as to the different types of sleep deprivation that are used.

Pilot experience of the Sleep Deprivation Protocol

Step I - Adapting the Protocol. As a first step in the piloting process, PCATI adapted four of the Protocol's sections to the local context – Israel in this case. This was done based on PCATI's on-the-ground experience, bearing in mind the legal framework in Israel, and the reality in which interviews with victims are carried out and affidavits taken. For example, interrogations are often long, commonly lasting between two weeks to a month; interviews with victims are conducted in detention, a few weeks at minimum after the interrogation ended, and in far from ideal settings (e.g. limited time and with a separating glass barrier). The adaptation led to a shorter Protocol that reflects typical interrogation patterns in Israel and enables questions that are more open (professional medical terms were not altered). The four sections were then translated to Hebrew. The translation was reviewed by lawyers who regularly conduct prison visits. It is worthwhile noting that the adaptation and translation process was done in view of creating a practical hands-on legal tool rather than a research protocol.

Step II – Piloting. The Protocol was piloted in seven cases, all involving Palestinians who had been subjected to an ISA interrogation in the previous 12 months. In six of the cases, lawyers visited and interviewed detainees using the Protocol in full. In the seventh case, health professionals – a physician and a psychologist – supplemented an Istanbul Protocol (IP) evaluation with questions from the supplementary Protocol regarding sleep patterns and sequelae. The cases were selected in an effort to reflect existing diversity. Two of the cases were of female detainees who were subjected to psychological torture during interrogation; two cases involved male detainees whose interrogation included mostly psychological torture; and the last two cases involved male detainees subjected to an interrogation that included "enhanced interrogation techniques" (i.e. stress positions and beatings in addition to the psychological torture). All cases included deprivation of sleep, a fact that was known to PCATI beforehand, as the Protocol was piloted only in cases where affidavits had previously been taken and thus rapport established. The six interviews were carried out by female and male lawyers and took place in three different prisons over a period of three months. The IP evaluation was conducted in prison with one of the female detainees who had been interviewed by the lawyers.

Step III – Evaluation. Each interview and the IP evaluation were analyzed by PCATI based on feedback from the lawyers and health professionals involved, and in light of the quality of the information collected. The information in each Protocol was compared to that captured in affidavits previously taken in the same cases. Follow-up visits were conducted with the six interviewees.

Following the pilot, the lawyers reported that the Protocol improved their way of asking questions during the interview, and they felt more comfortable in asking about intimate issues related to sleep and rest such as re-occurring dreams. The structure of the Protocol enabled them to collect new information; the section exploring the so-called "rest time" was particularly revealing as detainees often experienced a fragmented and insufficient resting period. Interestingly, lawyers were surprised that the interviewees, male and female alike, had hardly any hesitation in talking about their sleep patterns and dreams. Health professionals added some of the questions in the Protocol to their IP evaluation. Additionally, the process of adapting and implementing the Protocol enabled staff and external professionals to better conceptualize what sleep deprivation actually "consists of." Following the pilot-phase, PCATI concluded that the Protocol, which should and will be used in Arabic and in Hebrew, has best impact when not used as a stand-alone tool but as an integrated part of the process of taking testimony from a detainee. It is planned that the revised Protocol will be added to the standard interviewing toolkit for lawyers starting in 2020.

Conclusion

DIGNITY, REDRESS and PCATI seek to inform and influence policy debates, and ensure better acknowledgement of psychological methods of torture and ill-treatment. Our study has shown that developing a specific interdisciplinary protocol has improved documentation practices among lawyers working with PCATI. We envisage further pilot-testing of the Sleep Deprivation Protocol in other countries as well as the development of new documentation tools for other methods that build on the Istanbul Protocol, medical and legal knowledge, and field research. We hope that the Protocol(s) will be informed by local practices and used widely in the future.

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Protocol on Medico-Legal Documentation of Sleep Deprivation[2]

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[2]Pérez-Sales, P., Søndergaard, E., Shir, E., Cakal, E., & Brasholt, M. (2019). Protocol on Medico-Legal Documentation of Sleep Deprivation. Torture Journal, 29(2), 28–55.

Abbreviations

UNCAT: UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984)

Istanbul Protocol: UN Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1999)

Preface

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

Historically, sleep deprivation has been used for different objectives but, primarily, to cause stress and duress for the purpose of extracting information and confessions. Detention centers with poor conditions is another context in which sleep deprivation, as a consequence of sleep disruption, takes place. This is often due to overcrowding, insufficient or no mattresses, and poor conditions of transportation between the courts and detention facilities.

The aim of the Protocol is to improve documentation of sleep deprivation used in such settings (most often during interrogation) and therefore to clarify the facts of the case so that stronger legal claims can subsequently be submitted to local and international complaints mechanisms.

The Protocol has been developed based on a methodology involving: compilation and review of legal and health knowledge on sleep deprivation, also in non-torture contexts; drafting by first author; discussion in the group of international experts;[1] pilot-testing by PCATI; and evaluation by the three organizations and the group of experts.

Despite generic elements of sleep deprivation, the context in a specific country will determine many aspects of the factual situation. Each context differs and as such this Protocol could serve as a guideline or a checklist of elements to be considered in a specific context.

We hope that this Protocol will assist in the discussions between the various stakeholders and provide guidance on what can be documented and how to document sleep deprivation.

Definitions

The Protocol refers to the following definitions that have been agreed in the group of experts:

Total sleep deprivation (TSD)*:* Elimination of sleep for a period of time (at least one night) after the person has been awake for an extended period. It is an absolute value (e.g. 43 hours).

Partial sleep deprivation (PSD)/Sleep restriction (SR)*:* Reduction in sleep time below an individual's usual baseline or the amount of sleep needed on a regular basis to maintain optimal performance. It is a relative value (e.g. 4 hours sleep in a person with an

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

average baseline sleeping time of 7 hours, means a PSD of 3 hours).

Sleep disruption (SD)*:* Interruption or fragmentation of sleep, where frequent arousal disrupts the normal dynamics of sleep for the person. Sleep disruption is associated with an increase in awakenings and, typically, a reduction of deep sleep although the total amount of time might seem similar to a normal night's sleep (e.g. 7 hours of sleeping time with interruptions due to hunger, heat or loud noise). It can be deliberate or not.

Minimum duration of necessary sleep*:* There is a small variability in individual needs among adults (from 5 to 8 hours). There is a widely accepted consensus of an average of 7 +/- 1 hours of daily continuous sleep as part of a normal sleep pattern. For an adult (18-65) the minimum duration of necessary sleep is no less than 6 hours and for an older adult (>65), not less than 5 hours. The minimum duration for children (under 18) is higher (Hirshkowitz et al., 2015; Watson, Badr, Belenk, & Bliwise, 2015).

This is a recommendation during normal circumstances and should also be the minimum during detention or interrogation (see Editorial, this issue).[2]

Resting Periods*:* Time without interrogation or any other administrative interruption including transportation.

Legal and Medical Considerations[3]

Legal aspects

The use of sleep deprivation has been recognized in the international human rights framework as a method of torture or cruel, inhuman or degrading treatment or punishment. There is, however, no universally accepted legal definition of what constitutes sleep deprivation or what is sometimes referred to as 'prolonged' sleep deprivation.

The legal assessment needs to be based on the four elements found in the definition of torture in article 1 (1) of the *UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (UNCAT). Accepting the premise that sleep deprivation is primarily used for obtaining information or confession, two elements under the definition emerge to be particularly significant: *intentionality* and *severity* of physical or mental pain or suffering. Notably, Article 3 of the European Convention on Human Rights (ECHR) has also been interpreted to require these two elements. If these elements cannot be identified, the treatment can still amount to other forms of ill-treatment (i.e., cruel, inhuman or degrading treatment or punishment). This is explored below when reviewing their application to sleep deprivation.

Severe pain or suffering, whether physical or mental, is accepted to arise out of an individual method or a combination, whether occurring on one occasion or over time (ICTY, 2002: §182). Therefore, it can be short-lived and need not be

[2] Although some military regulations have proposed lower levels as incidental to normal routines, even a 4-hour daily minimum, medical standards show that less of a 6 hours daily level is unacceptable regardless of human variability. This is more so the case if sleep deprivation is combined with other stressors that produce cognitive and emotional exhaustion or if it lasts for more than one day and there is a cumulative effect.

[3] For a fuller discussion, please refer to Cakal. E. (2019). Befogging reason, undermining will: Understanding sleep deprivation as torture and other ill-treatment in international law. Torture Journal 29(2).

prolonged (CAT, 2006: §13; ICTY, 2006: §300). Mental pain can constitute torture or ill-treatment on its own and need not be coupled with physical pain.

Despite such complexities, the nexus between sleep deprivation and torture has become well-established. The UN Committee against Torture (CAT) has criticized the use of sleep deprivation by a number of states, providing clear indications of outer limits. Most prominently, its observations with respect to the United States focused on the guidelines found in the interrogation rulebook in the US Army Manual that provide: 'Use of separation must not preclude the person getting four hours of continuous sleep every 24 hours' (United States Army, 2006, Appendix M). CAT held that, particularly with the understanding that a person could be subjected to this for a renewable period of 30 days, this amounted to 'authorising sleep deprivation—a form of ill-treatment' (CAT, 2014: §17). Of particular concern was that this rule could be interpreted in such a manner as to allow for 40 continuous hours of interrogation with only four hours of sleep on either end. The US, when questioned by the CAT, rejected that this was the practice. Similarly, CAT has also criticized Israel for using sleep deprivation.[4] Based on the understanding that it is not inherently harmful, CAT did not categorically state that sleep deprivation amounted to torture in all cases, as evidenced by their need to detail the durations concerned.

