Model Curriculum on the Effective Medical Documentation of Torture and Ill-treatment

Educational Resources for Health Professional Students

Prevention through Documentation Project

2006-2009

International Rehabilitation Council for Torture Victims

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Preface

Torture is one of the most traumatic and destructive human experiences. Its purpose is to deliberately destroy not only the physical and emotional well-being of individuals but also, in some instances, the dignity and will of entire communities. Although international human rights and humanitarian law consistently prohibit torture under any circumstance, torture and ill-treatment are practised in nearly half of the world’s countries. Prevention of and accountability for torture are essential to the rule of law and the development of civil society. It concerns all people because these practises impugn the very meaning of our existence and our hopes for a brighter future. Respect for such a basic human right may well demonstrate our capacity to respect other human rights as well.

In recent years, health professionals have recognised the importance of human rights in health, and increasingly have worked to protect and promote human rights as a means of promoting health and preventing human suffering. They have played an important role in the prevention of and accountability for torture through the effective investigation and documentation of torture and ill-treatment. Health professionals were instrumental in the development of the first international guidelines for medico-legal documentation of torture and ill-treatment that are contained in the UN’s Manual on the Effective Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol). The Istanbul Protocol was developed in 1999; it was the result of three years of analysis, research, and drafting undertaken by more than 75 forensic doctors, physicians, psychologists, human rights monitors, and lawyers representing 40 organisations and institutions from 15 countries.

Medical documentation of torture and ill-treatment is often crucial in judicial proceeding, human rights investigations and monitoring, and in the care of torture survivors. Medical evaluations of torture and ill-treatment involve a thorough clinical evaluation of an individual’s physical and/or psychological health. Medico-legal documentation of torture and ill-treatment requires a careful clinical history and examination by a health professional who is knowledgeable about the medical and psychosocial consequences of torture and sensitive to cross-cultural issues and interpersonal dynamics between traumatised individuals and persons in positions of authority.

This Model Curriculum on the Effective Medical Documentation of Torture and Ill-treatment (Model Curriculum) was developed to enable health professional students to effectively investigate and document torture and ill-treatment. It consists of nine Modules and related supporting documents and contains essential information for students to develop the knowledge and skills required to conduct medical evaluations of torture and ill-treatment. The Modules include information on how to interview an alleged torture victim as well as the comprehensive guidelines for performing clinical examinations to detect physical and psychological evidence of torture and ill-treatment.

Each Module includes a summary of objectives and content, suggested discussion questions and teaching formats, and a list of primary references. The Modules are designed to be used by instructors in seminar discussions or lecture presentations, and by individual students or student groups. The Content of the Model Curriculum is based on the Istanbul Protocol and a number of manuals and resources that were subsequently developed by Istanbul Protocol authors and editors, and their colleagues (see Resources below).
Acknowledgments

The Model Curriculum was developed by Vincent Iacopino MD, PhD, Senior Medical Advisor, Physicians for Human Rights using the resources listed below. The Model Curriculum was edited by Madhavi Dandu, MD, MPH, University of California, San Francisco and copy edited by Gregory Wong, Wesleyan University. Editorial comments and suggestions were kindly provided by Önder Özkalpçı MD, International Rehabilitation Council for Torture Victims; Alejandro Moreno, MD, JD, Boston Center for Refugee Health and Human Rights

Many of the materials used for the preparation of the Model Curriculum were developed through the Preventing Torture through Investigation and Documentation (PtD) Project, a collaboration between the Human Rights Foundation of Turkey, REDRESS, Physicians for Human Rights, and the International Rehabilitation Council for Torture Victims. The contributors of those materials included: Hülya Üçpınar, Türkcan Baykal and Şebnem Korur Fincancı, with comments and contributions provided by Lutz Oette, Anna-Lena Svensson-McCarthy, Nieves Molina Clemente, Ole Vedel Rasmussen, Thomas Wenzel and Vincent Iacopino.

The PowerPoint files that were developed for each of the nine Modules in the Model Curriculum were based on contributions from a number of individuals:

Module 1: Vincent Iacopino, Physicians for Human Rights; Bent Sorensen, International Rehabilitation Council for Torture Victims


Module 3: Türkcan Baykal MD, Human Rights Foundation of Turkey; Allen Keller MD Bellevue/NYU Program for Survivors of Torture; Uwe Jacobs PhD, Survivors International; Kathleen Allden, MD, Indochinese Psychiatric Clinic; Vincent Iacopino, Physicians for Human Rights

Module 4: Vincent Iacopino, Physicians for Human Rights; Önder Özkalpçı MD, International Rehabilitation Council for Torture Victims; Alejandro Moreno, MD, JD, Boston Center for Refugee Health and Human Rights; Ole Vedel Rasmussen, MD, DMSc, International Rehabilitation Council for Torture Victims; Türkcan Baykal MD, Human Rights Foundation of Turkey; Caroline Schlar, PhD, Human Rights Foundation of Turkey, Emre Kapninp, Human Rights Foundation of Turkey; Kathleen Allden, MD, Indochinese Psychiatric Clinic

Module 5: Vincent Iacopino, Physicians for Human Rights; Önder Özkalpçı MD, International Rehabilitation Council for Torture Victims; Alejandro Moreno, MD, JD, Boston Center for Refugee Health and Human Rights; Ole Vedel Rasmussen, MD, DMSc, International Rehabilitation Council for Torture Victims; Lis Danielsen, MD, DMSc, International Rehabilitation Council for Torture Victims

Module 6: Türkcan Baykal MD, Human Rights Foundation of Turkey, Caroline Schlar, PhD, Human Rights Foundation of Turkey, Emre Kapnin, Human Rights Foundation of Turkey;
Kathleen Allden, MD, Indochinese Psychiatric Clinic; Vincent Iacopino, Physicians for Human Rights

Module 7: Vincent Iacopino, Physicians for Human Rights; Alejandro Moreno, MD, JD, Boston Center for Refugee Health and Human Rights; Önder Özkalipçi MD, International Rehabilitation Council for Torture Victims

Module 8: Vincent Iacopino, Physicians for Human Rights; Alejandro Moreno, MD, JD, Boston Center for Refugee Health and Human Rights; Önder Özkalipçi MD, International Rehabilitation Council for Torture Victims

Module 9: Vincent Iacopino, Physicians for Human Rights; Alejandro Moreno, MD, JD, Boston Center for Refugee Health and Human Rights; Önder Özkalipçi MD, International Rehabilitation Council for Torture Victims

The two Case Examples included in Modules 7 and 8 were developed by: Vincent Iacopino, Physicians for Human Rights; Alejandro Moreno, MD, JD, Boston Center for Refugee Health and Human Rights; Önder Özkalipçi MD, International Rehabilitation Council for Torture Victims. The PowerPoint presentations were edited by Madhavi Dandu, MD, MPH, University of California, San Francisco and copy edited by Gregory Wong, Wesleyan University.

The two Psychological Evaluations used in Module 6 were provided by: Uwe Jacobs PhD, Survivors International; Kathleen Allden, MD, Indochinese Psychiatric Clinic.

All Self-Assessment files were developed by Vincent Iacopino, Physicians for Human Rights with editorial comments and suggestions provided by Madhavi Dandu, MD, MPH, University of California, San Francisco and copy edited by Gregory Wong, Wesleyan University.

