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Torturers and their victims: Theory, research, and clinical perspectives

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Abstract

This article provides an overview of the psychological dynamics associated with torture and examines its consequences on the victims. Initially, we investigate the psychological processes driving torturers to engage in extreme violence and brutality. Central to this exploration are the concepts of dehumanization and desensitization, which allow torturers to emotionally distance themselves from their victims and enact their aggressive behaviors. We elucidate how dehumanization and desensitization are often associated with the presence of a disordered personality, such as psychopathy, antisocial personality disorder, and narcissistic personality disorder. Subsequently, we delve into the complex interplay of survival and defense mechanisms utilized by victims during the traumatic experience of torture. We examine how victims may form a traumatic bond with their tormentors as a coping mechanism for their physical and psychological suffering—a bond that may persist even after their release. This bond may manifest as a heteronomous will, in which victims continue to adhere to the torturer's demands even after liberation, resulting in a deconstruction of their identity and a profound sensation of existing as "living dead." This enduring bound can profoundly impact victims' emotions, behaviors, and relationships, contributing to the onset of severe clinical conditions, with evidence showing increased prevalence of post-traumatic stress disorder, anxiety, depression, and somatic symptoms among survivors. Finally, we evaluate therapeutic interventions that have demonstrated effectiveness in treating individuals who have endured torture. Drawing from a diverse range of therapeutic approaches, such as psychodynamic psychotherapy, trauma-focused cognitive-behavioral therapy, narrative exposure therapy, and the wraparound approach, clinicians can address the multifaceted psychological needs of torture survivors. Through empathetic and respectful therapeutic interventions, torture victims can receive the necessary support to navigate through the processing of their traumatic experiences. Consequently, they can regain a sense of agency and restore their self-esteem, thereby progressing along the trajectory towards achieving healing and recovery.

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1. Introduction

In the history of humanity, torture has been one of the most brutal expressions of power and control. According to Article 1 of the United Nations Convention, torture is defined as any act deliberately inflicted upon individuals and causing severe pain or suffering—whether physical or mental—with the intent of obtaining information or a confession, punishing them for an act they have committed or are suspected of having committed, or for purposes of intimidation or coercion (United Nations, 1984).

Despite significant efforts to eradicate torture, it is estimated that this practice is still used in over 130 countries (Wenzel, 2007). Indeed, despite being prohibited under international law, torture persists as a method employed to coerce confessions and compel individuals or collectives to abandon their convictions (O'Mara, 2018). There are many methods of torture, and all of them aim to inflict physical, sexual, and/or psychological violence, damaging the victims' body and mind, humiliating them, disrupting their biological rhythms, and destroying their social bonds and trust in humanity (Sironi & Branche, 2002).

One critical aspect of torture lies in the intricate interpersonal bond forged between the torturer and the victim, characterized by an intense and distorted connection that may seem to transcend common understanding. Only few studies have been conducted on this topic.

Therefore, the aim of this article is to explore the dynamics that unfold between torturers and their victims, delving into the psychology of the torturer and how the victim attempts to survive the abuses. Accordingly, we will focus on the perpetrator-victim relationship and the persistence of tortured mental states in the victim. Then, we will examine the psychopathological outcomes of torture and the potential treatments for those who have endured this devastating experience.

2. The psychology of torturers

How does an individual manage to torture another person in cold blood? How can the perpetrator remain indifferent in the face of the victim's extreme suffering? What psychological mechanisms influence the torturer's behavior? These are just a few of the many questions that arise when confronted with the extreme violence implied in torture. It is always challenging to understand the motives driving someone to commit such brutal actions.

One of the prevailing psychological processes in torture contexts is *dehumanization*. Dehumanization is the psychological process through which individuals or groups are perceived and treated as subhuman, often resulting in the denial of their inherent dignity, rights, and emotional experiences (McLoughlin & Over, 2018; Smith, 2014). Therefore, it allows the

torturer to attribute non-human characteristics to the victims, reifying them and thus treating them as objects (Alison & Alison, 2017; Harris & Fiske, 2011; Hickey, 2015; Kteily & Landry, 2022). Victims are depicted by torturers as "beasts" or "animals", enabling the perpetrators to justify the use of violence against them (Hickey, 2015; Smith, 2014). In this way, the torturers banish from themselves the feelings of compassion and the sense of responsibility towards their victims, facilitating the use of extreme violence and coercion (Alison & Alison, 2017; Harris & Fiske, 2011).

Also, *emotional desensitization* can have an important role in torture contexts. Emotional desensitization is the process through which repeated exposure to distressing or violent stimuli reduces the individual's emotional responsiveness (Guo et al., 2013; Rankin et al., 2009). Such diminished sensitivity can lead to a decreased capacity for empathy and an increased likelihood of aggressive behavior (Mrug et al., 2016). In the domain of torture and protracted violence, emotional desensitization manifests when torturers, consistently engaging in violent and aggressive actions, experience diminished sensitivity towards the distress of their victims, viewing their suffering as an inherent outcome of their victim roles. A veteran interviewed in Boulanger's study (2008), who had killed many victims and committed acts of torture, stated:

"I show no sad emotions…I have no feelings. It's like there's nothing there. It's like half of my personality is gone because when you do a lot of killing and stuff like that …when you see a lot of death, you lose your feelings and your personality" (Boulanger, 2008; p. 642).

Both dehumanization and emotional desensitization may be underpinned by unconscious defense mechanisms that enable the torturers to emotionally detach from the victim's suffering.

Sigmund Freud (1894) introduced the concept of defense mechanisms, focusing primarily on repression. He described these mechanisms as unconscious processes employed to shield individuals from anxiety, internal conflict, and emotional discomfort (Freud, 1894). Defense mechanisms operate by distorting, minimizing, or avoiding reality to maintain psychological equilibrium and psychological coherence (Cramer, 2002; Freud, 1894; Perry & Cooper, 1986). Anna Freud (1936) expanded upon this foundational work, by identifying and describing several defense mechanisms and their functions. Vaillant (1997) further contributed to this understanding by proposing that defense mechanisms could be classified along a continuum from the most dysfunctional to the most adaptive. The continuum includes four levels: narcissistic-psychotic (e.g., denial), immature (e.g., acting out), neurotic (e.g., intellectualization), and mature (e.g., sublimation). This hierarchical classification implies that the predominant use of low-level defense mechanisms in adults may indicate reduced adaptability and increased

psychological vulnerability compared to those who predominantly use more mature mechanisms. McWilliams (2011) also advanced the understanding and classification of defense mechanisms. She stressed that primitive defenses emerge during early childhood, are characterized by preverbal, prelogical, rigid, and all-encompassing patterns of thought; in contrast, secondary defenses, which typically develop later in infancy, involve specific transformations of thoughts, feelings, or a combination of both. Recent research (e.g., Békés et al., 2021; Di Giuseppe, 2024; Granieri et al., 2017; Silverman & Aafjes-van Doorn, 2023) demonstrates that defense mechanisms can be reliably assessed. Tools such as the Defense Mechanism Rating Scale (DMRS; Perry, 1990) and the Defense Style Questionnaire (DSQ; Andrews et al., 1993; Bond et al., 1983) are effective in capturing a spectrum of defense mechanisms, ranging from primitive to mature forms.