Methods that undermine will or capacity have, to date, been accepted as having the capacity to amount to torture and, more, often as other forms of ill-treatment. Principle 6 of the UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, for one, requires other ill-treatment to be interpreted to include "the holding of a detained or imprisoned person in conditions which deprive him, temporarily or permanently, of the use of any of his natural senses, such as sight or hearing, or of his awareness of place and the passing of time." Drawing on the range of impairments emanating from the medical literature, it is reasonable to interpret this to capture any form of sensory deprivation, blunting of the senses or temporal disorientation, including the use of sleep deprivation.

This is also echoed in Principle 1 of the *Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas*, which protects individuals from 'forced intervention or coercive treatment, from any method intended to obliterate their personality or to diminish their physical or mental capacities.' Impairment to one's attention, memory, and communication, as stressed by medical literature on harms, directly impinge on capacity, and hence are readily proscribed by these principles.

The link between sleep deprivation and the obliteration or diminishing an individual's personality was further drawn by the case of *Maritza Urrutia v. Guatemala.* The Inter-American Commission requested that the Inter-American Court find a 'violation because of the use of: methods tending to

[4] It found one individual to have been permitted to sleep for about one hour in 24 over the course of 4 days, which constituted torture from a medical point of view. In another case, brought before the High Court of Israel (HCJ 2210/96), the detainee had been kept awake for 39 hours followed by 5 hours' rest, then for 47 hours with 2 hours' rest, and then for 22 hours with 5 hours' rest, 47 hours with 5 hours' rest, 46 hours with 5 hours' rest, and finally 48 hours with 6 hours' rest. The situation had perhaps been urgent, but that unquestionably constituted mental torture. (CAT. (1998). Report. E/CN.4/1998/38, §24); see also CAT/C/ISR/CO/5, para. 30.

obliterate or diminish her personality, such as sleep deprivation' (§78(b)).

The European Court of Human Rights has considered the use of sleep deprivation in interrogation contexts. For instance, in *Mader v. Croatia*, where the applicant was 'deprived of sleep and forced to sit on a chair continuously for two days and nineteen hours' at a police station, the court found that this on its own amounted to inhuman treatment (§108). In *Bati v Turkey*, where the applicants were subjected to sleep deprivation for several days, as well as physical and verbal assault during interrogation, the court accepted that this treatment 'was liable to harm their mental integrity' (§114).

In *Bagel v. Russia*, the applicant, amongst other things, alleged that he had 'insufficient time to sleep on the days of transport'. The court, accepting that the applicant was able to sleep at least from 11pm to 5am each night, ruled that he was not subjected to any sleep deprivation (§70). This precedent was followed more recently in *Sadretdinov v. Russia*, where the applicant complained of the 'authorities' failure to ensure that he enjoyed eight hours' sleep on court hearing days' (§96). Similarly dismissing this limb of his claim, the court stuck to the sufficiency of the six-hour rule in stating that:

> *"The applicant had no less than six hours of sleep per night. Moreover, the authorities took steps to ensure that he had enough sleep during at least three nights per week (when he did not take part in court hearings)."*

In *Strelets v. Russia*, the applicant complained of insufficient sleep on days of court hearings, over several consecutive days, being woken up at 6am and being brought back to the cell after 10pm. Notably, the pronouncement of the national court's judgment started at 8.30pm and finished at 0.30am. Holding it to be inhuman and degrading treatment, the European Court of Human Rights reasoned as follows (§62)

> *"the cumulative effect of malnutrition and inadequate sleep on the days of court hearings must have been of an intensity such as to induce in the applicant physical suffering and mental fatigue. This must have been further aggravated by the fact that the above treatment occurred during the applicant's trial, that is, when he most needed his powers of concentration and mental alertness."*

Continuous Interrogation. Sometimes sleep deprivation is considered incidental to interrogation. There is no guidance regarding the maximum length of interrogation permitted in any international standards.[5] According to studies, an average police interrogation lasts a maximum of two hours exceptionally repeated up to three times with enough time for rest and refreshment among interrogations (Gudjonsson, 2003; Leo, 1996).

[5] The United Nations Body of Principles for the Protection of All Persons under any form of Detention or Imprisonment does not establish strict rules regarding the length of interrogation sessions although it does require recording of the duration of any interrogation and of the intervals between interrogations. The International Commissions of Jurist has included "adequate periods for rest and refreshment", again without more clear guidance. As does the Advisory Council of Jurists of the Asia Pacific Forum of National Human Rights Institutions in their Standards for Interrogation of detainees. The European CPT Standards also suggest that interrogations should not be held for lengthy periods, but does not give a concrete recommendation (Morgan & Evans, 2001). The US Supreme Court ascribes to the "totality-of-the-circumstances" test, that assume that all relevant factors must be assessed, including the application of physical abuse or psychological coercion; the time, length, circumstances, and place of the interrogation; and the age and education of the detainee, along with other considerations.

Given the above discussion, legal assessments of whether sleep deprivation amounts to torture or ill-treatment should be determined on a case-by-case basis.

These legal considerations have guided the questions in this Protocol.

Medical aspects

Time-limited sleep deprivation does not leave any known chronic problems, but in the acute stage—i.e. while the sleep deprivation takes place, and in the hours and days following the incident—both physical, emotional and cognitive consequences may be seen and then disappear again spontaneously. These consequences have been described in several scientific studies (see sources below) undertaken in laboratories where total or partial sleep deprivation has been induced for the sake of the study. Other studies have been undertaken among people who have been deprived of sleep as a result of their work, for example during night shifts. In the following, a brief overview of some of the most important findings from such studies will be given. The study results have inspired the questions in the Protocol.

All acute consequences of sleep deprivation described below have been presented in meta-analyses or in systematic reviews, i.e. in scientific papers presenting cumulative results from several different studies, thereby increasing the validity of the findings.

Perception of pain. Sleep deprived individuals have been shown to have a lower pain threshold and also to score higher when asked about their perception of pain (Schrimpf et al., 2015).

Anxiety, mood changes and psychosis. In some studies, sleep deprived individuals have been shown to have higher levels of anxiety (Pires et al., 2016). They have also been shown to have less inhibition and greater emotional reactions to negative stimuli (Beattie, Kyle, Espie & Biello, 2015). Last but certainly not least, it has been shown that sleep deprived individuals may develop both visual and auditory hallucinations as well as other symptoms related to how the surroundings are perceived. This includes temporal disorientation, i.e. lack of ability to properly assess time. With sleep deprivation lasting for days, symptoms may proceed to frank psychosis and delirium (Waters, Chiu, Atkinson & Blom, 2018), the latter being a life-threatening condition that requires immediate medical attention.

Cognition. Several studies have been undertaken assessing the impact of sleep deprivation on cognitive performance. The studies are heterogeneous and therefore difficult to compare, but overall it can be concluded that studies show a clear negative impact of sleep deprivation in more complex areas of cognition. The effect on simple tasks related to attention (e.g. tests assessing a person's ability to react to a simple visual stimulus on a screen) is even more pronounced, and the effect of sleep deprivation on cognition increases with increasing amounts of sleep deprivation (Lim & Dinges, 2010; Lowe et al., 2017; Philibert, 2005). Interestingly, a person's ability to assess his or her own performance has been shown to be mostly preserved during sleep deprivation (Jackson et al., 2017).

Many studies have also investigated the long-term consequences of chronic sleep deprivation, for example as the result of a chronic sleep disorder like sleep apnea and others. An increased risk of—among others—hypertension and diabetes mellitus has been found in people with chronic

sleeping problems. This, however, is beyond the scope of a protocol on medico-legal documentation of sleep deprivation and will not be dealt with further here.

Summing up, sleep deprivation may lead to acute physical, emotional and cognitive consequences, and when documenting sleep deprivation, all these aspects must be considered. Symptoms of sleep deprivation are diverse and may range from hardly noticeable cognitive impact to life-threatening delirium.

Sleeping problems are commonly found among torture survivors irrespective of whether they have been subjected to sleep deprivation or not. Asking about current sleeping problems should therefore always be part of the clinical assessment of a torture survivor.

PROTOCOL

1. Purpose

This is a generic protocol to guide the part of an interview with an interviewee that relates to documentation of sleep and sleep deprivation. As such, this Protocol complements the Istanbul Protocol when specific documentation on sleep deprivation is required.

It is designed to be used by lawyers and health professionals during interviews in a detention facility or after release. The average time of application in its entirety is estimated at 40 minutes.

Combined or cumulative effects of the general detention and interrogation context and the various methods used are of importance. Ill-treatment and torture are often not based on single individual techniques (which may or may not be damaging if considered one by one) but is the result of the combined interaction of methods. Thus, sleep deprivation is often not a single element but part of a wider context that must be assessed in the interview (see below).

While some information may be collected by both health and legal professionals (i.e., sections 1-5), two sections of the Protocol require specific qualifications (i.e., sections 6 and 7). An organisation may consider whether to train staff so that they can be qualified to ask certain questions outside their usual professional skill-set. However, this approach has its limitations and should always be guided by the principle of doing-no-harm.