Resources

As mentioned above, the content of the Model Curriculum is based on the Istanbul Protocol and a number of manuals and resources that were subsequently developed by Istanbul Protocol authors and editors, and their colleagues, to supplement the Istanbul Protocol, including extensive training materials developed by the IRCT and partner organisations, the Human Rights Foundation of Turkey (HRFT) and Physicians for Human Rights (PHR) for the Prevention through Documentation (PtD) Project. Selected materials were excerpted and adapted from these resources to develop a comprehensive curriculum for health professionals in the course of their training. The primary resources used for the development of the Model Curriculum include:


Case Examples #01 and 02 (Case Summaries, Narratives and Guidelines for Instructors). The Effective Documentation of Torture and Ill-treatment in Sudan, Khartoum, February, 21-24 2006. Physicians for Human Rights, REDRESS, the Sudanese Organization Against Torture (SOAT) and the AMEL Treatment Centre.

PtD Training Materials (IRCT Prevention through Documentation (PtD) Training Materials): The PtD training programme was developed in collaboration between the Human Rights Foundation of Turkey, REDRESS, Physicians for Human Rights and the International Rehabilitation Council for Torture Victims (see: http://www.preventingtorture.org). The legal materials were developed by REDRESS and Hulya Uçpinar with comments provided by Anna-Lena Svensson-McCarthy. The medical and psychological materials were developed by Stine Amris, Margriet Blaauw, Türkcan Baykal, Lis Danielsen, Emre Kapkin, Şebnem Korur Fincancı, Caroline Schlär and Ole Vedel Rasmussen with comments provided by Vincent Iacopino and Thomas Wenzel. The primary materials selected for the Model Curriculum include (available at: http://www.preventingtorture.org):


Each Module contains a list of the primary resources used for its development. It is important to note that clinicians who conduct forensic medical evaluations of alleged victims of torture and ill-treatment should be familiar with the entire content of the Istanbul Protocol, especially if they refer to the application of Istanbul Protocol standards in their medico-legal report(s).
# Glossary

<table>
<thead>
<tr>
<th><strong>Medical Terms:</strong></th>
<th><strong>Definition</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Axilla</td>
<td>Armpit</td>
</tr>
<tr>
<td>Brachial plexus</td>
<td>The nerves running from the spine into the arm</td>
</tr>
<tr>
<td>Callus</td>
<td>An area of thickening of bone at the place of healing</td>
</tr>
<tr>
<td>Cerebral oedema</td>
<td>Swelling of the brain</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>Partial impairment of memory, thinking, perception or mood</td>
</tr>
<tr>
<td>Counter-transference</td>
<td>Potential emotional reaction of the clinical evaluator toward the alleged torture victim</td>
</tr>
<tr>
<td>Depigmentation</td>
<td>Complete loss of pigment from a patch of skin</td>
</tr>
<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual (American Psychiatric Association)</td>
</tr>
<tr>
<td>Haematuria</td>
<td>Blood in the urine</td>
</tr>
<tr>
<td>Hyperpigmentation</td>
<td>Increase in pigmentation of an area of skin</td>
</tr>
<tr>
<td>Hypopigmentation</td>
<td>Partial loss of pigment from an area of skin</td>
</tr>
<tr>
<td>Intrusive memories</td>
<td>Involuntary, unpleasant and recurrent memories of an incident</td>
</tr>
<tr>
<td>Ischemia</td>
<td>Decreased blood flow</td>
</tr>
<tr>
<td>Laceration</td>
<td>A wound in which the skin is torn by blunt force</td>
</tr>
<tr>
<td>Medical Evaluation</td>
<td>An assessment of physical and/or psychological evidence by a clinician</td>
</tr>
<tr>
<td>Medical history</td>
<td>An individual’s personal account of a health problem</td>
</tr>
<tr>
<td>Medico-legal</td>
<td>Relating to that branch of medicine that assists the courts</td>
</tr>
<tr>
<td>Necrotic</td>
<td>Devitalized (death of) body tissues</td>
</tr>
<tr>
<td>Neuropathy</td>
<td>Nerve damage</td>
</tr>
<tr>
<td>Oedematous</td>
<td>Swollen</td>
</tr>
<tr>
<td>(edematous)</td>
<td></td>
</tr>
<tr>
<td>Parasthesias</td>
<td>A skin sensation such as burning, itching, tingling, with no apparent cause</td>
</tr>
<tr>
<td>Pathognomonic</td>
<td>A pathological finding that has only one cause</td>
</tr>
<tr>
<td>Perianal</td>
<td>Around the anus</td>
</tr>
<tr>
<td>Petechiae</td>
<td>Clusters of very small bruises</td>
</tr>
<tr>
<td>Psychosomatic</td>
<td>Apparently physical symptoms that have a psychological cause</td>
</tr>
<tr>
<td>symptoms</td>
<td></td>
</tr>
<tr>
<td>Retinal haemorrhage</td>
<td>Bleeding into the back of the eye</td>
</tr>
<tr>
<td>Sequelae</td>
<td>The consequences of a medical problem</td>
</tr>
<tr>
<td>Striae distensae</td>
<td>Stretch marks of the skin</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>Subdural bleeding</td>
<td>Bleeding between certain layers of fibrous tissue covering the brain</td>
</tr>
<tr>
<td>Tonic-clonic fits</td>
<td>The common form of epileptic convulsions or seizures</td>
</tr>
<tr>
<td>Transference</td>
<td>Feelings that a survivor of torture has towards the clinician that relate to past experiences, but which are misunderstood and towards the clinician personally</td>
</tr>
<tr>
<td>Urethral meatus</td>
<td>The aperture at the end of the penis through which urine is voided</td>
</tr>
</tbody>
</table>

**Legal Terms:**

- **Allegation (of torture)**: A claim (as yet neither proved nor disproved) that an incident of torture has occurred.
- **Applicant**: Person making an application under an individual complaint procedure.
- **Application**: Letter or other form of submission asking a judicial body to consider a case under an individual complaint procedure.
- **Arrest**: The act of apprehending a person for the alleged commission of an offence or by the action of an authority.
- **Asylum**: Asylum is sought by individuals who do not wish to return to a country, usually their own, where they are at risk. If granted, it means being allowed to remain in a country which is not their own. It may be temporary or permanent.
- **Corroboration**: Evidence which supports or confirms the truth of an allegation.
- **CPT**: Council of Europe’s Committee for the Prevention of Torture.
- **Crimes against humanity**: Serious acts, such as torture, committed as part of a widespread or systematic attack against a civilian population, whether or not they are committed in the course of an armed conflict.
- **Declaration**: A particularly formal resolution, usually of the United Nations General Assembly, which is not as such legally-binding, but sets out standards which states undertake to respect.
- **Derogate**: To temporarily suspend or limit.
- **Detention**: Depriving a person of personal liberty except as a result of conviction for an offence.
- **Domestic law or legal system**: National law or legal system; law or legal system which is specific to a particular country.
- **Enforcement (of obligations)**: Making the obligations effective; ensuring that they are respected.
- **Fact-finding**: Carrying out an investigation to discover the facts.
- **Impunity**: Being able to avoid punishment for illegal or undesirable behaviour.
- **Incommunicado detention**: Being held by the authorities without being allowed any contact with the outside world.
- **Individual complaint**: A complaint relating to a specific set of facts affecting an individual or individuals.
- **Instrument**: A general term to refer to international law documents, whether legally binding or not.
**Inter-governmental body**  
A body or organisation composed of the governmental representatives of more than one country.