Otto Kernberg (1967) also underscored the critical role of defense mechanisms in the organization and structure of personality. He classified personality structures into neurotic, borderline, and psychotic categories, highlighting that defense mechanisms are essential for identifying these structures. Specifically, individuals with borderline and psychotic personality structures are inclined to employ primitive defenses, while those with neurotic structures utilize a range of defenses, mainly including neurotic and mature forms. According to the current version of the Psychodynamic Diagnostic Manual (PDM-2; Lingiardi & McWilliams, 2017), the defensive structures are fundamental to personality functioning. Thus, defense mechanisms not only reflect but also reinforce the configuration and stability of personality. The specific defensive patterns associated with personality structures profoundly affect how individuals handle conflicts and interpersonal relationships, playing a pivotal role in their overall psychological experience. Adding to this, Lazarus and Folkman (1984) integrated defense mechanisms with the notion of coping. They described coping as cognitive and behavioral strategies aimed at managing distressing situations that involve perceptions of threat, loss, or challenge.

A torturer with psychopathy displays a primitive (borderline or psychotic) level of personality organization (Kernberg, 1984) and exhibits profound empathy deficits and an inability to consider others rights, viewing people as little more than tools for their own pleasure and showing total indifference to their suffering (Cleckley, 1976; Hare, 1999). Psychopaths desire to live on the edge, fail to accept responsibility for their malevolent actions, easily break rules, and lack accountability for obligations or commitments. From a young age, they also display behavioral problems: they are often violent with peers, exhibit destructive behavior at school,

repeatedly lie, and take pleasure in destroying property and inflicting suffering on animals (Hare, 1970). For a psychopathic individual, closeness to others is associated with control and domination, as they dehumanize their victims, compel them to submit to their will, and thereby assert their own power (Schimmenti et al., 2014). The classical configuration of psychopathy is characterized by a distinctive set of traits and behaviors, including egocentrism and a sense of superiority, emotional superficiality, an inability to experience remorse or guilt, the ability to manipulate others through deceit and lying, lack of empathy, impulsivity, and antisocial behaviors (Hare, 1970, 1999). Psychopathic personalities are primarily characterized by the use of primitive defenses such as *omnipotent control* (McWilliams, 2011). Through this defense, torturers experience a sense of absolute power over others, accompanied by profound pleasure derived from inflicting suffering. Specifically, the torturers perceive themselves as having total and inviolable control over their victims, a dominion that extends beyond the normal limits of power and coercion. This omnipotence, coupled with a severe lack of empathy, leads the torturers to disregard the suffering and pain of the victims, resulting in an indifference to the intensity of their violence (Altman, 2008).

However, having total dominance over an individual represents merely an illusion. Victims, in fact, can react and rebel against the abuses they suffer, displaying aggressive or uncooperative behaviors. According to Mackey and Miller (2004), victims can attain some control over their tormentors through refusal and rebellion. Just as a young child can make an adult feel powerless by refusing to obey their commands, so prisoners can seemingly exert control over their torturers by refusing to cooperate. Faced with these behaviors, torturers may experience powerlessness, frustration, and vulnerability, and in order to regain control, they may resort to further violence and brutality (Altman, 2008). What is generated is a complex dynamic: the use of extreme violence by torturers may emerge as a pathological response to their inability to achieve absolute control over their victims. Therefore, torture may become structured around the establishment of a distorted internal dynamic of the torturer, characterized by sadism, manipulation and control, all manifested through a cruel form of tyranny, wherein the victims are constantly monitored and tormented (Luci, 2017, 2018).

A psychopathic torturer may also employ additional defense mechanisms, such as *denial*. Through this mechanism, torturers may disavow the severity of their actions or the harm inflicted upon their victims, thereby minimizing their own involvement and guilt. Torturers might refuse to acknowledge the reality of their actions or emotions; for instance, they may downplay the severity of their violent acts or the impact on their victims or seek to justify their behavior as normal or acceptable. *Rationalization* is another defense mechanism frequently used

by torturers: rationalization allows them to provide self-serving explanations for their violent or manipulative behavior. For example, they may convince themselves that their actions were necessary or that the victims somehow deserved their treatment. *Projection*, on the other hand, is a mechanism through which individuals reject their own unacceptable thoughts, emotions, or impulses and attribute them to others. According to Schwager (2004), the profile of torturers is often marked by a defensive, judgmental, and hypocritical stance, as they project their own "dark side" onto their victims (Kim et al., 2005). This means that torturers may attribute negative behaviors, attitudes, or characteristics to their victims that actually reflect their own traits, which they are unwilling to recognize.

An example of a psychopathic individual who committed acts of torture is Albert Fish, also known as "The Gray Man." Over the years, Fish was repeatedly admitted to and discharged from various psychiatric institutions, where he was diagnosed with an "abnormal" and "psychopathic" personality (Brown et al., 2014; Schechter, 2012). The nickname "Gray Man" was given to him due to his outward normalcy and appearance in daily life. Fish, in fact, appeared to be a respectable and ordinary elderly man, dressed in gray clothing, and exhibited a calm demeanor (Brown et al., 2014; Vronsky, 2004). He derived great pleasure from hearing the screams of horror and agony from his victims and showed no remorse or guilt for the brutal acts he perpetrated (Ramsland & McGrain, 2009).

A torturer may also be characterized by a sadistic personality (Hickey, 2015). Sadism is defined as deriving pleasure from inflicting physical or emotional suffering on others (Davies & O'Meara, 2007; Webber et al., 2013). This concept extends beyond mere sexual sadism to encompass a general gratification obtained through the intentional infliction of physical or psychological pain (Lobbestael et al., 2023). Freud (1927) viewed sadism as a regression to the sadistic-anal phase, where a child displays sadistic behaviors through the control of feces, representing a primitive form of power and control. Furthermore, Freud (1920) considered sadism as expression of the death drive, which propels individuals toward destruction and aggression, and specifically as a form of perversion where pleasure is derived from causing pain or suffering to others. Lacan, on the other hand, conceptualized perversion based on the mechanism of *disavowal*, a defense initially introduced by Freud (1927). According to Lacan (1956-1957), sadism represents a type of perversion in which the individuals refuse to acknowledge their dependence on the desire of the Other, instead seeking to assert total control over it. In this context, disavowal serves as a central mechanism for the individual avoiding to confront symbolic castration: the individual refuses to acknowledge the fundamental truth

concerning the impossibility of being entirely omnipotent. Practically, sadistic individuals identify with a symbolic object, such as the phallus or the instrument of torture, representing the desire of the other, transforming their experience of desire into a role-playing scenario where moral rules do not exist and they become omnipotent. Through disavowal, sadistic individuals not only avoid facing their own pain but also uses the relationship with others to fulfill their desire in a manner that superficially appears as a form of total control (Kahraman-Erkuş, 2020). Therefore, even in the case of a sadistic torturer, the tendency towards omnipotent control remains evident.

Pérez-Sales (2020) highlighted that sadistic torturers often control aspects such as sounds, noise, light, temperature, and the organization of time, deriving pleasure from the suffering of their victims. These characteristics, especially when associated with a profound lack of empathy, enable the torturers to disregard the suffering and pain of their victims. This allows torturers to develop indifference toward the intensity of their violence. In such circumstances, the victims begin to perceive themselves as objects existing solely to fulfill the torturers' desires (Grubin, 1994; Pérez-Sales, 2020). The pleas, cries for help, and futile attempts to break free can be experienced by torturers as additional sources of gratification and excitement, further motivating them to inflict greater suffering. Then, by using *rationalization*, the torturers may provide themselves with logical or reasonable explanations for the brutal actions they have committed, justifying their violence and attempting to convince themselves that torture is necessary and legitimate (Hart et al., 2022).