The following key aspects of the context should be highlighted:

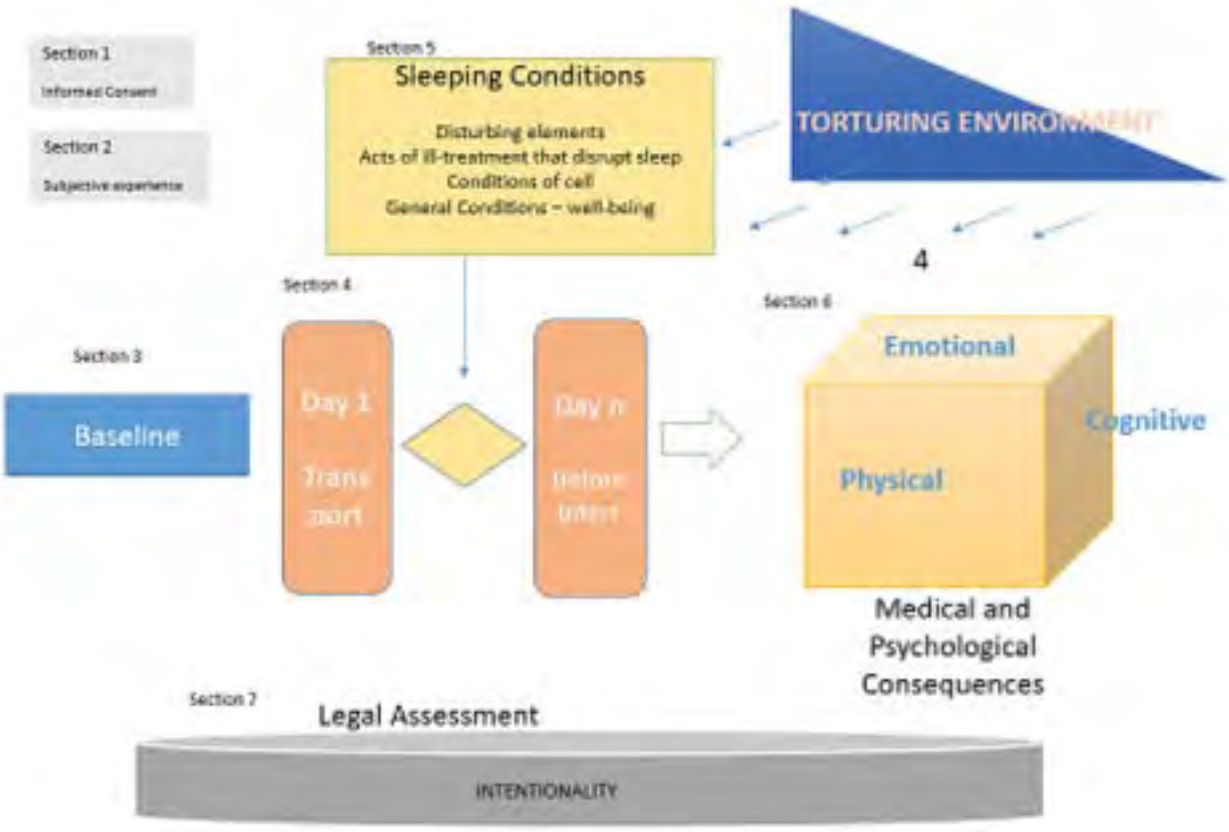
a. **Importance of time**: The Protocol is used to assess the consequences of sleep deprivation after an interval of time following the pertinent event(s). It can be days but more often the interview is undertaken weeks or months after the event(s). At this point, no biological measures or tests would be possible (e.g., Actigraphy, EEG or Evoked potentials).
b. **Torturing environment**: Imposing sleep disruption is usually part of a more overall *torturing environment* that often involves threats, humiliation, deprivation of water/food and/or sensory deprivation (e.g., blindfolded). A *torturing environment* is defined as "a set of conditions or practices that obliterate the control and will of a person and that compromise the self" (Pérez-Sales, 2017)).
c. **Verification of the information obtained during the interview**: The interrogator must record the hour of beginning and ending of interrogation and time allowed for rest. In some countries, the interviewer may have access to the logbook of the interrogation and will be able to compare the information obtained during the interview with the information in the logbook.

d. **Each country has its specific political and local context** and each detaining institution has its specificities regarding methods allowed or prohibited. This should be taken into consideration when applying the Protocol.

2. Overview of the Protocol

You will be taken through seven different sections:

- Informed Consent and General Considerations for Interviews;
- Subjective Experience;
- Baseline: Sleep Pattern before Detention;
- Diary of Sleep: What Happened?
- Sleeping Conditions;
- Medical and Psychological Consequences; and
- Legal Assessment of Sleep Deprivation.



2. Protocol

Section 1. Informed Consent and General Considerations for Interviews

Informed consent involves making sure that when the interviewee consents to an interview (and to the subsequent use of the information that has been provided), the interviewee is fully informed of and has understood the potential benefits and risks of the proposed course of action. Each case must be assessed individually considering the seriousness of the allegation and what the potential risks could be at every step of the process.

The interviewer should obtain informed consent from the interviewee according to the ethical guidelines mentioned in the Istanbul Protocol (see Chapter II).

Key elements of informed consent:

- *Information:* About yourself and the purpose and objectives of the interview.
- *Comprehension:* Assess whether your interviewee has really understood the information. Mental ability, language, age, and other aspects may affect the individual's ability to give informed consent. The higher the risk, the higher the obligation to ensure a proper understanding of potential risks.
- *Voluntariness:* Agreement to be interviewed should be voluntary and no pressure should be exerted or promises made in an effort to gain the information.

Approach:

- Explain to the interviewee the purpose of the interview and how the data will be used in the future and then obtain the interviewee's acceptance of the interview and each of the follow-up steps (verbal or written).
- Explain that the interviewee has the right to withdraw from the interview at any point and how this can be done.
- Tell the interviewee how you plan to follow-up on his/her situation.
- Follow the general considerations for interview as mentioned in the Istanbul Protocol, and explain to the interviewee how the interview will be conducted. Explain that the interviewee will be asked about the sleep pattern and eventual lack of sleep. This should be done without influencing or prompting answers by highlighting the potential consideration of sleep deprivation as ill-treatment or torture.[6]
- Please stress that as in any assessment, it is important to be as accurate as possible.
- The interviewer should also be aware of the risk of re-traumatisation (see the Istanbul Protocol, Chapter IV).

[6] The potential relationship between sleep deprivation and torture can be raised at end of the interview with the purpose of providing meaning to the victim's experience and eventually alleviate guilt or trauma symptoms.

SECTION 2. SUBJECTIVE EXPERIENCE

This section is intended to describe the sleep deprivation in the interviewee's words.
Please collect the answers as verbatim as possible.

Do you think you were sleep deprived? Why?

How do you think that this affected you during detention and/or interrogation?

How do you think that this affected you during detention and/or interrogation?

SECTION 3. BASELINE: SLEEP PATTERN BEFORE DETENTION

This section is intended to assess potential vulnerabilities linked to the interviewee's minimum duration of necessary sleep and circadian rhythm. It is especially relevant if the interviewee was submitted to interrogation during the night or at changing times. Taking the months before detention as reference point, ask the following questions on normal sleep pattern and previous sleep problems before detention.7

1. How many hours on average do you sleep to feel well? _____

2. If you have to do a very difficult task,which hours of the day would be the best for you to get perfectly concentrated?
   (a) Early morning
   (b) Midday
   (c) Afternoon
   (d) Evening
   (e) Late in the night

3. One night you remain awake to do a task between 3-5 AM. How will you feel?
   (a) Perfectly fine
   (b) Sleepy but fine
   (c) A bit slow and confused
   (d) Very slow and confused
   (e) I could not do it

4. One night you are awakened by others to do a task between 3-5 AM. How will you feel?
   (a) Perfectly fine
   (b) Sleepy but fine
   (c) A bit slow and confused
   (d) Very slow and confused
   (e) I could not do it

5. Previous sleep problems. Did any of the following happen to you at least 3 times a week at any time during the months before detention?
   (a) Cannot get to sleep within 30 minutes [Early insomnia]
   (b) Wake up in the middle of the night or too early in the morning and cannot go back to sleep [Maintenance insomnia]
   (c) Have bad dreams [Nightmares and disturbing dreams]
   (d) Have other sleep problems (for instance, bruxism, constant movement of the legs, snoring, snoozing…)

Explain

_____

_____

6. Describe contents if there were already bad dreams before detention:

_____

_____

_____

7 The questions are based on selected items adapted from the Morningness-Eveningness Questionnaire (MEQ) and Pittsburgh Sleep Quality Index (PSQI) (see Annex).

Section 4. Diary of Sleep: What Happened?

This section is intended to provide a quantitative account of sleep deprivation as objectively as possible.

If the person, who has been subjected to the deprivation can remember each day, individualize them and give an accurate account of what happened almost day-by-day then use Option 1. If the person is not able to remember each day separately, then use periods of detention as in Option 2.

If in doubt, use Option 1 whenever possible.

Note that there may be some gaps in the information but try to collect the facts in as detailed a manner as possible.