**Judicial procedure**  
A procedure before a judicial body.

**Monitoring**  
Seeking and receiving information for the purpose of reporting on a subject or situation.

**NGO**  
Non-governmental organisation

**Non-governmental actors**  
Private persons or groups acting independently of the authorities.

**Perpetrator**  
The person who has carried out an act.

**Recommendation**  
A suggested course of action. Recommendations are not legally-binding.

**Reparation**  
Measures to repair damage caused, eg. compensation.

**Sanction**  
A penalty imposed for a state’s failure to respect its legal obligations.

**State responsibility**  
Holding a state accountable under international law.

**State Party (to a treaty)**  
State which has agreed to be bound to a treaty.

**Treaty**  
International law document which sets out legally-binding obligations for states.

**War Crimes**  
Grave breaches of the Geneva Conventions 1949, committed in the course of an armed conflict against persons or property protected by the Conventions, and other criminal violations of the rules of war.

### Clarifications of Terms:

**Use of the term “patient”**  
Individuals who allege torture and ill treatment are sometimes referred to as “patients” even in the context of medico-legal evaluations.

**Physicians/Clinicians**  
The terms “physician” and “clinician” are often used interchangably in this Curriculum. Keep in mind that psychological evidence may be evaluated by physicians, psychologists and clinical social workers. Physical evidence, however, is evaluated by physicians (medical doctors) only.
INTRODUCTION

Purpose of the Model Medical Curriculum

The primary purpose of Model Curriculum is to provide health professional students with essential knowledge and skills to prevent torture and ill-treatment through effective investigation and documentation of these practises using Istanbul Protocol standards. The Curriculum was developed specifically for health professional students. Practicing clinicians interested in training other clinicians on the effective investigation and documentation of torture and ill-treatment should consider additional educational material developed through the PtD Project (see generic and country-specific Training of Trainers and Training of Users materials available at: http://www.irct.org/Purpose---principles-2715.aspx). Health professional students should seek to complement this curriculum with other educational materials that address the broader context of health and human rights, in an effort to promote health and human dignity through the protection and promotion of human rights.

Who Are These Educational Resources For?

Medical evaluations of physical and psychological evidence of torture and ill-treatment require students to have some basic scientific knowledge and clinical experience. The Model Curriculum is most appropriate for health professional students who have already learned anatomy, physiology, pathology, physical examination techniques, and have had some exposure to clinical medicine and psychiatry or clinical psychology.

The Model Curriculum was designed to be used by instructors who wish to teach a 10 to 20 hour course and by individual students or student groups. The Modules may be applied to a number of teaching formats including, seminars, lectures, and self-study. Instructors should contact the IRCT to access materials for instructor use only.

As mentioned above, clinicians and legal experts who are already in practise and have some familiarity with the investigation and documentation of torture and wish to implement Istanbul Protocol standards using a multiple-day symposium format should access PtD materials available at: http://www.irct.org/Purpose---principles-2715.aspx. The overall objective of the PtD Project is to make a substantial and tangible contribution to the prevention of torture and ill-treatment worldwide by conveying knowledge and skills to health and legal professionals about systematised and high quality investigation and documentation of these unlawful acts. The PtD training format includes national adaptation of generic, international material for the training of trainers and subsequent training of clinicians and legal experts. The PtD educational materials also may be helpful to train health professional instructors who intend to teach the Model Curriculum on the Effective Medical Documentation of Torture and Ill-treatment.

Curriculum Materials

Model Curriculum:
Consisting of 9 Modules (see Summary of Content below). The Modules serve as the overall knowledge base for the Model Curriculum.

PowerPoint (PPT) Presentations:
There is PPT Presentation to accompany each of the 9 Modules. The Presentations were designed primarily for instructors who prefer to use a lecture format. The content of the PPT presentations closely parallels that of the Modules.

**Case Examples #01 and #02:**
Two case examples have been incorporated into Modules 7 and 8. They are designed to give students practical experience interviewing alleged victims of torture and documenting physical and psychological evidence. The medical evaluations that students develop from these case examples should be applied to Mock Court Proceedings in Module 9.

**Psychological Evaluations 1 and 2:**
Two Psychological Evaluations are included in Module 6 to provide students with an opportunity to develop clinical impression from information contained in actual asylum cases.

**Self-Assessments (quizzes):**
For each Module, there is a related Self-Assessment that is designed specifically for individual student users to assess their knowledge of curriculum content. The Self-Assessments may be applied to other teaching formats as well.

**Audiotape File:**
In Module 3, students will listen to an audiotape of an interview with a torture survivor, Sr Diana Ortiz, to better understand the challenges of interviewing survivors, particularly the emotional reactions of survivors and clinicians.

**Summary of Content**

**Module 1: International Legal Standards**

The first Module provides students with a foundation for understanding how torture is defined in international law, and the duties of States to prohibit torture and ill-treatment. It reviews common torture practices in the world today. As mentioned above, instructors should add country-specific information such as national norms and regional practice. A number of resources are suggested for this purpose. Module 1 also discusses international and regional monitoring mechanisms that health professionals should be aware of and specific safeguards for individuals deprived of their liberty. Module 1 should provide students with a foundation for understanding country-specific challenges to torture prevention and accountability and help them identify effective remedial measures.

**Module 2: Istanbul Protocol Standards for Medical Documentation of Torture and Medical Ethics**

Module 2 introduces students to the Istanbul Protocol, its purpose, history, content, applications and limitations. It reviews procedural safeguards relevant to medico-legal evaluations of torture and ill-treatment. Module 2 also provides a review of medical ethics relevant to torture documentation and outlines the duties of clinicians working with alleged torture victims and detainees in general. Instructors should include additional information on country-specific rules and regulations regarding medical documentation of torture and ill-treatment. This will aid students in addressing country-specific challenges. Module 2 also reviews general guidelines for gathering evidence.
Module 3: Interview Considerations

Module 3 provides a detailed review of interviewing considerations that is relevant not only for clinicians, but lawyers, adjudicators and human rights investigators/monitors. The Module first reviews a wide range of preliminary considerations (interview settings, trust, informed consent, privacy, empathy, safety and security, re-traumatisation, gender considerations, cultural and religious awareness, working with interpreters, and transference and counter-transference reactions, among others) and then discusses how to conduct interviews and the content of the interviews. Students will be asked to listen to an audiotape of a radio interview with a torture survivor and apply what they have learned in Module 3 to their experience of listening to a survivor. This practical exercise will help students to understand the emotions reactions of survivors (transference) and common reactions of clinicians (counter-transference).

Module 4: Torture Methods and their Medical Consequences

Module 4 provides students with a detailed review of the relationship between specific methods of torture and their physical and psychological health consequences. It reviews specific torture methods and ill-treatment, how they are applied, and the possible acute and chronic physical findings associated with them. This information will help students to correlate medical findings and specific allegations of torture and ill-treatment. The Module also provides a review of common psychosocial consequences of torture and ill-treatment and factors that may affect the variability of psychological evidence.