A notable example of the dynamics of domination, control, omnipotence, and sadism is Robert Hansen, commonly known as "The Butcher Baker" (Gilmour & Hale, 2016; Newton, 1992). Hansen kidnapped, tortured, and murdered between 17 and 21 women in Alaska during the 1970s and 1980s. Prior to selecting his victims, he meticulously planned their abduction and transport using his private plane to his remote cabin in the Alaskan wilderness. At this secluded location, the victims endured sexual torture before being taken to isolated areas in the Alaskan woods. There, they were released, often semi-nude and handcuffed, and Hansen would then pursue them as if he were a hunter, armed with rifles and knives.

Another personality disorder frequently linked to the psychology of torturers is *narcissistic personality disorder* (NPD). This disorder is typified by a consistent pattern of grandiosity, an insatiable need for admiration, and a notable lack of empathy, all of which can contribute to callous and cruel behaviors. Individuals with NPD often exhibit an inflated sense of self-importance, an excessive fixation on personal achievement and adulation, and a disregard for

the feelings of others (American Psychiatric Association (APA), 2022). This disorder might also be characterized by an extreme need to control and dominate others, stemming from a personality configuration marked by emotional detachment from others and a total focus on oneself and one's own needs (Lingiardi & McWilliams, 2017). In psychodynamic literature (Chrétien et al., 2018; Gabbard, 2014; Gandino et al., 2018; Kernberg, 1970; Kohut, 1971), NPD is presented along a continuum. At one end is the overt or grandiose narcissist, characterized by explicit behaviors characterized by a constant seeking of attention and approval from others. At the other end is the covert or vulnerable narcissist, who displays introverted and reserved behavior, is more sensitive and vulnerable, but still maintains feelings of grandiosity and resentment. The vulnerable narcissist's quest for approval is subtle, often expressed through hypervigilance regarding others' reactions and a persistent concern for his or her status. Vulnerable narcissists are particularly characterized by narcissistic withdrawal (Cain et al., 2008; Gioia et al., 2020; Jauk & Kaufman, 2018). Through this defense mechanism, the individual retreats from social interactions and relationships to protect their fragile ego and self-esteem. In general, the manifestation of narcissism accompanied by components of sadism and antisocial behaviors is referred to as "malignant narcissism" (Kernberg, 1984). Kernberg (1984) described malignant narcissists has showing strong traits of narcissism and at the same time a tendency to sadistic aggression, thereby likening them to individuals with psychopathic disorders.

According to McWilliams (2011), NPD is characterized by the presence of the defense of *devaluation*. Through this defense, the torturers tend to perceive the victim as inferior and worthless, which helps them to carry out violent acts, legitimizing their own aggressiveness. *Emotional isolation* is another defense frequently used by narcissistic torturers, because it allows them to create the emotional distance needed to act without feeling emotionally involved in the suffering inflicted upon the victim. Accordingly, by reducing the capacity to experience intense emotions, the torturers can remain clear-headed and focused on their actions without being disturbed by conflicting feelings. When malignant narcissism is accompanied by Machiavellian traits—characterized by manipulative, detached, and morally insensitive behaviors, as well as a self-centered disposition and a tendency toward deception— and psychopathy, it forms a unified construct termed the Dark Triad of personality (Furnham et al., 2013; Wright et al., 2017), which is associated with extreme malevolence and harmful behavior.

To gain further insight into the inner world of the victim, the torturers may also *identify with their victims*. This process involves actively seeking to understand the victims' experiences, emotions, and vulnerabilities. By doing so, torturers aim to acquire a deeper understanding of what causes

the victims the most pain and how they can exert greater control over them. Termed as "sadistic paternalism" (Pérez-Sales, 2017, p.19), this dynamic enables the torturers to intimately understand their victims' thought and feelings, thereby allowing them to exploit the victims' vulnerabilities and weaknesses to their advantage during interrogations. The torturers become acquainted with details such as their victims' place of residence, family members, children, partner, likes, dislikes, and so on. Nothing about the victims' life remains unknown to the torturer, not even their pain. Furthermore, the torturers see the victims naked, witness their suffering, hear their screams, and observe their trembling. In this way, it seems that the victims become nothing more than puppets in the hands of their tormentors (Luci, 2017, 2018).

However, while certain personality pathologies are associated with the psychology of torturers, not all perpetrators of torture exhibit severe personality disorders. In contrast to the prevalent notion of torturers as practitioners of sadism who derive pleasure from inflicting pain or suffer from psychiatric illnesses, some torturers surprisingly appear to be ordinary people who merely comply with instructions. Many individuals may engage in brutal acts solely by adhering to directives and yielding to authority—an observation substantiated by famous social psychology experiments, such as those conducted by Milgram (1974) and Zimbardo (1971, 2007). By adhering to cruel rules or laws, the torturers create a psychological distance between themselves and the victim, rationalizing their actions as sanctioned by higher authority and dutifully obeying directives without assuming personal responsibility for the victim's suffering, but rather seeing themselves as mere executors (Bocchiaro, 2009). Sadly, this observation speaks volumes about the ease with which evil can manifest in human behaviors: merely acquiescing to cruel and sadistic directives without resistance may, in certain instances, suffice to transform individuals into torturers (Arendt, 1963).

3. Adaptation and survival

How do the victims endure, not only physically but also psychologically, the atrocious and disturbing experience of torture? According to Pérez-Sales (2017), in these circumstances the victims may undergo what he terms as *adaptation to horror*. In other words, the victims are compelled to adapt, almost becoming accustomed, to the traumatic context in which they live daily, attempting to normalize the surrounding horror. Screams, cries, pain, silences, and unpleasant smells become integral parts of the environment in which victims are forced to exist.

In such extreme situations, *emotional suppression* may emerge in the victims. In order to survive, they may endeavor to silence the emotions they feel, especially those overwhelming feelings stemming from the violence endured. In fact, emotional suppression enables the victim to

maintain self-control. Some individuals might emotionally withdraw, attempting to distance themselves from their emotions to shield themselves from pain and suffering. Others might try to conceal physical manifestations of their emotions, such as crying or trembling, to avoid drawing the attention of their captors (Nickerson et al., 2017). Additionally, emotional suppression prevents dwelling on the future, which could potentially exacerbate feelings of despair. By emotional suppression, the victims may even stop thinking about how to escape and focus on how to survive or make the imprisonment more bearable, so that they often direct their attention towards small practical objectives, such as receiving an extra piece of bread or a blanket (Herman, 1992).

Furthermore, in order to preserve their mental health and mitigate the risk of being overwhelmed by anxiety and despair, victims may unknowingly employ other defense mechanisms. Jun and collaborators (2015) observed that the defenses most commonly adopted by victims of extreme torture are dissociation, acting out, devaluation, denial, and splitting.