Option 1: *What happened, day-by-day.*

	How many hours were you interrogated continuously?	**How many hours could you sleep continuously?**	**Were you deliberately or accidentally awoken or kept awake during the resting period?** 1. Never 2. Sometimes 3. Regularly 4. All the time
1st day			
2nd day			
3rd day			
4th day			
5th day			
6th day			
7th day			
8th day			
9th day			
10th day			
Etc.			

Option 2: *Description by periods of time.*

1. How did you keep track of the time?

_____

_____

2. Hours and distribution of sleep:

Time Event [a]	Estimated total duration (hours or days)	How many hours could you sleep continuously? (estimate)	How many hours were you interrogated continuously? (estimate)	Were you interrogated during the night? 1. Never 2. Sometimes 3. Regularly 4. Always	Were you awakened during periods of sleep or rest? 1. Never 2. Sometimes 3. Regularly 4. Always
During Transport		n/a	n/a	n/a	n/a
Before Interrogation(s)[b]			n/a	n/a	n/a
During Interrogation(s)[c]					n/a
After Interrogation[d]			n/a	n/a	

[a] If your case does not involve an interrogation, you need to change these categories and adapt them to your needs. You may prefer to order periods according to locations (for example places of detention), authority in charge, or according to acts of mistreatment (before/after subjected to certain acts). Listen to the interviewee's account and decide which markers would be most appropriate to organize the diary of sleep.)

[b] From arrival until first interrogation.

[c] From the first to the last interrogation.

[d] After the last interrogation.

Maximum Sleep Deprivation

During this period, please note:

- What was the longest time (number of hours) of continuous interrogation throughout the entire period of detention?
- What was the maximum number of hours that you were forced to be awaken? (you can specify more than one time, if there were different very significant situations)

Chronic Sleep Deprivation[8]

- Total number of hours that the person slept during sleep deprivation (when using description day by day): _____
- Average number of hours in which the person is allowed to sleep by day, by the number of days that the person was detained (when using the description by stages during detention): _____

[8] Please note that the absolute number of hours or days (see schema) may not give the full picture or even be misleading when the hours of sleep vary. By way of example, in a detention facility where regulations establish minimum sleep of 6 hours per 24 hours, the detainee may be allowed to sleep 6 hours in the beginning of day X and 6 hours at the end of the following day. Thus, the person will be sleep deprived for a total of 40 out of 48 hours within the two days—without contravening the regulations. This is why the distribution is as relevant as the total number of hours.

Section 5. Sleeping Conditions

The following questions explore conditions that might affect sleeping during the time allocated to it by the authorities. If the person could not sleep during these periods, ask why. Please include all situations without taking into consideration whether this was intentionally done or not.

	YES	Explain
1. Disturbing elements		
General noise or music		
Screaming, shouting or other disruptions coming from other detainees.		
Shouts or other noises produced by staff or interrogators		
Being taken somewhere for exercise, shower, bathroom etc.		
Roll call or cell search		
Other elements		
2. Acts intentionally aimed to disrupt sleep during resting periods		
Water in face/body		
Stress positions		
Use of restraints		
Forced standing or walking		
Other acts causing pain that prevents you from sleeping		
3. Conditions of the cell		
Temperature		
Constant light		
Hygiene, sanitation		
Rats, mice, lice, bedbugs or other insects or animals		
Overcrowding		
Lack of ventilation		
Size of the cell		
Other elements		
4. Person's physical or emotional state impedes sleeping		
Pain		
Anxiety		
Fear		
Rumination		
Shame, humiliation, guilt		
Rage		
Hallucinations		

SECTION 6. MEDICAL AND PSYCHOLOGICAL CONSEQUENCES

This section of the Protocol should be applied by a medical or psychological expert.

Have you ever required medical treatment for insomnia?

☐ YES ☐ NO

If yes, describe:

Have you suffered from previous diseases that affected sleep (especially neurological or endocrinological disorders)?

☐ YES ☐ NO

If yes, describe:

Checklist of cognitive symptoms linked to detention[9]

This checklist assesses the person's cognitive symptoms during detention and interrogation and afterwards.

Column A: While you were sleep restricted, did any of these items occur to you and if yes, how often?

Column B: Did any of these symptoms improved or worsened when all situations of sleep deprivation ended, and you could sleep again (usually after your period of detention)? (only ask for items marked as "Often" or "Always" in column A)

During your time in detention, did the following happen:	A: During sleep deprivation	B: After sleep deprivation
Items	1. Never 2. Sometimes 3. Often 4. All the time	1. Improved 2. Not changed 3. Worsened
1. **Consciousness.** Did you ever lose it?		
If yes: Reasons for losing consciousness: (a) Beatings in head/traumatic brain injury (b) Suffocation/Asphyxia (c) Emotional fainting (anxiety, fear…) (d) Other forms of pain (e) Other		
2. **Orientation**. Were you able to say more or less how much time you had been detained?		
3. **Orientation**. Did you usually know, approximately, the time of the day? (morning, afternoon, evening or night)		
4. **Awareness**. Did you feel sleepy while not being interrogated?		
5. **Awareness**. Did you feel sleepy *most of the day* while not being interrogated?		
6. **Concentration and Memory**. Did you ever notice that you could not remember basic information about yourself (e.g. the name of very close family members or details of your infancy)?		
7. **Concentration and Memory**. Did it happen that you were not able to understand even simple questions from others (detainees, relatives, interrogators or prison staff)?		
8. **Concentration and Memory**. Were you able to recall, immediately after detention, how your cell was (do not use if the person was blindfolded)?		

[9] Items selected and adapted from MOCA and Brief Neuropsychological Assessment questionnaires to a context of detention and sleep deprivation (see Annex).

During your time in detention, did the following happen:	A: During sleep deprivation	B: After sleep deprivation
Items	1. Never 2. Sometimes 3. Often 4. All the time	1. Improved 2. Not changed 3. Worsened
9. **Perception**. Did it happen to you that you perceived your surroundings altered (e.g. walls and/or ceiling as moving or as falling upon you?)		
10. **Perception**. Did you hear voices or see figures *outside your head,* which you later realized were unreal?		
11. **Judgement**. Were you presented with documents (e.g., probes, confession, statement, etc.) that you were not able to understand?		
12. **Judgement**. Were your legal rights explained to you, but you were not able to understand the contents of the conversation?		
13. **Judgement.** Did you experience any situation when you tried to talk but found it difficult to find the right words and you felt blocked?		
14. **Subjective Self-Assessment**. Do you think you were fit for interrogation while in detention?		
15. **Subjective Self-Assessment**. Do you think you were fit to make decisions?		

Please explain or give details of any of the above if necessary (e.g. circumstances, symptoms, subjective experience or whatever can help to understand the item).

Checklist of emotional symptoms linked to detention[10]

This checklist assesses the person's emotions during interrogation and detention and interrogation and afterwards.

Column A: While you were sleep restricted, did any of these items occur to you and if yes, how often?

Column B: Did any of these symptoms improve or worsen when all sleep deprivation ended and you could sleep again? (only ask for items marked "Often" or "Always" in column A)?

During your time in detention, did it happen to you that:	A: During sleep deprivation	B : After sleep deprivation
Items/symptoms	1. Never 2. Sometimes 3. Often 4. All the time	1.Improved 2. Not changed 3. Worsened
Emotions, Feelings and Somatization		
1. **Sadness**		
2. **Anger** (at yourself or others)		
3. **Terror, Fear**.		
4. **Anxiety** including problems breathing, or panic attacks		
5. **Pain** without apparent reason (i.e. stomachache, headaches or others)		
Acting emotions		
6. **Self-Harm**. Urge to act against himself/herself (e.g., cutting or hitting)		
7. **Suicide ideas**. Thoughts about taking your own life		
8. **Suicide plans or actions.** You had a defined plan or even tried to kill yourself		
9. **Apathy**. Abandonment due to complete hopelessness		
Secondary Emotions – Emotions related to others		
10. **Shame**. Intense humiliation or debasement		
11. **Guilt**. Self-accusation. Intense remorse		
Detaching emotions		
12. **Dissociation**. Feeling everything unreal or dazed, like if everything did not really happen to you.		
Positive Emotions		
13. **Control**. Calm, feeling in charge.		
14. **Happiness**. Moments of joy despite everything		

[10] Items selected and adapted from the Positive and Negative Affect Schedule (PANAS) and Profile of Mood States (POMS) to a context of detention and sleep deprivation.

Severity of pain and suffering.[11]

A person under sleep deprivation may feel pain and suffering due to it. The level of pain and suffering is relevant in the legal world and needs to be assessed. Pain is the unpleasant sensory experience associated with sleep deprivation. Your body is in pain. It relates to how you feel it. Suffering is the unpleasant subjective experience associated with sleep deprivation. You suffer because of your pain. It relates to how you life it.

Please, according to what happened during your worst moment of sleep deprivation mark a cross in each line as appropriate

PAIN	SUFFERING	TIREDNESS	SLEEPINESS
Can you rate the pain experienced due to not being allowed to sleep?	Can you rate the suffering experienced due to not being allowed to sleep?	Can you rate tiredness experienced due to Sleep Deprivation?	Can you rate sleepiness during interrogation?
100 – Worst imaginable pain	100 – Worst imaginable suffering	100 – Cognitive and Emotionally Exhausted	100 – Worst imaginable sleepiness
100			
90			
80			
70			
60			
50			
40			
30			
20			
10			
00			
0 – No pain	0 – No suffering	0 – No tiredness	0 – No feelings of sleepiness

[11] Measures based on the Visual Analog Scale for Pain (See for a review Hawker, Mian, Kendzerska, & French, 2011).