Module 5: Physical Evidence of Torture and Ill Treatment

Module 5 provides a detailed review of physical examination methods used to evaluate physical evidence of torture and ill-treatment. It begins with a review relevant questions for the medical history, then provides a systematic organ system review of physical evidence, and concludes with information on medical photography and relevant diagnostic tests. Module 5 will help students assimilate the information needed to evaluate and effectively document physical evidence of torture and ill-treatment. The Self-Assessment quizzes for Modules 4 and 5 will also help students to recognise common physical evidence of torture, provide accurate interpretations of their findings, and understand indications for diagnostic test.

Module 6: Psychological Evidence of Torture and Ill Treatment

Module 6 addresses psychological evidence of torture. It provide clinicians with understanding of the central role of the psychological evaluation, how to conduct and psychological evaluation and how to interpret relevant findings. It reviews the value and limitations of using diagnostic classifications and the use of psychometric instruments. It also includes information on evaluating children who have been directly or indirectly exposed to torture. Case information for two Psychological Evaluations are included at the end of Module 6 to provide students an opportunity to formulate their own clinical impressions and review them with other students and the instructor.

Module 7 & 8: Case Examples

Modules 7 and 8 are designed to help students develop interview and examination skills that are essential to the effective documentation of torture and ill-treatment. Modules 7 and 8 each consist of a Case Example for a role-play interview of an alleged torture victim. Each
Module contains Case Summary/Referral information that the students review prior to conducting an interview. Role-players act the part of an alleged torture victim using a Case Narrative file, which the students do not have access to. The physical examination findings are limited to photographic images. Each Module contains suggestions for instructors on how to implement the Case Examples and detailed guidelines for instructors to assist with the analysis of the cases.

**Module 9: Writing Reports and Testifying in Court**

Module 9 provides information on how to write a medical report and provide court testimony. The Module reviews a number of general considerations for report writing, the content of medical reports, how to formulate appropriate interpretations and conclusions, and how to convey them to adjudicators. The Module also discusses how to address the problem of inconsistencies in an individual’s case. Students may be asked to bring their written reports from the Case Examples in Modules 7 and 8 and participate in a Mock Judicial Proceeding, wherein they have an opportunity to present their evidence in “court” and play the role of a cross-examining lawyer. Instructors should consider adding course evaluation component to the end of Module 9.

**How to Use these Educational Resources**

**Teaching Formats**

Each Module includes a summary of Objectives, Content, Discussion Questions, Teaching Formats, and Primary References. This information can be applied to several different teaching formats including:

**Didactic Lectures**

Instructors with limited course time (i.e. 10-12 hours) may prefer to use a lecture format, in which case, PPT presentations can be used as the primary tool for knowledge transfer. The Discussion Questions contained in each module may be used for subsequent class participation. Though the practical applications in Modules 3 (interview analysis), 6 (clinical impressions of Psychological Evaluations) 7 and 8 (medical evaluations of Case Examples) and 9 (mock court proceedings) were designed primarily as group activities, PPT presentations for these Modules can be used as case demonstrations for the entire class.

Self-Assessment quizzes are available for each Module and instructors may use these as the basis for knowledge assessments. Suggestions for individual research or assignments are included in each Module and may be used for knowledge assessments. Another option would be to ask students to keep a journal and make entries throughout the course. Suggestions for journal entries are included in the Teaching Format section at the beginning of each Module. They should consist of several paragraphs (no more than a page) that are shared only with the instructor or with the entire class. Reflections in student journals could be a formal or an informal tool to assess student progress.

**Seminars**

Seminars are an ideal teaching format as they provide more time for student interactions and for practical applications and group activities that are suggested for each Module. In the seminar format, it would be advisable for the students to read the content of each module.
in advance of attending class. PPT Presentations are not as useful as they are redundant with the content of the Modules. Seminar classes may be structured to address the Discussion Questions listed for each of the Module or to work on a Group Activity. Suggestions for group activities are also included in each Module. The process for group activities is as follows:

- Divide the class into several groups and assign each group with one or more tasks
- A facilitator should be identified to moderate the discussion and rapporteur should be identified to record the group’s findings and report them when the class reconvenes
- After 20-30 minutes of group discussion, the entire class should reconvene
- Rapporteurs should briefly report on their group’s findings
- Open class discussion

Knowledge assessment may be based on participation and performance in seminar discussions and group activities. Student also may be required to submit their written reports for Modules 7 and 8. Another option would be to ask students to make journal entries throughout the course as described above. The Self-Assessment quizzes would likely not be used in the seminar format.

**Student Groups**

Health professional students may initiate their own course if instructors are not available and/or there is no time allotted for such electives in the students’ curriculum. A seminar format would be advisable for such student groups, but any combination of the teaching formats could be applied for such purposes.

**Individual Students**

Individual students may access the Model Curriculum online and take the course at their own pace. This would be a very effective way of learning how to document torture and ill-treatment when there are no courses/instructors/student groups available. While individual, self-programmed studies may be convenient for students, the practical applications component of the Model curriculum would be limited.

Individual students should focus on the Modules rather than PPT Presentations. They should read through the Discussion Questions and give them careful consideration. The Self-Assessment quizzes for each Module would be useful for students to assess their progress. They also may consider keeping a journal as described above.

**National Adaptation of the Model Curriculum**

Torture practices vary, to some extent, in different regions of the world, as do national legal standards, and the extent of human rights monitoring and documentation of such practices. A systematic, country-specific review of legal standards and torture practices is beyond the scope of this Curriculum. It is highly recommended that instructors and students research and include relevant country-specific materials for effective national adaptation of the modules contained in this curriculum.

The Prevention through Documentation Project has included 10 target countries (Georgia, Mexico, Morocco, Sri Lanka Uganda, Ecuador, Egypt, Kenya, the Philippines, and Serbia).
Country assessment reports by the IRCT are available (see: http://www.irct.org/Target-countries-2709.aspx) and may serve as a model for national adaptation efforts. A series of national adaptation resources have been developed to relate generic, international materials to local settings (see: http://www.irct.org/Purpose---principles-2715.aspx or contact the IRCT for additional information)

**Guest Speakers**

It is highly recommended for Model Curriculum instructors to contact local treatment centers for survivors of torture, and/or other experienced clinicians or providers who may be available to participate in the Model Curriculum course, especially in supervising the practice interviews for the cases included in Modules 7 and 8.
MODULE 1
INTERNATIONAL LEGAL STANDARDS

OBJECTIVES

• To understand basic definitions of torture and other forms of cruel, inhuman and degrading treatment or punishment
• To familiarize students with the international legal standards on the prohibition of torture and ill-treatment
• To obtain a clear understanding of the torture practices in the world today and relevant country-specific practices
• To be familiar with international and regional monitoring mechanisms
• To understand basic torture prevention and accountability measures, including specific safeguards for those deprived of their liberty
• To identify international and country-specific needs for prevention and accountability measures, including specific safeguards for those deprived of their liberty
• To identify country-specific challenges in preventing torture and holding perpetrators accountable including effective remedial measures in this regard

CONTENT

• Definition of torture and ill-treatment
• Brief review of the purpose of torture and its history
• Review of relevant international standards for torture prevention
• Torture in the world today, including practices, the role of state and non-state actors, common situations for allegations
• Review of country-specific legal standards and torture practices [to be provided by Instructors]
• Overview of prevention and accountability measures
• International and regional monitoring mechanisms and formal inspections of detention facilities
  o Human Rights Committee
  o UN Committee against Torture
• Regional monitoring mechanisms
• Other monitoring mechanisms
  o The UN Special Rapporteur
  o International criminal courts and tribunal
  o The International Committee of the Red Cross (ICRC)
• Safeguards against torture for those deprived of their liberty
  o Notifying people of their rights
  o Use of officially recognised places of detention
  o Humane conditions of detention
  o Limits on interrogation
  o Access to a doctor
  o The right to challenge the lawfulness of detention
  o Safeguards for special categories of detainees
    ▪ Women in detention
    ▪ Juvenile detainees
    ▪ People with mental health problems
DISCUSSION TOPICS

• Compare and contrast similarities and differences between international standards and national legislation
• Develop a 10-12 point country-specific plan for torture prevention and accountability
• Discuss how international, regional and national organisations can work together for the effective investigation and prevention of torture.
• Discuss the role of health professionals in torture prevention and accountability.
• Discuss the relationship between human rights and human security in general, and specifically with regard to national anti-terror policies/practises and torture.