During episodes of torture, *dissociation* helps the victims temporarily avoid the horror they are enduring by detaching themselves from their body and reality. This dynamic creates a "safe mental space" where the victim can retreat to cope with events without feeling overwhelmed (Steinberg & Schnall, 2000). *Acting out*, on the other hand, leads the victims to react with violence, attempting to escape or brave the perpetrators. *Devaluation* causes the victims to feel unworthy and guilty, thereby believing themselves deserving of the torture they endure. By internalizing the belief that they deserve their torment, victims may attempt to regain a semblance of control over the unbearable circumstances, albeit through a distorted and self-deprecating lens. Through *denial*, the victims unconsciously reject the traumatic reality they are experiencing, downplaying their emotions and blocking out the most painful sensations and memories as a means to avoid reliving the experience of the torture. Lastly, *splitting* may serve the victims as a way to confront the complexity of the experiences, by seeing their perpetrators as entirely evil or good, or viewing themselves as ignoble or martyr, on the basis of the perpetrators' specific actions and their own responses. In both cases, splitting may serve as a way to reduce emotional pain (McWilliams, 2011).

These mechanisms, operating at an unconscious level, constitutes a desperate and instinctive attempt that allows the victims to withstand the unbearable situation and to endure the suffering of torture. Therefore, these mechanisms can initially provide a sort of immediate psychological "shield"; however, they can become dysfunctional and problematic in the long term. In fact, the

very relationship between the torturers and the victims may become further distorted over time, as the victims seeks to survive.

4. Traumatic bonds

Torture is characterized by a power imbalance between torturers and their victims: the torturers command, while the victims suffer, are isolated from others, are humiliated, and are treated as objects by torturers. Over time, the victims might realize that if they want to survive, they must adapt to the desires of torturers, thus inadvertently triggering a dynamic of *fusion and dependence* with them (Pérez-Sales, 2017). The victims might thus attempt to anticipate the moves of their torturers to avoid punishments, while simultaneously striving to please them. This because understanding the torturers' personality may be essential for the victims' survival (Amone-P'Olak, 2009).

However, the dynamic of dependence might even become mutual. The victim relies on the torturer to survive, but the torturer might also become dependent on the victim—for example, because he or she need information that only the victim possesses and has little time. This relationship can be depicted as a "grim game of chess" (Villani, 2011), in which the torturers seek their victims' weaknesses and vulnerabilities while the victims endeavor to comprehend and adapt to the demands and quirks of their tormentors. Being aware of this dynamic, the torturers may deliberately alternate moments of kindness with threats, to create further psychological imbalance in the victims and increase their control and manipulation power over them (Bailey et al., 2023). Seemingly insignificant gestures such as a small gift, a cigarette, a smile, a touch, or even the simple act of being listened to can have incredible power over the victims: it is not about the value of the gift itself or the two minutes a cigarette may last, but about acknowledging the victims as members of the human community, deserving of receiving a cigarette or being listened to for a while. These acts of apparent benevolence, which are manipulative in truth, can alter the victims' perception, generating confusion and creating a sort of illusory emotional attachment to their torturers (Pérez-Sales, 2017).

In many instances, torturers may also seek the approval, respect, gratitude, and even love of their victims, as these feelings enable them to perversely gratify their sense of omnipotence and control (Herman, 1992). Sometimes, the torturers may also instill a sense of obligation in the victims through phrases such as: "If it weren't for me, you would be starving in the streets" (Hopper & Hidalgo, 2006, p.199). This alternation in attitudes might be interpreted by victims in a distorted way, paradoxically leading them to see their perpetrators as their sole and potential saviors (Herman, 1992).

During these confusing exchanges, the victims might even begin to develop a particular bond with their aggressors in order to preserve their own life. This paradoxical dynamic, often defined in terms of *traumatic bonding* (Bailey et al., 2023; Casassa et al., 2022; Effiong et al., 2022; Painter & Dutton, 1985), is based on an *identification with aggressor*. It involves a process where individuals, following a traumatic experience, begins to internalize and adopt the characteristics, behaviors, or beliefs of their perpetrators (Ferenczi, 1932/1988; Lahav et al., 2022; Sultana Eliav & Lahav, 2023; Schimmenti, 2017b). The identification with the aggressor may result in what is commonly known as *Stockholm syndrome*, a term describing the condition in which kidnapping or hostage victims develop feelings of sympathy, affection, or even love towards their captors (Bailey et al., 2023).

The traumatic bond with the torturer occurs when multiple factors are concurrently present: (1) the victims must perceive a threat to their survival; (2) they must feel unable to escape from the torturers; and (3) they must perceive humanity and kindness from the torturers, even if this occurs in a fragmented manner and within a cycle of abuse (Bailey et al., 2023; Casassa et al., 2022; Pérez-Sales, 2017).

Contrary to common belief, the traumatic bonds in these cases represents a widespread tendency rather than an exception. The extended duration of captivity, characterized by continual exposure to life-threatening circumstances and profound isolation, leaves the victims in a state of vulnerability. In such conditions, they may find solace in the sole remaining relationship—that which exists with their tormentors. Consequently, victims gradually adopt the perspective of their torturers, reshaping their perception of the world accordingly (Amone-P'Olak, 2009). It is well-known that many hostages, after being released, exhibit surprising behaviors, such as supporting the cause of their captors, visiting them in prison, and even fundraising for their defense (Hickey, 2015; Strentz, 1982).

According to Symonds (1982), victims undergo a forced regression to a "psychological infantilism" (p. 99) that drives them to attach to the very persons threatening their life. Therefore, the attribution of a distinct syndrome, such as the Stockholm syndrome, to individuals enduring prolonged torture may be inaccurate. Their psychological mechanisms appear to reflect a regressive survival strategy rather than a clinically defined syndrome, akin to the responses observed in vulnerable children subjected to the dominance of a harsh parental figure for protection (Bailey et al., 2023; Casassa et al., 2022). By developing an emotional attachment with their torturers, and consequently by internalizing their values, perspectives, and demands, the victims try to reduce the risk of further abuse. The traumatic bond partly serves

to alleviate fear and anxiety in the victims, also offering them a perceived sense of security (Effiong et al., 2022).

Ferenczi (1933) effectively elucidated the phenomenon whereby a child, upon reaching a threshold of anxiety induced by abuse, becomes subservient to the authority of the adult aggressor. Subsequently, the child endeavors to anticipate and fulfill every whim of the aggressor in a bid to sustain the illusion of affection. Notably, in order to preserve a semblance of attachment to the perpetrator, the child might even justify the endured abuse and lauds the perpetrator's virtues. Similarly, victims of torture may develop over time a *traumatic identification* (Schimmenti, 2017b) with the aggressor, involving a distorted emotional bond wherein the victim develops feelings of gratitude towards the aggressor, despite the abusive context. In this case, the internal characteristics of the abuser are completely internalized by the victim until the two psychological realities (that of the abuser and that of the victim) overlap. This traumatic identification is often challenging to identify, as it is frequently obscured by primitive defense mechanisms, such as denial, which involves negating the existence of the traumatic events that precipitated the identification process and the subsequent impacts on the individual's self-representation. This process contributes to perpetuating the cycle of dependency and coercive adaptation, keeping the victim trapped in a harmful psychological relationship with the torturer (Cantor & Price, 2007; Lahav et al., 2022).