Long term symptoms

This section reflects general and specific symptoms.

General symptoms. The Protocol is part of an overall assessment that will normally include an Istanbul Protocol, where there is a comprehensive assessment of medical and psychological consequences of torture.

As far as sleep deprivation is part of an overall system of torture, where cumulative and combined effects are seen, it is difficult to attribute specific long term problems to sleep deprivation.

If possible:

(a) Tailor the clinical interview to symptoms that the person attributes to long term medical and psychological consequences of sleep deprivation.
(b) Use clinical scales detailed in Annex including in the instructions that the person considers the answers *in relation to sleep deprivation.* For instance, if the PCLC-V is used to assess symptoms of post-traumatic stress disorder, explain the person that each item (flashbacks, avoidance behaviours, intruding thoughts…) should be in relation to sleep deprivation (i.e., flashbacks on how was sleep deprivation, avoidance of sleeping time, recurrent thoughts regarding nightmares or not being able to sleep etc.).

Update questionnaires to the most recent and reliable version available at the moment of doing the assessment.

ICD Diagnosis:

Additional Diagnosis:

Specific Symptoms. Use the World Health Organization's criteria (ICD) for sleep related disorders in force at the time of assessment. Consider here only those sleep disorders in which *emotional or physical causes during detention are considered to be a primary factor*, and which are not due to other identifiable physical or psychological disorders that appeared after detention. Consider, at least:

1	**Insomnia.** A condition of unsatisfactory quantity and/or quality of sleep, which persists for a considerable period of time, including difficulty falling asleep, difficulty staying asleep, or early final awakening.	[0] No insomnia [1] More than 1 hour for falling asleep [2] Difficulty staying asleep [3] More than two hours early wakening [4] Difficulties in all areas
2	**Hypersomnia.** Hypersomnia is defined as a condition of either excessive daytime sleepiness or sleep attacks not secondary to insomnia.	[0] No [1] Sometimes [2] Always
3	**Inversion of circadian/sleep rhythm**. The person sleeps during day and is awoken during nights.	[0] No [1] Sometimes [2] Always
4	**Sleepwalking [somnambulism].** The individual gets out of bed, usually during the first third of nocturnal sleep, and walks about, exhibiting low levels of awareness, reactivity, and motor skill. Upon awakening, there is usually no recollection of the event.	[0] No [1] Sometimes [2] Always
5	**Sleep terrors [night terrors].** Nocturnal episodes of extreme terror and panic associated with intense vocalization, motility, and high levels of autonomic discharge. The individual sits up or gets up, usually during the first third of nocturnal sleep, with a panicky scream. Quite often he or she rushes to the door as if trying to escape, although very seldom leaves the room. Recall of the event, if any, is very limited.	[0] No [1] Sometimes [2] Always
6	**Nightmares**. Dream experiences loaded with anxiety or fear. There is very detailed recall of the dream content. The dream experience is very vivid and usually includes themes involving threats to survival, security, or self-esteem. Quite often there is a recurrence of the same or similar frightening nightmare themes. During a typical episode there is a degree of autonomic discharge but no appreciable vocalization or body motility. Upon awakening the individual rapidly becomes alert.	[0] No [1] Sometimes [2] Always
7	**REM Sleep Behavior Disorder** . The person physically acts out vivid, often unpleasant dreams with vocal sounds and sudden, often violent arm and leg movements during REM sleep. It is sometimes called dream-enacting behavior. Differential diagnosis with Sleep Terrors requiere Actigraphy or Polysomnographic Tests.	[0] No [1] Sometimes [2] Always

Section 7. Legal Assessment of Sleep Deprivation

The legal qualification of sleep deprivation (torture per Article 1 of the CAT, or CIDT per Article 16 of the UNCAT or below the threshold of Article 16 of the UNCAT) would depend upon the specific circumstances of the case, including whether other forms of ill-treatment occurred or not. Try to seek information that may be useful for the legal assessment of the case. The below questions relate to two key elements to be analyzed to distinguish torture and CIDT in the legal domain: (1) Purpose and Outcome and (2) Intentionality

Purpose and outcome

These questions are essential if you are going to do research. In case that sleep deprivation was linked to interrogation, these are the main variables that you will use to compare and relate to all the other measures. They are less useful if you are collecting information for medical documentation of cases.

Purpose of Sleep Deprivation[1]		
1. Was sleep deprivation related to obtaining information?	Yes	No
2. Was sleep deprivation related to obtaining a confession?	Yes	No
3. Did you sign a confession (whether true or not)?	Yes	No
4. Did you have fabricated memories? "Fabricated memories" are statements that the person recognized as true while they were not, and the person honestly thought at that moment that they were true. It is an *induced answer* prompted under disorientation/confusion by suggestions made by the interrogator. The person rejects them when recovers control.	Yes	No
5. Did you have false memories? "False memories" are elements that the person believes as true while they are not, produced by the pressure of the situation. The person doubts if they are real memories or not even after recovering control.	Yes	No
6. Did you have false memory after interrogation? Some persons can have false memories months or even years after the events. The person cannot distinguish new and false memories.	Yes	No
7. Do you think that sleep deprivation was related to any other purpose? Can you explain or provide examples: (punishment, humiliation, submission etc.)	Yes	No

[1] Questions that may help to answer the scale: *Can I ask you whether there was confession? We do not need to enter details, unless you specifically wish to do so; Did you provide any information against your will? Did you sign a statement or confession? – We do not need to know if the contents were true, partially true or untrue; Did you ever during the interrogation recover in memory anything that were not able to remember before interrogation? Were these memories kept in time or new memories appeared that did not exist before the interrogation?*

ASSESSMENT OF THE INTENTION BEHIND THE USE OF SLEEP DEPRIVATION[12]

These questions aim to document the intention of using sleep deprivation and as such, the use of sleep deprivation was not incidental or simply a regular aspect of the normal interrogation or detention conditions.

1. ***Purpose made explicit.*** During the interrogation, the interrogator mentioned sleep manipulation/deprivation (either positive ("let him sleep"), or negative ("you will continue until…")).
a. No b. Yes. Explain:

2. ***Purpose made explicit.*** You heard that someone gave orders related to your sleep.
a. No b. Yes. Explain:

3. ***Pattern***. Night interrogations.
a. No b. Yes. Explain:

4. ***Context criterion.*** Physical environment impeded sleeping.[13]
a. No b. Yes. Explain:

5. ***Context criterion***. Actions that impeded sleeping (e.g., shouting/opening the door. without any other reason).
a. No b. Yes. Explain:

12 Items selected and adapted from the Intentionality Assessment Checklist (IAC)(Pérez-Sales, 2017)

13 If you know the answer from previous questions, no need to repeat the question.

6. ***Aim/Objective.*** Any change occurred after signing a confession or statement.
a. No b. Yes. Explain:

7. ***Fragmentation.*** Person is allowed rest time in cell in a fragmented and insufficient manner (in various times ofday and for short and variable periods of time)
a. No b. Yes. Explain:

8. ***Prolongation.*** Sleep deprivation is maintained after the person's explicitcomplaint of need to sleep.
a. No b. Yes. Explain:

9. ***Viciousness criteria.*** Reiteration in spite that the person falls asleep during interrogation (awakening manoeuvres).
a. No b. Yes. Explain:

10. ***Systematicity - Planification***. Other persons explained a similar pattern (Do you know of other persons who experienced similar problems with sleep?).
a. No b. Yes. Explain:

11. ***Prolongation***: More than 24 hours without being allowed to sleep.
a. No b. Yes. Explain:

Annex—Additional Questionnaires

The Protocol can be complemented with the following assessment tools.

Torturing Environment	
Torturing Environment Scale	Measures profiles of torturing environments in 8 dimensions: Manipulation of environment, fear/threats, moderate pain, critical pain-amputation-death, sexual identity, need to belong- collective self, identity, meaning, purpose and coercive interrogation. References: Pérez-Sales P (2017). *Psychological torture. Definition, Evaluation and Measurement.* Routledge. Chapter 18 and Annex 5.
Interrogation Practices	
The Scale for Coercive Interrogation	The scale for coercive interrogation has 36 items and includes 9 dimensions: rapport-building, cognitive interviewing, threats, confrontation-imposition, deception, emotional manipulation, cognitive manipulation, moral manipulation and physical coercion.
Clinical measures	
Posttraumatic Stress Disorder	The Posttraumatic Checklist Civilian Version – 5 (PCL-C-5), a 20-item questionnaire that provides a diagnosis of PTSD according to DSM-V Criteria.[1] There are also short screening versions available, like the BSS for PTSD.[2] The International Trauma Questionnaire is a 12-item measure that provides diagnoses of PTSD and Complex PTSD according to ICD-1. The Dissociative Experiences Scale (DES-II) provides a measure of states of dissociation. Can be tailored to reaction within detention periods.
Daily Functioning	Consider measures that assess the autonomy of the person after release from detention (e.g., work, study, community and family life).