TEACHING FORMATS

• Group Activity:
  - Divide the class into several groups and assign each group with one or more (or all) of the Discussion Topics listed above.
  - A facilitator should be identified to moderate the discussion and rapporteur should be identified to record the group’s findings and report them when the class reconvenes.
  - After 20-30 minutes of group discussion, the entire class should reconvene
  - Rapporteurs should briefly report on their group’s findings
  - Open class discussion

• Individual Research/Assignment(s):
  - Conduct literature research on the psychology of abuse and write a two-page essay analyzing different theories. Provide your opinion with supporting information
  - Develop a 10-12 point, country-specific plan for torture prevention and accountability
  - Develop a country-specific list of organisations and bodies relevant to torture and ill-treatment

• Journal Entry: (Instructor to assign students to write a few paragraphs -- no more than a page on one or more of the following)
  - Respond to one or more of the Discussion Topics
  - Why do you think health professionals should or should not be concerned about torture and ill-treatment?

PRIMARY RESOURCES

• The Istanbul Protocol, Chapters I and III, Annex I
• The Torture Reporting Handbook
• Action Against Torture: A Practical Guide to the Istanbul Protocol for Lawyers
• Medical Investigation and Documentation of Torture: A Handbook for Health Professionals
• Combating Torture: A Manual for Judges and Prosecutors
• The Torture Reporting Handbook

1.1 What is Torture?

Torture, as understood in international law, involves several elements: the infliction of severe pain (whether physical or psychological) by a perpetrator who acts purposefully and
on behalf of the state. The United Nations Convention against Torture defines torture this way:

For the purposes of [the] Convention, the term “torture” means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is 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. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions. [Article 1.]

1.2 Purpose of Torture

There are several purposes which torture can serve but the broad objectives include the maintenance of social control, the defence of ruling regimes and the suppression and punishment of political opponents and suspected criminals. In practice this means that torture is frequently used in interrogations to force confessions. In some police and security forces, torture is a short-cut to “effective” policing through which officers can quickly gain convictions via confessions. However, torture is also used for other purposes: to disable political or social activists by intimidation or the infliction of serious trauma, to ensure compliance and collaboration from people so that they will infiltrate and/or testify against suspected “enemies” of the government. Torture and other forms of violence can be perpetrated to assist ethnic cleansing, the expulsion of one or more ethnic groups from the territory claimed by another. The social views or political stance or ideology of people who have thus been brutally tortured are immaterial to those perpetrating the torture. More generally, torture can be used to induce in a population a sense of terror. And of course, where torture has become institutionalised or where police can act with complete impunity, the threshold at which torture is seen as an appropriate tool can decrease. Moreover, torture can occur where there is no obvious purpose. There have been numerous examples recorded of individuals being arrested and tortured solely because they were, by chance, present in a location where alleged criminals or political targets of the authorities were present. No amount of torture would make them reveal information they do not have (though of course they could be induced to confess to some illegal activity in which they have not participated).

The power of torture to evoke confessions as well as to induce fear in the person under threat of torture has led some law enforcement officials to use it for their own ends. In some countries, police or prison officers have extorted money from detainees by the threat of, or actual, infliction of torture. And prison guards threatened with having their already low wages further cut if a prisoner escapes, may not hesitate to use violent forms of repression against prisoners.

The targets of torture are a mix of those who have long been recognised as potential victims -- foremost, political or military opponents of the ruling power -- as well as others who are under-recognised as targets for torture: alleged criminals, the poor and marginalised, and ethnic minorities (both in their country of origin and as asylum-seekers). Some victim groups do not fit into traditional understandings of political torture: sexual minorities, religious groups, women and children (particularly vulnerable when used as a weapon against male family members), civilians caught in civil wars or in conflicts across borders,
and “accidental” victims -- those who are arrested because they have the misfortune to be in a place where security agents are carrying out arrests.

1.3 History of Torture

Torture has been practised throughout history. The Romans, Jews, Egyptians and many others cultures in history included torture as part of their justice system. Romans had crucifixion, Jews had stoning and Egyptians had desert sun death. All these acts of torture were considered necessary (as to deter others) or good (as to punish the immoral).

Medieval and early modern European courts used torture, depending on the accused's crime and social status. Torture was deemed a legitimate means to extract confessions or to obtain the names of accomplices or other information about a crime. Often, defendants already sentenced to death would be tortured to force them to disclose the names of accomplices. Torture in the Medieval Inquisition began in 1252 and ended in 1816 when a papal bull (formal statement by the Pope) forbade its use. Universal prohibition against torture was realized only in the aftermath of WWII in 1948 and the UN Convention on Torture against Torture was was adopted by the UN General Assembly considerably later in 1984.

1.4 Other Definitions

The World Medical Association’s Declaration of Tokyo (1975), which proscribes physician involvement in torture, uses a briefer, less legalistic definition which omits the element of severity of suffering but which otherwise embodies the elements of torture cited above.

[Torture is] the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason. [Preamble.]

1.5 Cruel Inhuman & Degrading Treatment & Punishment (CID)

The exact boundaries between “torture” and other forms of “cruel, inhuman or degrading treatment or punishment” (CID or “ill-treatment”) are often difficult to identify and may depend on the particular circumstances of the case and the characteristics of the particular victim. Both terms cover mental and physical ill-treatment that has been intentionally inflicted by, or with the consent or acquiescence of, the state authorities. The ‘essential elements’ of what constitutes torture contained in Article 1 of the Convention against Torture include:

- The infliction of severe mental or physical pain or suffering;
- By or with the consent or acquiescence of the state authorities;
- For a specific purpose, such as gaining information, punishment or intimidation.