The dynamics of traumatic bonding can also be explained through Bowlby's (1969) attachment theory. Humans are intrinsically motivated to seek proximity to other individuals who can provide support in times of need, in order to gain security and protection. An important characteristic of the attachment system is that it is more easily activated in times of stress and danger: threatened individuals feel a greater need to seek protection and are more likely to bond with others. In this context, *any form of attachment is better than no attachment* (De Zulueta, 2007). Painter and Dutton (1985; Dunton & Painter, 1993) defined indeed the traumatic bond established in contexts of abuse and torture as a "powerful emotional attachment". In an attempt to feel attached, victims turn to the nearest source of hope—paradoxically, the torturer—to regain a state of psychological and physiological calmness. This contributes to the denial and dissociation of the traumatization involved in torture. Since the torturers have severed the victims' ties with family and caregivers, the victims seek to replace healthy bonds with a perverse bond with their aggressors, creating a state of dependency reinforced by the torturers' alternating moments of kindness, brutality, and confusion (Pérez-Sales, 2017). This dynamic of fusion and dependence between torturers and their victims may continue to exist even after the victims' release from captivity.

5. The persistence of tortured mental states

When the victims are finally released and return to everyday life, they may experience dissociative states stemming from the dynamics of the identification with the aggressor (Altman, 2008; Luci, 2017, 2018). Scholars investigating the psychological effects of torture on victims (e.g., Herman, 1992) have delineated how the very act of torture engenders a distorted reality wherein every facet of the victim's existence is meticulously controlled by the perpetrator, persisting even beyond instances of torture. Throughout the duration of captivity, torturers capitalize on the vulnerability of their victims to effect a profound alteration in their identities, often referred to as *brainwashing* (Altman, 2008; Luci, 2018; Pérez-Sales, 2017).

Notably, in a study concerning brainwashing, Lifton (1961) examined the indoctrination and mental manipulation methods employed by the Chinese regime during the communist revolution and Mao Zedong's governance, introducing the concept of *thought reform*. With this term, Lifton refers to techniques used by perpetrators to dismantle and reshape the victims' identity and thought processes to align them with the goals of the coercive authority. This process may involve breaking down the victims' previous beliefs and internalized relationships, and reconstructing them to fit the imposed ideology or thought system. Lifton identified eight techniques used to manipulate thought and control victims within totalitarian environments. These techniques include environmental control, control of time and information, creation of a hierarchy of authority, use of confession techniques, promotion of a worldview as totalitarian, manipulation of emotions, employment of social coercion, and promotion of a culture of secrecy and suspicion towards others. During thought reform, individuals may face intense social, emotional, and psychological pressure to abandon their previous beliefs, confess alleged "errors" or "deviations", and adopt a new set of prescribed beliefs and behaviors. This can lead to profound psychological stress and a loss of personal identity, as individuals are coerced into relinquishing their autonomy of thought and accepting an externally imposed worldview.

This example makes it clear why returning to everyday life is an extremely difficult challenge for torture victims. The impositions of torturers during the period of captivity can generate identity alterations that may compel torture victims—even after their release—to continue living according to their torturers' expected will (Cantor & Price, 2007; Pérez-Sales, 2017; Villani, 2011). Even though scientific literature provides few direct references to post-torture ritualistic behaviors of victims, there is anecdotal evidence that many survivors adopt these behaviors as an expression of the coercive control endured during captivity and as a means to preserve a sense of continuity with the past. In this context, Monica Luci (2018) recounts the narrative of

a young man who endured torture. She delineates how the victim experienced a profound loss of autonomy, perceiving the presence of an internal intruder. Consequently, torture may engender a fusion between the psychology of the victim and the tormentor, blurring the distinction between agency and action and making it unclear what party is doing what.

This complex dynamic has been explained by Sussman (2005), who delineated how individuals subjected to torture may undergo a transformation into a truly *heteronymous will*, embodying the intentions of their abhorred and feared tormentors. In other words, some torture victims relinquish control over their own volition, which becomes almost assimilated into the torturer's desire, acquiescing to and aligning their actions with the anticipated objectives of their aggressor. Once transformed into a heteronomous will, victims may become complicit in their own betrayal, acting contrary to their own interests or values as a result of the manipulation endured during torture. In essence, the victims may evolve into an instrument of their own subjugation, experiencing a process wherein their identity and autonomy are wholly usurped.

As Sussman (2005) described:

"What the torturer does is to take his victim's pain, and through it his victim's body, and make it begin to express the torturer's will. The resisting victim is committed to remaining silent, but he now experiences within himself something quite intimate and familiar that speaks for the torturer […]. My suffering is experienced as not just something the torturer inflicts on me, but as something I do to myself, as a kind of self-betrayal worked through my body and its feelings […]. The victim of torture finds within herself a surrogate of the torturer" (Sussman, 2005; p.29).

Therefore, it is not uncommon that victims persist in adhering to routines reminiscent of their detention conditions, such as consuming meals at prescribed times set by their perpetrators, conforming to their preferences in grooming, and strictly adhering to preordained schedules for bodily functions. These behavioral patterns could result from the deep-seated fusion established between the victim and the torturer, whereby erstwhile imposed regulations gradually assimilate into the victim's identity. According to Sussman, therefore, torture aims to make each of its victims a natural slave.

Furthermore, the persistent fear of experiencing pain or punishment if the perpetrators' directives are not followed may leave an indelible mark on the victim's psyche, inducing a state of vigilance and hyperarousal. Survivors may also persist in fearing their torturers, harboring beliefs that they are under constant surveillance or pursuit, apprehensive of potential harm or retribution (Herman, 1992; Hopper & Hidalgo, 2006). Also, survivors frequently perceive themselves as passive or devoid of agency. Nevertheless, this does not signify an abandonment

of proactive behavior; rather, it reflects the internalization of the extensive control wielded by the torturer over all aspects of their lives. Consequently, even after achieving freedom, survivors may misconstrue their spontaneous behaviors or initiatives as acts of defiance, thereby fearing potential reprisal and punishment.

According to Ebert and Dyck (2004), torture practices aim to create a "living dead" (p.618). Through torture and coercion, torturers render their victims incapable of comprehending, reacting to, and communicating their internal experiences, resulting in identity deconstructions and alterations. In certain instances, firmly held convictions of victims may become destabilized and values distorted, to the extent that they are supplanted by extremely divergent beliefs—namely, those of the torturer. As already mentioned, such identity alterations may endure even following the release.

In George Orwell's novel *1984*, a chapter is dedicated to the torture chamber known as Room 101 (Orwell, 1949). Here, O'Brien, the torturer, informs his victim Winston:

"You will be hollow. We shall squeeze you empty, and then we shall fill you with ourselves" (Orwell, 1949; p. 269).

While this quote originates from a work of fiction, its pertinence in this context is noteworthy, as it encapsulates the torturer's objective of depleting the victim of every characteristic, value, and aspect of personality: the torturer seeks to ensure that the victim returns home with a fundamentally altered mindset and perspective, wherein nothing remains but the influence of the torturer him- or herself.

In reality, the psychological effects of torture on survivors might be similar to those described in novels such as 1984, as one can immediately observe while examining direct testimonies concerning survivors' perspective:

"Once I was safe, I thought I was free on my torturers. I actually believed I would never see them again, that I would never have to smell them or hear their voices. But what I soon realized was that they were within me; they literally had made their home inside my soul. So often I felt as if they were dancing within me, reminding me that they were part of my life. I felt so dirty, so contaminated by evil. I know it sounds strange, but often times I feared that I would contaminate my family and my friends – so I distanced myself from everyone. None of them could understand why I spent so much time alone or why I bathed so frequently. I was afraid if I told them I was trying to wash my torturers off me – if I shared my true feelings – they would think I was crazy and lock me up" (Ortiz, 2001; 18-19).