1 https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

2 Brief Screening Scale for PTSD.

The following tools are referenced in the Sleep Deprivation Protocol

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Protocol on medico-legal documentation of solitary confinement[3]

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Key points of interest

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

Abstract

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

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

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

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

Introduction

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

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

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

Within a criminal justice system, solitary confinement is applied in places of detention from the moment of police arrest and later during pre-trial stages and criminal investigation and/or during imprisonment. Some countries use solitary confinement towards prisoners who await sentencing and the execution of a death sentence. Solitary confinement is also used during administrative immigration detention, typically for the same reasons as within the criminal justice system, and in care institutions such as psychiatric hospitals, juvenile and child protection centres[1]. These latter institutions fall outside the scope of this Protocol, but its recommendations may still be of value when documenting and assessing solitary confinement used in those contexts.

Methodology

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

1 Although both the Convention on the Rights of the Child and the United Nations Rules for the Protection of Juveniles Deprived of their Liberty state that solitary confinement is strictly forbidden, it is used in many jurisdictions as a sanction for misbehaviours or allegedly as part of behaviour modification programs. Quite often solitary confinement is camouflaged in "stay-in-room" and other similar measures of isolation. In those cases where the local legislation allows it, further elements should be considered and explored related to (a) specific health effects on children (b) developmental and neurodevelopmental consequences (c) negative consequences in attachment (d) negative consequences of the use of reward/punishment methods as allegedly pedagogical methods. (Gagnon et al., 2022; McCall-smith, 2022; Royal College of Paediatrics and Child Health (RCPCH);Royal College of Psychiatrists;British Medical Association (BMA), 2018; UN General Assembly, 1990)

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

Conceptual, legal and medical/ psychological considerations

(1) Conceptual aspects

The Protocol refers to the following concepts and definitions:

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

- ***Confinement:*** The prisoner is typically placed in a confined space (most often a cell) for solitary confinement. This could be for example in a special wing of the detention facility or in their everyday cell. The conditions of this cell vary greatly from one country to another and even from one detention facility to another, for example in terms of size, ventilation, lighting, furniture, etc. (see the Protocol, section 3). The regime around solitary confinement also varies, for example in terms of access to outdoor space etc.
- ***Duration*:** It refers to the total time from the beginning to the end of the confinement and it will be measured in hours, days up to weeks, months and even years in the worst cases. Depending upon the form of solitary confinement there might be a fixed duration of the isolation whereas in other regimes it may be indefinite or open-ended. Note that duration also relates to multiple consecutive or near-consecutive stays in solitary confinement (see the Protocol, section 3).
- ***Without meaningful human contact:*** Despite its centrality to the international definition of solitary confinement, there is limited guidance in international human rights instruments. The Istanbul Statement on Solitary Confinement and the Essex Expert Group defined it as "the amount and quality of social interaction and psychological stimulation which human beings require for their mental health and well-being" (Istanbul Statement, 2007; Essex Paper 3, 2017).[4]
- **The term "solitary confinement".** National prison legislation may specifically refer to "solitary confinement", but such measures may also be referred to under other names such as 'isolation', 'segregation', 'ex-

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

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

clusion', 'separation', and 'cellular'. This Protocol uses the two terms "solitary confinement" or "isolation" interchangeably.

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

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

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

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

1. *Prisoners with physical or mental disabilities*
2. *Children:* defined as a person under the age of 18.
3. *Women who are pregnant, with infants or breastfeeding*[5]*:* This refers to women prisoners who are pregnant or who have recently given birth and who are now the main caregiver for their young child (breastfeeding or not).

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

(2) Legal norms

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

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

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

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

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

The Mandela Rules provide for prohibitions of solitary confinement in cases of indefinite solitary confinement, i.e., without an end date (Rule 43), prolonged periods (Rule 43) and when used towards specifically children, pregnant women or women with infants or breastfeeding and prisoners with mental or physical disabilities 'when their conditions would be exacerbated by such measures' (Rule 45(2)).[8] The last prohibition, which reflects principles stipulated in the United Nations Convention on the Rights of Persons with Disabilities and in the European Prison Rules (Rule 60.6.b), requires prison staff to consider whether prisoners suffer from any disabilities and if so, whether their conditions would be worsened by isolation. Regarding children, there are specific international regulations that forbid the use of solitary confinement in juveniles (McCall-smith, 2022; UN General Assembly, 1990), with also recommendations by medical and psychiatric international bodies (Gagnon et al., 2022; Royal College of Paediatrics and Child Health (RCPCH);Royal College of Psychiatrists;British Medical Association (BMA), 2018).

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

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

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

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

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

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

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

The European Court of Human Rights (ECtHR) has stated that solitary confinement can ultimately destroy the personality of the detainee and his/her social abilities (Ramirez Sanchez v. France) and that "solitary confinement without appropriate mental and physical stimulation is likely, in the long-term, to have damaging effects, resulting in deterioration of mental faculties and social abilities" (A.B. v. Russia). The ECtHR has ruled on the excessive use of solitary confinement in numerous cases.[10] The ECtHR has referred to the principle of proportionality in cases when assessing solitary confinement used as disciplinary punishment. By way of example, in *Ramishvili and Kokhreidze v. Georgia,* the applicant who had been sentenced to four years in prison, was placed in solitary confinement as a disciplinary punishment for using a mobile telephone. The court first observed that, amongst the available disciplinary sanctions, the administration chose the most severe one – confinement in a punishment cell. No consideration was given to such facts as, for example, the nature of the applicant's wrongdoing and the fact that it was his first such breach. The court found this to be CIDTP with reference to the conditions of the punishment cell (insufficient cell space (5.65 sq. m for two prisoners)); no outdoor exercise; no privacy; shared bed; and inadequate sanitary conditions.[11]

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

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

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

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

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

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

The African Commission on Human and Peoples' Rights (ACHPR) has too had occasion to consider solitary confinement. On one occasion, three political prisoners were held in 'almost complete solitary confinement, given extremely poor food, inadequate medical care, shackled for long periods of time within their cells and prevented from seeing each other for years' and it was held that the breadth of this treatment constituted, amongst other things, violations of article 5.[16] In another, the ACHPR found a violation in a case involving a journalist who was detained for 147 days, physically restrained and kept in solitary confinement for some periods.[17] It is difficult to discern the legitimate bounds of solitary confinement from the Commission's conflated reasoning in these cases.

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

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

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

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

15 Loayza-Tamayo v. Peru, Series C, No. 33, judgement of 17 September 1997, p. 58; Miguel Castro-Castro Prison v. Peru, Series C, No. 160, judgement of 25 November 2006; Cantoral-Benavides v. Peru, Series C, No. 69, judgement of18 August 2000, p. 62 and 104.

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

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

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

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

20 See British Columbia Civil Liberties Association

Inter-American jurisprudence also require that solitary confinement be used exceptionally[21] and, even then, proportionately.[22]

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

Solitary confinement should take place in cells that meet the minimum conditions according to the international standards, e.g., the Mandela Rules. There are further requirements related to solitary confinement imposed as a disciplinary measure, e.g., regarding the right to complain and judicial review (Rules 36 – 53 Mandela Rules).

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

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

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

21 Inter-American Commission on Human Rights, Resolution 1/08, *Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas*, 13 March 2008: 'Solitary confinement shall only be permitted as a disposition of last resort and for a strictly limited time, when it is evident that it is necessary to ensure legitimate interests relating to the institution's internal security, and to protect fundamental rights, such as the right to life and integrity of persons deprived of liberty or the personnel.'

22 Case of Montero-Aranguren et al. (Detention Center of Catia) v. Venezuela, Series C No. 150, Judgement of 5 July 2006.

23 The IACtHR views independent and autonomous monitoring as to the suitability of an individual to solitary confinement as essential (IACHR, Report on the Human Rights of Persons Deprived of Liberty in the Americas, OEA/Ser.L/V/II. Doc. 64, 31 December 2011, p. 417 and 418.

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

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

(3) Medical/psychological aspects

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

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

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

Consequences of isolation

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

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

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

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

formance and more restlessness. Some developed hallucinations, anxiety and even panic (Heron, 1957; Leiderman et al., 1958).
Learning may also be drawn from emergent fields of neuro-research that have linked loneliness with among others poorer cognitive performance, faster cognitive decline and depressive cognition (as an example, see Cacioppo & Hawkley, 2009). The need for sensory stimulation for human functioning is well documented also in other types of studies. In one randomised clinical trial a group of prisoners was allocated to solitary confinement for seven days and another group to normal treatment. The former group had decreased electroencephalogram activity and visual evoked potentials latency (impacts to electrical activity in the brain and visual pathways), both indicators of neurological dysfunction. Similar findings are seen in sensory deprivation (O'Mara, 2015). Recent neuropsychological studies further indicate that extended solitary confinement can cause brain damage (Akil, 2019), even irreversible ones (Coppola, 2019, Kupers, 2017).

Psychological reactions: Frequently observed psychological reactions in prison studies, even after shorter periods of solitary confinement, are anxiety, fear, feeling low, depression, and concentration problems (Stang et al., 2003). In one study, as many as 91% were found to suffer from anxiety and nervousness, and 70% described themselves "on the verge of an emotional breakdown" (Haney, 2003). Furthermore, 77% were in a state of chronic depression and two-thirds were suffering from more than one symptom at the same time (Haney, 2003; Smith, 2006). Higher levels of aggression and anger, hostility and withdrawal from other people during and after long-term solitary confinement, have also been described (Jackson, 1983; Miller, 1997). Many report feelings of estrangement from self and others, and experiences of confusion (Perez-Sales, 2017; Sveaass, 2009).