Cruel treatment, and inhuman or degrading treatment or punishment are also legal terms. These refer to ill-treatment that does not have to be inflicted for a specific purpose, but there does have to be an intent to expose individuals to the conditions which amount to or result in the ill-treatment. Exposing a person to conditions reasonably believed to constitute ill-treatment will entail responsibility for its infliction. Degrading treatment may involve pain
or suffering less severe than for torture or cruel or inhuman treatment and will usually involve humiliation and debasement of the victim. The essential elements which constitute ill-treatment not amounting to torture would therefore be reduced to:

- Intentional exposure to significant mental or physical pain or suffering;
- By or with the consent or acquiescence of the state authorities

It is often difficult to identify the exact boundaries between the different forms of ill-treatment as this requires an assessment about degrees of suffering that may depend on the particular circumstances of the case and the characteristics of the particular victim. In some cases, certain forms of ill-treatment or certain aspects of detention which would not constitute torture on their own may do so in combination with each other. Ill-treatment is, however, prohibited under international law and even where the treatment does not have the purposive element or, as far as degrading treatment is concerned, is not considered severe enough (in legal terms) to amount to torture, it may still amount to prohibited ill-treatment.¹

The Human Rights Committee has stated that: 'The Covenant does not contain any definition of the concepts covered by article 7, nor does the Committee consider it necessary to draw up a list of prohibited acts or to establish sharp distinctions between the different kinds of punishment or treatment; the distinctions depend on the nature, purpose and severity of the treatment applied.'²

Over the years a wide variety of abusive acts has been declared by authoritative bodies as violating the prohibition of torture and other ill-treatment. A sample could include:

- Severe forms of beatings, including beatings on the soles of the feet
- Suspension by the arms while these are tied behind the back and similar forced positions
- Infliction of wounds or injuries
- Cigarette burns, or burns with other instruments or substances
- Electric shocks
- Rape or other sexual violence or molestation
- Near asphyxiation
- Pharmacological abuse using toxic doses of sedatives, neuroleptics, paralytics, etc
- Mock executions and mock amputations
- Forced breach of religious or cultural prohibitions or taboos such as dietary codes
- Sensory manipulation methods, such as hooding (sensory deprivation) and constant noise (sensory bombardment)
- Forced to witness torture or atrocities being inflicted on others
- Prolonged solitary confinement, particularly if combined with incommunicado detention
- Extremely poor conditions of detention

¹ Only the practice of the European Court of Human Rights explicitly uses the notion of relative severity of suffering as relevant to the borderline between ‘torture’ and ‘inhuman treatment’. The usual approach is to use the existence or otherwise of the purposive element to determine whether or not the behaviour constitutes torture.

• Threats of any of the above being inflicted on the victim or family

1.6 Prohibition of Torture in International Law

Torture cannot be justified under any circumstances. The UN has condemned torture as a denial of the purposes of its Charter and as a violation of the human rights and fundamental freedoms proclaimed in the Universal Declaration of Human Rights. Torture is also prohibited by most domestic legal systems in the world. Even where there is no specific crime of torture in domestic law, there are usually other laws under which the perpetrators can be held to account. Nevertheless, acts of torture and ill-treatment remain widespread across the world.

The international community has developed standards to protect people against torture that apply to all legal systems in the world. The standards take into account the diversity of legal systems that exist and set out minimum guarantees that every system should provide. Judges and prosecutors have a responsibility to ensure that these standards are adhered to, within the framework of their own legal systems. Even if a country has not ratified a particular treaty prohibiting torture, the country is in any event bound on the basis of general international law, because the prohibition of torture is so fundamental.

The prohibition of torture in international law is notable in that it is absolute, applying at all times and in all circumstances. Article 5 of the 1948 Universal Declaration of Human Rights states: 'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.' The right to be free from torture and other ill-treatment is taken up in major international and regional human rights treaties, including the International Covenant on Civil and Political Rights (1966), the European Convention on Human Rights (1950), the American Convention on Human Rights (1978) and the African Charter on Human and People's Rights (1981). In 1984 the UN adopted the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, highlighting the particular attention given to this absolute prohibition, and providing additional rules to assist in prevention and investigation.

The prohibition of torture is the concern not only of those countries which have ratified particular treaties, but is also a rule of general or customary international law, which binds all states even in the absence of treaty ratification. In fact, the prohibition of torture is generally regarded as having the special status of a 'peremptory norm' of international law, and states cannot choose to disregard or derogate from it.

In addition to international law, many national laws will also include a prohibition of torture. However, the lack of a clear prohibition in domestic law will not release the state from its international legal obligations to refrain from and prevent torture under all circumstances, and to investigate allegations, punish perpetrators, and provide reparations to victims.

The prohibition against torture and other ill-treatment extends even to times of armed conflict, whether the conflict is international (between countries) or internal (within a single country).

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3 Article 38 of the Statute of the International Court of Justice lists the means for determining the rules of international law as: international conventions establishing rules, international custom as evidence of a general practice accepted as law, the general principles of law recognised by civilised nations and judicial decisions and the teaching of eminent publicists. General international law (customary international law) consists of norms that emanate from various combinations of these sources.
country). In times of conflict all parties have to refrain from subjecting anyone in their hands to torture and other ill-treatment, whether they are combatants taking part in the fighting, whether they no longer take part in the fighting (e.g. due to being detained, or being wounded or sick) or whether they are civilians. International humanitarian law, of which the Geneva Conventions form a part, contains laws protecting people in times of armed conflict. The prohibition against torture in humanitarian law is expressly found in a number of provisions of the four 1949 Geneva Conventions and their Additional Protocols of 1977. An act of torture committed in the context of an armed conflict is a war crime.

Torture is also considered to be a crime against humanity when the acts are perpetrated as part of a widespread or systematic attack against a civilian population, whether or not they are committed in the course of an armed conflict.

Under international law, the use of torture can be regarded as both the responsibility of the state itself and the individual criminal responsibility of persons involved. Those who carry out the act of torture can be tried in domestic and international courts.

In summary, the strong and unequivocal prohibition of torture means that torture can never be justified, in any situation, including public emergencies and even war. No case of torture, whatever the circumstances, can be ignored.

A number of UN bodies have been created by particular conventions to monitor compliance with these standards and provide guidance on how they should be interpreted. These bodies generally issue general comments and recommendations, review reports by states parties and issue concluding observations on the compliance of a state with the relevant convention. Some also consider complaints from individuals who claim to have suffered violations. In this way they can provide authoritative interpretations of the treaty provisions and the obligations that these place on states parties.

1.7 The United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1984

The UN Convention against Torture was adopted by the UN General Assembly in 1984. One hundred and thirty states were party to the Convention by August 2002. The Convention defines torture and specifies that states parties must prohibit torture in all circumstances. Torture cannot be justified during a state of emergency, or other exceptional circumstances, nor because of superior orders received by an official. The Convention prohibits the forcible return or extradition of a person to another country where he or she is at risk of torture. States must ensure that all acts of torture are offences under its criminal law – including complicity and participation in and incitement to such acts. States must establish jurisdiction over such offences in cases of torture where the alleged offenders are not extradited to face prosecution in another state, regardless of the state in which the torture was committed, or the nationality of the perpetrator or the victim (‘universal jurisdiction’). In exercising universal jurisdiction states are obliged to take suspected perpetrators of torture into custody, to undertake inquiries into allegations of torture and to submit suspected torturers to the prosecuting authorities. States must also co-operate with one

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4 Art. 2, the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
5 Art. 3 ibid.
6 Art. 4, ibid.
7 Articles 5, ibid.
8 Articles 6–8, ibid.
another to bring torturers to justice. Statements made as a result of torture may not be invoked in evidence – except against the alleged torturer. Victims of torture also have a right to redress and adequate compensation.