Notably, the torturers' influence may persist in the minds of their victims long after their liberation, extending over many years.

6. Psychopathological outcomes of torture

Experiencing extreme interpersonal stressors, such as those encountered during torture, poses a significant threat to the psychological integrity of victims, surpassing the complexities of fusion and dependency dynamics. The consequences of torture have been subject to careful investigation in the scientific literature, which revealed a strong association between exposure to torture and psychopathology.

It is imperative to underscore that the symptomatology resulting from torture encompasses a broad spectrum of psychological disorders (Loncar et al., 2015). Some studies (Duffy & Kelly, 2015; Gaddhar et al., 2014; Loncar et al., 2015; Oosterhoff et al., 2004; Von Werthern et al., 2018) have documented the high prevalence of clinical symptoms among survivors, including sleep disturbances, hyperirritability, episodes of anger, persistent headaches, tremors, social isolation, numbness, tachycardia, hypertension.

Other studies have highlighted the presence of severe post-traumatic symptoms and post-traumatic stress disorder (PTSD) resulting from exposure to torture (Blackmore et al., 2020; Carswell et al., 2009; Clawson et al., 2007; Eisenman et al., 2003; El Hajj, 2021; Farhood et al., 2006; Johnson & Thompson, 2008; Silove et al., 2002). It has also been observed that the exposure to torture is often associated with anxiety (Blackmore et al., 2020; Eisenman et al., 2003; Suhaiban et al., 2019; Wenk-Ansohn, 2007), especially phobic anxiety (Allodi & Rojas, 1985; Rabkin, 1979), and depression (Blackmore et al., 2020; Farhood & Noureddine, 2003; Nickerson et al., 2017; Steel et al., 2009; Suhaiban et al., 2019; Wenk-Ansohn, 2007).

Notably, the study conducted by Rončević-Grzeta and colleagues (2001) was quite revealing for understanding the psychopathological effects of torture. This study compared three groups of individuals. The first group consisted of torture survivors, the second group comprised individuals who had not experienced torture but had gone through other traumatic events, and the third group consisted of individuals who had never experienced torture or specific traumatic events. The results revealed that the group consisting of torture victims exhibited significantly higher depression and PTSD compared to the other two groups. This suggests that torture represents an extreme traumatic event, whose psychopathological impact is higher than many other traumatic experiences.

Also, Rathkea et al. (2020) observed psychotic manifestations, encompassing auditory/visual hallucinations and persecutory delusions characterized by trauma-related themes, within a cohort of survivors of torture and refugees diagnosed with PTSD. Similarly, Wenzel et al. (1999) posited an association between PTSD symptoms and the onset of psychotic symptoms among survivors of severe torture, with the potential for psychotic symptoms to manifest even years subsequent to the traumatic event.

Furthermore, some studies examined the psychopathological effects of specific types of torture. Especially, sexual torture has received extensive attention in the literature (Dehghan & Osella, 2022; Kizilhan, 2017; Loncar et al., 2006; Makumana et al., 2018; Norredam et al., 2005; Oosterhoff et al., 2004). It has been observed that especially women who had experienced sexual torture tend to develop PTSD and depressive symptoms (Loncar et al., 2006; Makumana et al., 2018). Kizilhan (2017) also found in a study on poly-traumatized women who were victims of rape and sexual torture, and who had also witnessed mutilated bodies and killed family members, that these women had developed PTSD, dissociative disorders, anxiety disorders, somatic disorders, and sexual dysfunction. In another study by Loncar and colleagues (2006), many female victims of sexual torture suffered from social phobia, with abortions and unwanted pregnancies deriving from the abuses significantly contributing to exacerbating psychiatric symptoms in the sample. A qualitative study by Dehghan and Osella (2022) illustrated the devastating impact of sexual torture on the victims' interpersonal relationships and perception of their own bodies. Regarding interpersonal relationships, the study revealed that the victims showed distrust and sexual inhibition. Some survivors even admitted to feeling disgust towards sexual intimacy, their own bodies, and any form of physical contact with others. Regarding body image, it was observed that the victims perceived their bodies as a source of pain and torment, describing it as "dirty" and exhibiting obsessive behavior towards bodily hygiene.

However, despite the limited published literature on the subject, it is noteworthy that men can also fall victim to sexual torture. Oosterhoff et al. (2004) stressed that many men refrain from reporting such experiences due to profound feelings of shame following sexual abuse, although in reality, such occurrences might be relatively common. For example, Norredam et al. (2005) showed that a substantial number of male survivors of torture also endured sexual abuse, subsequently suffering from genital trauma and significant urological and/or sexual dysfunctions. Leaman and Gree (2012) found, in a sample comprising both men and women, a high prevalence of sexual torture in men, which was associated with symptoms of PTSD.

It has also been observed that survivors of sexual torture may develop somatic disorders (Eisenman et al., 2003; Kirmayer et al., 2007; Makumana et al., 2018), with pain manifesting in the body parts where the assaults occurred. According to Kirmayer, Lemelson, and Barad (2007), somatic symptoms as a consequence of traumatic stress are common not only among survivors of sexual violence but also among individuals who have experienced other forms of torture. These physical manifestations may reflect the body's response to the stress associated with traumatic experiences, underscoring the link between chronic pain, PTSD, and torture. Berthold et al. (2014) found in a cohort of 136 Cambodian adult refugees that those with comorbid PTSD and depression also exhibited a high prevalence of physical health issues. In this respect, Choi and colleagues (2016) suggested that experiencing bodily pain can exacerbate psychological symptoms, serving as a constant reminder of the impact of torture on the victims. The relationship between persistent pain and reexperiencing torture events has been investigated by Taylor and colleagues (2013). Their study revealed that participants described the physical pain as unpredictable and pervasive, with traumatic memories triggering the pain while positive emotions mitigating it. Given the findings of relevant studies, it is evident that there is an urgent need to ensure adequate psychological support for torture survivors.

7. Treating survivors of torture

Torture represents one of the most horrific and disturbing traumatic experiences that an individual may endure. The implementation of tailored therapeutic approaches and specialized interventions is imperative to effectively address the multifaceted psychological ramifications stemming from the dynamics of torture.

However, it is crucial to underscore the considerable challenge involved in establishing a trusting relationship with patients who have endured torture. Torture can fundamentally disrupt an individual's ability to establish secure and healthy relationships, leading to significant difficulties in interpersonal interactions (de C. Williams & van der Merwe, 2013). Therefore, torture trauma often spoils the survivors' ability to form trusting relationships, which generates a significant challenge in therapy (Chouliara et al., 2023). All the therapeutic approaches, in this context, should function as a transformative "laboratory", offering the patient an opportunity to engage in a new relational dynamic characterized by trust, empathy, and acceptance from the therapist (Van der Kolk, 2014). This marks a departure from past traumatic relationships characterized by abuse. Consequently, the patient may gradually come to realize that not all relationships entail pain or danger. The trust and empathy extended by the therapist serve as a pivotal reference point—a prototype—illustrating how healthy and fulfilling relationships should ideally operate

(Leuzinger-Bohleber, 2015; Muller, 2018). Only once a solid foundation of trust has been established between the patient and therapist can the psychotherapist commence exploration of the victim's traumatic experiences (Schimmenti, 2022b). In this respect, Herman (1992) stressed that psychotherapeutic approaches advocating for rapid disclosure of traumatic memories without providing adequate contextualization for integration are not only therapeutically irresponsible but also potentially dangerous. Such approaches may result in patients disclosing memories but lacking the requisite resources to address them constructively.