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

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

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

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

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

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

Factors impacting the effect of solitary confinement

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

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

II. Protocol

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

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

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

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

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

The Protocol contains six sections:

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

Section 1. Informed consent

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

Section 2. Subjective experience

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

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

- Why do you think you were held in solitary confinement?

- *What do you remember from the period you spent in solitary confinement?* Include additional questions about what the person saw, heard, felt, smelled, or thoughts he/she had.

- *How do you think the solitary confinement affected you when it happened and immediately afterwards?*

- If some time has passed since the person was released from solitary confinement: *Does it still affect you today? If yes, can you explain how?*

Section 3. Circumstances and conditions of solitary confinement

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

a. The events leading up to the solitary confinement

- *How were you moved into solitary confinement?*

- *What was the process leading up to the solitary confinement?* (e.g., if solitary confinement was a disciplinary sanction)

- *What information were you given and when?* (e.g., about the reason for solitary confinement, expected duration, regime, complaint options, reviews and medical visits)

- *Do you have any pre-existing health conditions that might affect you during solitary confinement, and if so, were the detaining authorities aware of those, and did they take them into account? (e.g., claustrophobia, anxiety, depression)*

b. Duration

- *How many days/weeks/months/years have you been in solitary confinement in total?*

- *Was this one consecutive period, did you have any breaks from the solitary confinement during this time, or did you have multiple stays in solitary confinement? (i.e., a description of length of different stays and breaks)*

c. Contact with others during solitary confinement

- *Who were you in contact with during your time in solitary confinement?*
- *How often were you in contact with these people, and for how long?*
- *What was the purpose of this contact? (e.g., bringing person to the bathroom, serving food, check-in by staff, visits from outside)*
- *How were you in contact with these people? (e.g., by phone, through door, visit in the cell, access to others outside of cell)*
- *What was the purpose of the different types of contact you had?*
- *Did you get a chance to speak with them, were they silent all the time, or were you expected to keep silent?*

d. Conditions under which the solitary confinement took place

Try to collect as much information as possible about the room in which the solitary confinement took place and about the general conditions during solitary confinement. This may include:

- *Size and condition of the room*

- *Type and condition of bed and other furniture*

- *Access to outdoor air and light in the room (presence and size of windows, doors, ventilation openings)*

- *Artificial light and switches*

- *Temperature, dampness and air quality*

- *Sounds – noise – silence, incl. changes during the day*

- *Level of cleanliness including presence of dirt, mould, insects or other animals*

- *Access to clothes, footwear, covers/blankets*

- *Access to food, water, and toilet facilities (how often, time between, on demand?)*

- *Access to warning button/alarm or other means to notify staff in case of need*

- *Use of restraints (when, which types)*

- *Access to reading materials, radio, TV, or other activities in the room*

- *Access to work, open air exercise or other activities outside of the room (what, how often, for how long?)*

e. Contact with health professionals during solitary confinement

- *Did you receive unsolicited visits by a health professional during solitary confinement?* ☐ YES ☐ NO

- *If yes, how often did these visits happen? How long did the visits take, and what did the health professional do? Were you able to speak to the health professional in private?*

- *Did you yourself request to see a doctor or other health professional during the solitary confinement, and was your request granted?*

f. Access to legal safeguards during solitary confinement

- *Were you able to file a complaint about being placed in solitary confinement or the conditions of the confinement?* ☐ YES ☐ NO

- *Did you have access to free legal aid or to see a lawyer?* ☐ YES ☐ NO

- *Did regular reviews of the decision to place you in solitary confinement take place, and did you get a chance to be heard during these reviews? How often did these reviews happen?*

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

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

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

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

Please collect the answers as verbatim as possible.

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

Section 5. Assessing physical and psychological consequences

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

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

- *Did you experience any physical symptoms while being in solitary confinement (e.g., pain, sleeping problems, nausea, dizziness, bodily tension)?* Please describe in detail.

- *Did you experience any mental health problems while being in solitary confinement?* Please describe in detail.

- *Have you ever required medical or psychological treatment for these problems?*

- *Do you currently experience any mental health or social problems that you attribute to having been in solitary confinement?*

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

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

Table 1. Checklist of cognitive symptoms:

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

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

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

2: Checklist of emotional symptoms:

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

Questions related to the person's interactions with others:

- *After having been in solitary confinement, have you experienced any changes in your desire to be with others?* (e.g., wanting more or less contact, withdrawing from others or avoiding others altogether)

- *Do you experience any problems when being with others?* (e.g., concentration problems, lack of trust, disturbing thoughts, disturbing emotions (e.g., anger or disappointment), or psycho-somatic reactions (e.g., sweating, dry mouth, shaking, or dizziness))

- *Do you feel that being with others can help you?*

- *Is there a difference in your reactions depending on who you are with?* (e.g., family, friends, colleagues)

- *Do you feel that your reactions to being with others make things difficult for you?* (e.g., influences how the person fulfils his/her role in the family or the ability to work or study)

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

Table 2. Checklist of emotional symptoms.

	Did any of these emotions occur while in solitary confinement, and how often?	What was the situation after solitary confinement?
	1. Never 2. Sometimes 3. Often 4. All the time	1. Not applicable 2. Improved 3. Unchanged 4. Worsened
Emotions, Feelings and Somatisation		
1. Sadness		
2. Anger (at yourself or others)		
3. Terror, Fear		
4. Anxiety including problems breathing, or panic attacks		
5. Pain without apparent reason (e.g., stomach-ache, headaches or other reactions)		
7. Suicide ideation. Thoughts about taking your own life		
8. Suicide plans or actions. You had a defined plan or even tried to kill yourself		
9. Apathy. Feeling abandoned and without hope		
Secondary Emotions – Emotions related to others		
10. Shame. Intense humiliation or degradation		
11. Guilt. Self-accusation or intense remorse		
Detaching emotions		
12. Dissociation. Feeling that everything was unreal. Dazed, as if everything did not really happen to you.		
Positive Emotions		
13. Control. Calm, feeling in charge		
14. Happiness. Moments of joy despite everything		

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

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

Section 6. Legal assessment of solitary confinement
This section of the Protocol should be used by a legal professional. Try during the interview to seek the below mentioned information that will be useful for the legal assessment of the case.

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

- What type of solitary confinement was imposed in the specific case and why?

- Did the person belong to one of the vulnerable groups who should not be subjected to solitary confinement according to the Mandela Rules?

- Did the measure violate other principles of the Mandela Rules?

- E.g., was the measure in violation of an absolute prohibition?

- Did the measure amount to torture or ill-treatment (Articles 1 or 16 UNCAT)?

- Did solitary confinement violate other human rights norms? This legal assessment would relate to, *inter alia*, freedom from non-discrimination i.e., whether the instance was imposed discriminatorily.

Annex 1. Solitary Confinement. Quick Interviewing Guide.

Quick interviewing guide.

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

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

2. **Circumstances and conditions.**

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

3. **Health and functioning prior to detention and solitary confinement.** This section serves to:
   - Identify pre-existing health-conditions that indicate particular vulnerabilities
   - compare health status pre and post solitary confinement
   - determine whether the plaintiff has the burden of proof

   Collect information about:

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

4. **Physical and psychological consequences of solitary confinement.**

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

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

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

Annex 2. Additional questionnaires

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

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

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

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

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

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

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

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

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

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

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

The Mini-International Neuropsychiatric Interview. (M.I.N.I.) is a short structured diagnostic interview, developed jointly by psychiatrists and clinicians in the United States and Europe, for DSM-IV and ICD-10 psychiatric disorders. (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10
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Protocol on medico-legal documentation of threats[4]

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Key points of interest

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

Abstract

Introduction. The use of threats remains prevalent in law enforcement practices in many parts of the world. In studies with torture survivors, credible and immediate threats have been considered a distinctly harmful method of torture. Notwithstanding this prevalence, there is a considerable degree of difficulty in legally substantiating and establishing harms produced by threatening acts. It is also generally difficult to clearly identify the harms that go beyond the fear and stress inherent (therefore not unlawful) in law enforcement practices. We present a Protocol on Medico-Legal Documentation of Threats. The aim of the Protocol is to improve documentation and assessment of harms so that stronger legal claims can be submitted to local and international complaints mechanisms.

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

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

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Keywords: threats, psychological torture, documentation, Istanbul Protocol

Introduction

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

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

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

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

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

Methodology

The Protocol has been developed based on an interdisciplinary methodology developed by DIGNITY - Danish Institute against Torture, Public Committee Against Torture in Israel (PCATI) and REDRESS involving the following steps: compilation and review of health and legal knowledge on threats; initial drafting by the lead author; discussion among the members of the International Expert Group on Psychological Torture[1], and pilot-testing (cf. Søndergaard et al. 2019). This follows the same methodology as the protocols on sleep deprivation (Pérez-Sales et al. 2019) and solitary confinement (this issue) produced by the same authors.

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

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

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

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

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

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

The results of the pilot phase showed that: 1) using the same tool for documentation of threats created a common understanding of the matter among the lawyer and the psychologist that also facilitated better collaboration about the specific case; 2) there was a general recognition that the police practice of using threats should not be perceived as a normal procedure; 3) for the lawyer, using the Protocol created a more solid case and facilitated collecting evidence that would not have been considered otherwise; and 4) from the alleged victim's perspective, participation in the interview made the person understand that threats might violate his/her rights and should not be perceived as a "private matter" to be managed with by the person alone.