The Convention against Torture also obliges states parties to take effective measures to combat torture. States undertake to train law enforcement, medical personnel, and any other persons who may be involved in the custody, interrogation or treatment of detained individuals, about the prohibition of torture and ill-treatment. Interrogation rules and custody arrangements are to be kept under review to aid in preventing any acts of torture and ill-treatment. States must actively investigate acts of torture and ill-treatment – even if there has not been a formal complaint about it. Individuals have a right to complain about acts of torture and ill-treatment, to have their complaints investigated and to be offered protection against consequent intimidation or ill-treatment. Acts of cruel, inhuman or degrading treatment or punishment that do not amount to acts of torture are also prohibited and the provisions discussed in this paragraph also apply to such acts.

1.8 Torture in the World Today

Amnesty International documented cases of torture and other cruel, inhuman or degrading treatment in 81 countries in 2007. Some studies indicate that between 5 and 35% of the world’s refugees have been estimated to have experienced torture. In 2007, there were 15.9 million refugees around the world and an estimated 26 million people displaced internally by conflict. This suggests that the number of torture survivors in the world today may range from 2 to 15 million. These estimates do not include those affected by war or other human rights violations.

Among foreign-born patients presenting to an urban primary care center in the United States, approximately 1 in 9 met the definition established by the UN Convention Against Torture. As survivors of torture, these patients may have significant psychological and physical sequelae. This statistic underscores the necessity for primary care physicians to screen for a torture history among foreign-born patients and to effectively address their problems.

1.9 Country-Specific Legal Standards and Torture Practises

9 Article 9, ibid.
10 Article 15, ibid.
11 Article 14, ibid.
12 Article 10, ibid.
13 Article 11, ibid.
14 Article 12, ibid.
15 Article 13, ibid.
16 Article 16, ibid.
Torture practises vary, to some extent, in different regions of the world, as do national legal standards, and the extent of human rights monitoring and documentation of such practises. A systematic, country-specific review of legal standards and torture practises is beyond the scope of this Curriculum. The editors of the Model Curriculum advise instructors and students to research and include relevant country-specific materials for effective national adaptation of the modules contained in this curriculum. The Prevention through Documentation Project has included 10 target countries (Georgia, Mexico, Morocco, Sri Lanka Uganda, Ecuador, Egypt, Kenya, the Philippines, and Serbia). Country assessment reports by the IRCT are available (see: http://www.irct.org/Target-countries-2709.aspx) and may serve as a model for national adaptation efforts. A series of national adaptation resources have been developed to relate generic, international materials to local settings (see: http://www.irct.org/Purpose---principles-2715.aspx or contact the IRCT for additional information).

The following additional resources may be helpful in researching relevant country conditions:

**Human Rights Reports**

- United Nations Special Rapporteur on Torture: http://www2.ohchr.org/english/issues/torture/rapporteur
- The Council of Europe's Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT): http://cpt.coe.int/en
- The Country Reports on Human Rights Practises: http://www.state.gov/g/drl/rls/hrrpt
- Amnesty International: http://www.amnesty.org
- Human Rights Watch: http://www.hrw.org
- International Federation of Red Cross and Red Crescent Societies. http://www.ifrc.org
- International Rehabilitation Council for Torture Victims: http://www.irct.org
- Physicians for Human Rights: http://www.phrusa.org
- Médicins du Monde: http://www.medecinsdumonde.org

**Treatment Centers for Survivors of Torture**

- IRCT Members, Available at: http://www.irct.org/Find-IRCT-members-33.aspx

### 1.10 The Perpetrators

**State actors (those who act on behalf of the state)**

As is emphasised above, the legal definition of torture implies that the behaviour in question be carried out by, or with the approval of, a representative of the authority in power. Considering the common purposes of torture, which may be to obtain information during an interrogation, or sometimes, to intimidate the population as a whole in the face of
insurrection or disturbance, it is unsurprising that the principal perpetrators are those officials involved in the criminal investigation process, and those responsible for the security of the state.

This means that those most likely to be involved in torture and other forms of ill-treatment include:

- The police
- The gendarmerie (in countries where this institution exists)
- The military
- State intelligence agents
- Paramilitary forces or other armed groups acting in connection with official forces
- State-controlled counter-insurgency forces
- Prison officers
- Private contractors carrying out any of the above activities
- Co-detainees or other members of the general population acting with the acquiescence of or on the orders of public officials.

Health professionals, even those not directly employed by the state, may also be involved in acts of torture and other ill-treatment. Doctors, psychiatrists or nurses might participate in torture either by direct involvement (be it through medical monitoring of the torture, certifying someone fit for interrogation, or even using medical knowledge to design or refine methods of torture or other ill-treatment), by assisting in a cover-up (for example, by issuing misleading medical reports), or by omission (such as failing to give necessary treatment). As noted earlier, torture is a crime, and any involvement in torture can lead to criminal charges being brought against those involved, including health professionals.

**Non-state actors**

In addition, torture often occurs in the context of armed conflicts, particularly internal conflicts involving forces in opposition to the recognised authorities, and which exercise effective power. In such circumstances, torture and other forms of ill-treatment may also be inflicted, for example by opposition forces, who are also bound by customary international law and Geneva Convention standards to refrain from torture.

Furthermore, if an organised group, whether or not it is a party to an armed conflict, engages in acts of torture or other ill-treatment against a civilian population, on a systematic or widespread scale, it can be guilty under international law of violating the prohibition of torture or other ill-treatment.

**Protection from Third Parties**

The main focus of this Curriculum is on torture and other ill-treatment by state agents, particularly law enforcement officials. However, there is also a growing acceptance of the importance of safeguarding people from similar treatment carried out by private groups or individuals. States are responsible for safeguarding the rights of everyone within their jurisdiction and may under some circumstances be held accountable for acts carried out by private individuals if it supports or tolerates them, or fails in other ways to provide effective protection in law and in practise against them.

**1.11 Common Situations for Torture Allegations**

Torture and other forms of ill-treatment may take place in virtually any location. People are particularly at risk when they are deprived of their liberty, held in pre-trial detention or
subject to interrogation. The greatest risk is in the first phase of arrest and detention, before the person has access to a lawyer or court. People being held in incommunicado detention – without access to anyone in the outside world – are particularly vulnerable.

In some countries, torture is commonplace. Certain times and situations could, however, be considered as high-risk circumstances. These include conflict zones, and situations of political unrest or general violence.

Allegations of torture can come from a variety of sources and at different times. The primary source of information is clearly from the individuals themselves, and this could happen while in custody, immediately after release, or at a later date. The families of survivors are another extremely important source of information as the survivors of torture themselves may be unable, or unwilling, to speak out. In any of the descriptions below, the role of families should also be kept in mind. Information can also come from other sources, such as the media and the work of non-governmental organisations.

Health professionals may find themselves being called upon to assist with an investigation in addition to providing medical treatment. Documentation may range from clear, comprehensive notes that may be summarised later, to a full medico-legal report. Sometimes useful evidence can be gained from analysing clinical data on survivors of torture and presenting them in a way that does not permit individuals to be identified.

Detainees are probably the segment of population most likely to suffer torture and other ill-treatment since this kind of abuse is usually inflicted while an individual is in some form of custody. The greatest risk of torture and other forms of ill-treatment to individuals is in the first phase of arrest and detention, before they have access to a lawyer or court. Furthermore, incommunicado detention, which prohibits access to anyone such as their lawyer or family, is probably the single highest risk factor for torture since there is no external monitoring of the detention and interrogation process.