A robust therapeutic alliance lays the groundwork for implementing various therapeutic interventions that have shown effectiveness in addressing individuals exposed to torture. Specifically, in the context of treating survivors of torture, it is essential not only to address the immediate symptoms of trauma but also to intervene in the deeper and more complex psychopathological areas that emerge from extreme experiences. An adequate understanding and treatment of specific psychopathological concerns—such as dissociation, identity disturbances, and cognitive distortions—are essential for effective recovery. Several therapeutic approaches have been employed to address these issues, including *Narrative Exposure Therapy* (NET; Halvorsen & Stenmark, 2010; Patel et al., 2014), *Trauma-Focused Cognitive-Behavioral Therapy* (TF-CBT; Sjölund et al., 2009; Ter Heide et al., 2011), *Psychodynamic Therapies* (PDTs; Holmqvist et al., 2006; Özyıldırım et al., 2023), and the *Wraparound Approach* (WA; Kira, 2002). Additionally, these therapies can be combined with specific techniques such as *Eye Movement Desensitization and Reprocessing* (EMDR; Sjölund et al., 2009; Ter Heide et al., 2011) to enhance their effectiveness in treating survivors of torture.

Narrative Exposure Therapy (NET) is a cognitive behavioral therapy developed to treat PTSD in individuals who have experienced complex traumas such as torture, armed conflict, or other severe forms of violence (Joseph & Gray, 2008). NET addresses memory distortions and dissociation by constructing a chronological account of traumatic events, which enables patients to reprocess and integrate their memories in a less distressing manner. This approach seeks to mitigate avoidance and enhance emotional regulation, both of which are frequently impaired in survivors of torture (Halvorsen & Stenmark, 2010; Joseph & Gray, 2008; Patel et al., 2014). The foundation of NET is to help patients tell their personal history in chronological detail, reliving traumatic experiences through narration. During treatment, the therapist guides the patients through constructing a detailed timeline of traumatic experiences, encouraging them to describe the sensory, emotional, and cognitive details of various experiences (Myers & Davis, 2007). The main goal of NET is to help patients "re-educate" their brain regarding traumatic memories,

enabling them to integrate the traumatic experience into their life story more adaptively. Through repeated narration and gradual exposure to traumatic memories, the aim is to reduce fear and avoidance associated with traumatic memories, allowing the patients to process and integrate the experience within the broader context of their life (Neuner et al., 2004). In a study conducted by Halvorsen and Stenmark (2010), symptoms of PTSD and depression were examined in a sample of torture survivors. Following the administration of NET therapy, the results revealed a decrease in PTSD symptoms. However, regarding depression, no significant changes were observed. Patel and colleagues (2014) also found that both Cognitive-Behavioral Therapy (CBT) and Narrative Exposure Therapy (NET) confer moderate benefits in reducing distress and symptoms of PTSD in a sample of torture victims in the medium term (six months after treatment).

The Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) is primarily utilized for children, adolescents, and their families who are victims of trauma. This therapy focuses on addressing cognitive distortions and dysfunctional beliefs that arise from trauma. Through cognitive restructuring and anxiety management, TF-CBT aids in reshaping erroneous perceptions of safety and self-efficacy, thereby addressing persistent anxiety and fear (Cohen & Mannarino, 2015; Cohen et al. 2006). One of the fundamental principles of TF-CBT is gradual exposure to trauma. This entails guiding patients to share and explore the details of traumatic experiences in a structured and safe manner. Additionally, the therapy aims to restructure patients' erroneous or dysfunctional beliefs related to trauma. This cognitive restructuring process helps modify negative perceptions about their safety and ability to cope with situations (Cohen & Mannarino, 2015; Cohen et al., 2006). Patients learn specific skills to manage emotions and trauma-related reactions, such as recognizing emotions, stress management, and problem-solving. Lastly, TF-CBT focuses on identifying and developing the patients' personal resources, such as skills, talents, and support networks (Bisson et al., 2013). Generally, the treatment involves the use of exposure techniques, which can be divided into two main categories: in vivo exposure and imaginal exposure. During in vivo exposure, the patient is repeatedly exposed to situations they usually avoid to alleviate potential feelings of distress and fear associated with trauma (e.g., returning to the place where the traumatic event occurred). In imaginal exposure the patient engages in direct confrontation with the memory of traumatic events, focusing on the physical, emotional, and cognitive reactions associated with it (Foa et al., 2007). Studies examining TF-CBT effects on torture survivors are still limited, but they suggest that this approach cans serve to reduce PTSD and chronic pain symptoms in survivors of torture (Bisson et al., 2007, 2013;

Dibaj et al., 2020), especially when combined with Eye Movement Desensitization and Reprocessing (EMDR) techniques (Sjölund et al., 2009; Ter Heide et al., 2011).

Eye Movement Desensitization and Reprocessing (EMDR) is a therapeutic method for treating PTSD and is based on the concept that bilateral eye movements can facilitate the processing of traumatic memories. This process facilitates the desensitization and restructuring of memories, thereby reducing the intensity of PTSD symptoms and enhancing the ability to manage anxiety and distress (Luber, 2009; Shapiro, 1995). During an EMDR session, the therapist encourages the patient to recall a specific traumatic memory while providing bilateral stimulation. Throughout this process, the patient is guided to focus on the traumatic memory, exploring the associated emotions, physical sensations, and thoughts. Bilateral stimulation serves to reduce emotional reactivity and facilitate the processing of trauma-related information. In practice, this may result in emotional desensitization and cognitive restructuring of the traumatic memory, allowing the patient to reduce the intensity of PTSD symptoms and improve the overall quality of life.

Psychodynamic Therapies (PDT) are also frequently employed in the treatment of individuals who have undergone torture and suffer from PTSD. In particular, psychodynamic therapies (PDTs) are instrumental in exploring and resolving internal conflicts that may be exacerbated by torture. These therapies aim to understand the underlying processes contributing to the symptoms experienced by survivors, and to restore trust in relationships, eventually addressing the maladaptive dynamics of the identification with the aggressor (Schottenbauer et al., 2008). Different phases of PDTs can be delineated that are beneficial for processing the traumatic memories of torture victims. These phases are similar to those commonly used to treat complex posttraumatic stress disorder and dissociative disorders (International Society for the Study of Trauma and Dissociation, ISSTD, 2011). In the initial phase, it is paramount to cultivate trust within the therapeutic alliance and enhance the client's capacity for emotion regulation and mentalization (Schimmenti & Caretti, 2016). The subsequent phase is dedicated to reestablishing the client's trust in humanity, involving the work with negative expectations concerning relationships and self-sabotaging tendencies, which ultimately serves to deconstruct and resolve the identification with the aggressor (Schimmenti, 2022b). This phase may span an extended duration, potentially extending over several years. The third phase encompasses the detailed exploration of traumatic experiences and the dismantling of dissociative mechanisms that hinder the emotional and cognitive processing of trauma (Schimmenti, 2022a). In the final phase, the therapist aims to achieve emotional stabilization in the client (Schimmenti, 2017a). In all phases