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

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

I. Conceptual and Legal and Medical/Psychological Considerations

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

(1) Conceptual aspects

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

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

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

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

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

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

2. **Purpose***:* Threats as communication messages pursue a purpose. There are two broad categories of purposes that should be taken into account here:

a. **Threats linked to compliance.** The threatening person focuses on their demands, and the person threatened focuses on the costs of compliance or non-compliance of the demands (e.g., giving information). An essential element here is the differential way that the sender of the threatening message as contrasted with their receiver perceive the threat.
b. **Punitive or discriminatory threats.** The main aim of threats is to produce mental suffering through creating aversive cognitive and emotional states to produce short and/or long-term damage. Thus, the threats are unconditional to being compliant or not, and the purpose is to infringe mental pain in the person to whom the threats are made.

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

Psychological elements

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

will deal with your case from now on").

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

Contextual elements:

a. Historical or political context, including the evidence or the perception by the alleged victim that threats are being regularly used as a method of social control, punishment or discrimination in the place where the person is held.

b. Context of impunity, particularly in relation to the political costs of making the threats real and the perception of permissibility and impunity among political, military, or judiciary authorities. Moreover, the likelihood that the ill-treatment is authorised and protected by the chain of command.

c. Lack of legal safeguards, including access to a lawyer during the process of detention. This is linked, among other elements, to the perception of an absence of the possibility of outside help or to have access to any legally regulated protective measures (i.e. Habeas Corpus).

d. Conditions and place of detention: Being held in a clandestine place of detention or being under detention for an indefinite time, apparently giving the detaining body full control over the threatened person.

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

(2) Legal Norms

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

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

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

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

a. Severe pain: The assessment of the

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

b. Intention: The threat(s) need to be intentionally (i.e., deliberately) or (at least) recklessly made to create a threatening situation against the individual, either directly (explicit threats) or indirectly.

c. Purpose: Consider if a specific purpose can be identified, such as to coerce confessions, intimidation, punishment, or discrimination.

d. Official capacity: Some level of official involvement is required. Threats are often made by individuals with official capacity whose liability could be linked to the forms of liability mentioned in the definition of torture (article 1 UNCAT)[2],". Threats can also be made by fellow detainees or inmates, however, these will not satisfy the "official capacity" requirement unless the authorities knew or should have known about the situation and did not act adequately to remedy the situation and thus fall within liability of acquiescence, as stated in the definition of torture.

For the purpose of qualifying threats as other forms of ill-treatment, some level of official involvement is required. However, if one of the other three elements in the definition of torture is missing (i.e., severe suffering, intention or purpose), the act could still amount to other forms of ill-treatment if above the threshold. By way of example, an act causing severe mental suffering but missing either *intention* or *purpose* would likely amount to cruel or inhuman treatment. Threats with official involvement infringing on human dignity (e.g., humiliation) but missing severe suffering would likely amount to degrading treatment.

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

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

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

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

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

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

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

(3) Medical/psychological considerations

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

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

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

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

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

When documenting and assessing threats as torture, it is important to be aware of the following[3]:

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

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

II. Protocol

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

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

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

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

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

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

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

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

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

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

The Protocol consists of the following six sections:

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

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

Section 1: Subjective experience

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

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

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

- What were the main threats? Can you provide details about them?

- Who made the threat? In which context or circumstances?

- Which threat affected you the most?

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

- Did the threat refer to an action that would take place *immediately*? ☐ YES ☐ NO
- Did the person expect or predict the threat and *could be prepared* or have a way to face or cope with it? ☐ YES ☐ NO
- Did the person consider that even if being compliant, there were signs that the alleged perpetrator *would go on with the threat*? ☐ YES ☐ NO
- What did the person think that the alleged perpetrator wanted to achieve with these threats? Which was the alleged *purpose*? (E.g., obtaining information/confession, intimidation, punishment, discrimination).

- How did the alleged victim think that these elements affected them or persons around them? Why?

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

a. Threats against the person. Note whether the person was threatened with
- Permanent physical damage or death

- Severe physical or psychological pain or acts that would produce severe suffering, including torture

- Prolonged or indefinite detention

- False charges that would imply an accusation of serious crimes

- Non-compliance with legal safeguards (i.e., call to family, legal counsel, medical care)

- Elements that produce mental suffering through deep humiliation and shame, including
  - Threats to use relevant elements of identity in a denigrating, shameful or humiliating way (e.g., ethnic, religious, or political identity)

  - Threats to use cultural taboos relevant to the person (sexuality, food, dressing, prayers, or others)

  - Threats to being exposed or denigrated based on personal characteristics or vulnerabilities (e.g., gender or sexual orientation, physical characteristics, disabilities…)

  - Submission to situations of impossible choice (i.e., forced to harm others)

- Others (explain)

b. ***Threats [communicated to the* person] *to harm others*** including family members, friends, or other inmates

c. ***Threats [communicated to the* person*] to harm property, social standing, livelihood*** etc. (Please note if there is use of personal information is of a targeted nature to the alleged victim based on specific knowledge. This is in contrast to general threats where there may not be specific knowledge about the individual.)

d. ***Unspecific threats***. Elements that foster fear of the unknown. Including but not limited to the following examples:

- Darkness, empty rooms, cultural or physical isolation

- No information – Endless waiting time – Unknown legal status

- Ambiguous threats that suggest for instance death, pain or unknown but severe consequences ("Better talk and avoid what you have heard from others"; "You will regret what you said"; "The worst is to come")

Section 2. Medical and psychological consequences

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

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

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

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

b. Feeling in control.

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

The following sections are to be completed by clinicians.

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

- Symptoms of fear or anxiety during the events and immediately afterwards and their relation with the threats. Include bodily symptoms if relevant (trembling, shacking, hot and cold sensations…).

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

Explore also long-term symptoms that may include:

- Post-traumatic symptoms related to the threat, especially symptoms of avoidance and hyper vigilance. Collect, if possible, quotations and examples that suggest a causal relationship between threats and the symptoms, including but not limited to:

  • Flashbacks (context and contents)
  • Nightmares (contents and inner logic that the person gives to it)
  • Ruminative thinking
  • Triggering of avoidant behaviours
  • Triggering of emotional fainting / dissociative symptoms
  • Triggering of alarm response or hyperactivity
  • Triggering of panic attacks
  • Contents of delusional symptoms

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

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

In all cases, collect verbatim examples that show the connection between contents of the threats and these clinical syndromes.
Formulate a diagnosis according to international psychiatric classifications if this is possible.

(2) Non-clinical consequences

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

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

Section 3. Description of environment

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

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

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

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

Section 4. Psychosocial history[4]

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

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

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

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

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

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

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

- History of anxiety-related disorders, specifically panic attacks or generalised anxiety disorder.
- Personality traits that are relevant to the impact of threats. Consider giving special consideration to[5]:

  1. Trait and state anxiety
  2. Locus of control under stressful situations
  3. Self-efficacy
  4. Tendency to suppress thoughts
  5. Intolerance to uncertainty
  6. Intolerance to ambiguity

- Worldviews that might impact on fear-processing (e.g., lack of confidence in human beings or institutions due to past experiences)

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

Section 5. Credibility of threats

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

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

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

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

Section 6. Legal assessment

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

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

a. Official involvement: Do you have information that the threats were made by a person in an official capacity? Do you have information that the threats were made with the consent or acquiescence of a public official? Do you have information that such a person was somehow involved in the situation? (e.g., by consenting to the threat being made)

b. Severe suffering: Do you have documentation that the threat or its consequences were serious enough to amount to torture or ill-treatment? *The clinical assessment of the consequences as made above should be used here.*

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

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

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

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

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

c. Intention: Is there any information indicating that the threat was intentionally made? Note: *The question of intentionality is not necessarily linked to explicitness. It may be circumstantial particularly in the case of contextual or non-verbal threats.*

d. Purpose: Is there any information indicating that the threat was made for a particular purpose (such as punishment, intimidation, coercion, or discrimination)?

e. Context: What were the series of events and stressors present in the environment in which the threat was made?

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

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

Final reflections

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

Annexes

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

Annex 1. Threats as Torture. Quick Interviewing Guide.

1. Fear and anxiety related to threats are enhanced by all other elements of a **torturing environment** involving attacks on cognitive or emotional functions. *Assess threats in the overall framework of the torturing environment and in particular in the interactions with other torturing situations.* Pay special attention to: (a) frightening or intimidating space (b) hunger-thirst and attacks to basic body functions (c) pain-producing conditions including life-threatening conditions (asphyxia…)

2. Ask openly about the **subjective experience** of threats in the alleged victim words: types, relevance, and impacts. Collect answers as verbatim as possible.

   - Who made the threats?
   - What were the main threats?
   - Which one affected the person more?
   - What is the subjective logic behind that?
   - Was it referred to an action that would take place immediately?
   - Could the person somehow prepare or cope?
   - Was there an expectation that the alleged perpetrator would go on and make it real?
   - How affected was the person during the period of torture and at the time of examination?

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

3. **Vulnerabilities**:

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

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

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

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

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

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

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

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

7. **Credibility**

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

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Annex 2. Additional questionnaires for experimental use.

The Protocol can be complemented with the following assessment tools.

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

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

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

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