of treatment, a critical role is played by the analysis of transference and countertransference. These dynamics occur when the patient's (transference) and therapist's (countertransference) feelings, emotions, and past relationships are projected and re-experienced within the therapeutic relationship (Busch & Milrod, 2018). According to Stolorow (1995), transference is characterized by two dimensions: the repetitive dimension, where the patient fears and expects the therapist to behave as past tormentors did, and the "self-object" dimension, where the patient strongly desires a healing or corrective experience that was lacking in their childhood or, more specifically, during the traumatic event. While transference can provide the therapist with valuable insights into the patients' past experiences and dysfunctional cognitive and emotional patterns that may influence their life, countertransference allows the therapist to connect with aspects of their clients' history. Through countertransference, therapists may experience feelings of powerlessness, anger, and frustration akin to those felt by the client during the torture period or, on the opposite side, they may feel sometimes omnipotent and sadistic, experiencing the same feelings of the tormentors. Essentially, countertransference enables the therapist to connect with the internal representations of the victims and their history. It is essential for the therapist to manage their own countertransference to prevent being overwhelmed and overpowered by it, avoiding collisions and collusions with the client's emotional experience (Gabbard, 2014). In a recent investigation by Özyıldırım et al. (2023), the effectiveness of long-term PDT was examined in patients diagnosed with PTSD stemming from torture and severe human rights violations. For individuals with severe clinical symptoms, pharmacotherapy was administered in conjunction with PDT. Among individuals receiving solely PDT, enhancements were observed in their psychological functioning as treatment progressed and the number of sessions increased. Notably, discernible improvement became more prominent from the third month of therapy onward. The findings of this study also indicated that patients receiving both pharmacotherapy and PDT demonstrated greater psychological improvements compared to those undergoing PDT alone. Holmqvist et al. (2006) evaluated psychopathology and self-image in fourteen traumatized refugees with backgrounds of war and torture experiences after administration of 15-months trauma-focused PDT. After completion of treatment, an overall reduction in global psychopathology and an improvement of self-image were observed, with a significant decline in PTSD symptoms.

Another PDT approach that can be useful for addressing extreme trauma and torture is group-analytic therapy (Bion, 1948; Foulkes, 1968). Group analysis regards the group itself as a therapeutic environment, offering individuals who have endured severe trauma such as torture an opportunity to explore and process their experiences within a supportive and secure

environment. Given that trauma often disrupts relational dynamics, group analysis provides a safe space to examine and working through the repetition of dysfunctional relational patterns, struggles with trust or intimacy, and other trauma-related challenges. Moreover, participation in a group setting enables patients to share their experiences and listen to those of others, thereby mitigating the emotional isolation often associated with trauma. Additionally, group members can learn from each other and discover new adaptive strategies for coping with trauma-related difficulties. The capacity to emotionally and cognitively resonate with others' experiences within the group facilitates the establishment of mutual support. Emotional mirroring, a key phenomenon in group analysis, involves other participants responding empathically to an individual's emotions and thoughts, thereby providing valuable support and validation (Bateman & Fonagy, 2016; Di Maria & Lo Verso, 1995). Empirical evidence suggests that group PDT is effective in alleviating traumatic and depressive symptoms over the long term. Specifically, a study by Levi et al. (2017) demonstrated the efficacy of group PDT in treating traumatized adults, resulting in a reduction of post-traumatic and depressive symptoms among participants, with these improvements maintained during the 12-month follow-up period after therapy completion.

The Wraparound Approach (WA) is an interdisciplinary and highly specialized model designed to address complex trauma resulting from torture. It integrates essential family and social support to tackle psychological difficulties within the community and support network, aiding survivors in restoring a sense of belonging and security (Kira, 2002). The primary goal of this approach is to restore the compromised functions of the survivor, promoting the recovery of a sense of safety, connection, autonomy, identity, self-realization. This model requires the active involvement of survivors' families and surrounding community. WA is thus centered on the empowerment of survivors and their family, encouraging the active participation of key figures in the victims' life. Only few studies have been conducted that use this promising, humanistic approach to the treatment of torture survivors. Among these, Raghavan and colleagues (2013) evaluated a torture treatment program examining the WA efficacy in treating 172 torture survivors. Follow-up assessments revealed that 45% of survivors showed clinically significant improvement, with psychotherapy and educational sessions, but also obtaining secure immigration status, predicting symptom improvement.

It is imperative to underscore that the aforementioned psychotherapeutic approaches represent only a selection of the diverse array of methods utilized in the treatment of torture survivors. Moreover, the efficacy of each therapeutic technique may vary depending on factors such as the

individual needs of the patient, cultural nuances, and the availability of resources. As such, the selection of the most appropriate therapeutic approach should be informed by a thorough and collaborative assessment conducted by the therapist in conjunction with the patient. This assessment should consider the intricate and unique dynamics of the torture experiences endured by the patient.

It is also crucial in the context of torture trauma, to acknowledge the relevance of social support, access to community resources, pharmacological interventions, and involvement of the familial network in the survivor's journey toward healing from torture, as highlighted in the WA. These elements not only increase the efficacy of the implemented psychotherapy but also contribute to fostering a supportive environment and providing essential resources to address the multifaceted challenges associated with recovery from torture.

8. Conclusions

The dynamics involved in the relationship between torturers and their victims indicates the presence of a multifaceted interplay characterized by complex psychological and behavioral factors. Through dehumanization, sadistic omnipotence, and coercive control, torturers establish complete dominance over their victims, relegating them to objects of manipulation and submission. Conversely, victims, in an effort to survive, may form a traumatic bond with their aggressors by identifying with them. This bond can engender a psychological dependency on the torturer, persisting even after the victims are liberated. The torturer's manipulative tactics, such as alternating between acts of kindness and violence and offering small concessions, serve to further solidify this paradoxical and perverse bond with the victims. Therefore, our analysis of the psychological bond between torturers and victims might be relevant for elucidating the power dynamics inherent in situations of abuse and coercion. This examination has enabled the identification of mechanisms utilized by torturers to maintain control over their victims, shedding light on the psychology of victimization and elucidating how victims navigate extreme circumstances of violence and fear. Such insights may also contribute to a deeper understanding of victims' adaptation and survival mechanisms, which may serve for avoiding the stigmatization of some apparently self-destructive behaviors of the victims and for tailoring appropriate clinical interventions aimed at supporting them in their journey towards healing.

In fact, the exposure to torture trauma often results in the development of severe psychopathological disorders among victims, including PTSD, depression, anxiety disorders, somatic disturbances, and even psychotic symptoms. It is crucial for victims to receive assistance and justice from society, but it is also critical that they can turn to mental health professionals

who can employ appropriate therapeutic interventions to help them process the traumatic events they endured. The combination of social justice and appropriate treatments may represent the foundation for restoring their identity, autonomy, relationships, and well-being.

Authors' Contribution

EVM and AS collaborated on the conceptualization of the manuscript. EVM drafted the initial version, which was subsequently revised and edited by AS.

Conflict of Interest Statement

The authors declare that the research was conducted in the absence of any potential conflict of interest.

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