It should also be remembered that while torture per se is less common once a person is on remand or sentenced and in prison, deliberately poor conditions of detention, certain treatment or punishments inflicted by staff, or a failure to protect individuals from other prisoners, may also amount to forms of ill-treatment or, in some cases, torture.

1.12 Where Does Torture and Ill-treatment Occur?

Torture can occur anywhere but usually occurs during the initial phase of arrest and detention, thus often in the hands of police, gendarmerie, military or other security agencies and may be in official places of detention such as police stations, or in unofficial (or 'secret') locations. The fact that torture may not just be confined to places of detention is recognised in the Statute of the International Criminal Court, which states that it may occur when a person is “in the custody or control” of a party. Torture and other forms of cruel, inhuman and degrading treatment or punishment can also occur in the hands of opposition forces and informal militias. There is a duty on the state to protect people from these groups and to investigate and punish as necessary.

Torture is not just limited to what happens in the interrogation room, but may also relate to specific elements of the conditions of detention which are constructed to deliberately aggravate the mental and physical suffering. Often the generally harsh conditions of detention (including inadequate or insufficient food, hygiene, personal cleanliness, access to toilets, and access to medical care) are aimed at exerting further pressure on individuals and contribute to and form part of ill-treatment that may in some cases constitute torture.
1.13 Obligation to Investigate and Bring to Justice

The prohibition of torture is not limited to a negative obligation to refrain from causing suffering, but also contains wider obligations including the obligation to investigate allegations and bring the perpetrators to justice. The UN Convention Against Torture (UNCAT) states clearly in article 12: “Each State Party shall ensure that its competent authorities proceed to a prompt and impartial investigation, wherever there is reasonable ground to believe that an act of torture has been committed in any territory under its jurisdiction.” The next article adds an obligation to ensure that individuals have the possibility to lodge a complaint, and that this complaint be investigated.

The European Court of Human Rights (ECtHR) has noted that without such a duty to investigate, “the general legal prohibition of torture and inhuman and degrading treatment and punishment, despite its fundamental importance, would be ineffective in practise and it would be possible in some cases for agents of the state to abuse the rights of those within their control with virtual impunity.” The Inter-American Court of Human Rights has similarly found the failure to mount an effective investigation to be a violation of the right to be protected against torture and inhuman treatment.

Investigations should not be dependent on the lodging of a complaint. States must launch an investigation whenever there is reasonable suspicion that torture has taken place. The ECtHR has stated in this regard that where an individual is taken into police custody in good health but is found to be injured at the time of release, it is incumbent on the state to provide a plausible explanation as to the cause of the injury. Since it is likely that health professionals would be amongst the first to discover any signs of abuse, the initiation of an investigation relies heavily on their awareness, assessment and subsequent action.

1.14 Formal Inspection of Detention Facilities

There are a number of bodies that may have the ability to conduct regular inspection of detention facilities. These could be monitoring bodies from within the prison authority; governmental inspection bodies; independent ombudsmen; national human rights commissions; the office of the public defender or other bodies from within the legal system; international organisations; domestic non-governmental organisations (NGOs).

The International Committee of the Red Cross (ICRC) visits people deprived of freedom in times of armed conflict, to check that they are treated humanely and in accordance with international law (both humanitarian law and human rights law). The ICRC undertakes visits under nonnegotiable modalities which include: access to all places of detention and all people detained and to make a register of all those who wish to have their details recorded; the possibility to select individual detainees to talk with in private, and the possibility to repeat the visits as often as is deemed necessary. During visits, the ICRC takes the humane treatment of detainees to encompass not only freedom from torture and other ill-treatment, but also general conditions of detention that maintain both the physical and mental integrity of the individuals. Their findings are communicated and discussed on a confidential basis with the concerned authorities.

Other bodies, particularly human rights NGOs, are sometimes more likely to gain ad hoc permission to conduct an inspection, rather than regular access. On occasion, inspections might be limited by restricted access to the detainees, or detainees may be wary of complaining for fear of retribution. In such cases it is nevertheless often possible for the
inspection team to assess the likelihood of prevailing ill-treatment, especially in relation to
the physical conditions of detention. Most often, existing national oversight mechanisms will
have most access to prisons, but may have less access to police stations. Access to
interrogation centres and military camps may be even more restricted.

Recognising the vulnerability and need for enhanced protection of people in custody, the UN
adopted an Optional Protocol to the UN Convention Against Torture in December 2002. This
instrument creates a mechanism for regular inspection, by independent international and
national bodies, of all places where people are deprived of liberty, within countries that
agree to be bound by this Protocol.

**1.15 Official Complaints to Human Rights Bodies and Other Organisations**

Allegations of torture and other ill-treatment can be presented to a variety of human rights bodies. Many countries have a human rights ombudsman or a commission which might receive and investigate complaints. This might also be a body with a specific mandate on treatment of prisoners. Additionally, there are numerous regional and international human rights mechanisms which can also, under certain circumstances, receive allegations. These include the UN Committee Against Torture, the UN Human Rights Committee, the UN Special Rapporteur on Torture, the UN Special Rapporteur on the Right to Health, the UN Special Rapporteur on Violence against Women, the European Court of Human Rights, the African Commission on Human and Peoples’ Rights, the Inter-American Commission on Human Rights and others (see The Torture Reporting Handbook, section 8.2).

In situations where the ICRC is active, the humanitarian organisation can, under specific circumstances, receive allegations of arrest and detention of individuals and make direct enquiries of their whereabouts with the authorities and during visits to places of detention. If located, the ICRC is often able to put the detainee in contact with their family through a system of Red Cross Messages.

**1.16 Recently Released Detainees**

Individuals who have recently been released from detention or prison might seek medical and legal advice concerning their treatment while in custody. This could, in some circumstances, be their first opportunity to detail fully their conditions of detention and any ill-treatment they may have undergone. The continuing physical and mental effects of ill-treatment may also lead recently released detainees to seek medical treatment. The initial concern of the individual seeking medical care might be to receive treatment, rather than the actual allegation of torture, but good contemporaneous notes will help if he or she wants these effects to be documented in due course. The person giving advice or treatment should inquire sensitively into the possibility of ill-treatment, and advise on avenues of further action (see The Torture Reporting Handbook, section 8.2).

**1.17 NGO Information Gathering**

Non-governmental human rights organisations, including medical organisations, or any other body engaged in monitoring and advocacy, may uncover evidence of torture and other ill-treatment during their work. Through a combination of meticulous research including field-work, interviews with survivors and families, meetings with public officials, information from the media, and cooperation between organisations, it may be possible to identify a pattern of human rights abuses that may not have been evident when viewing each source
separately. This is often the way in which systematic torture and other ill-treatment come to light.

1.18 Late Allegations

Given the traumatic effects of torture, evidence may be kept concealed by survivors before being disclosed by them much later. The newly disclosed evidence could be the result of a change in government or government policy which can lead to an uncovering of the actions of their predecessors. Mountains of evidence can surface through various types of truth and reconciliation commissions which are working to uncover past abuses as part of a national healing process. Additionally, allegations might come to light at different stages of a legal process, even at quite late stages. There have also been cases when acknowledgement of torture practices appeared in interviews and publications of retired officials who had been responsible for acts of torture or other ill-treatment earlier in their lives.

2. Prevention and Accountability

Preventing torture and other forms of ill-treatment is primarily an act of political or professional will and the responsibility to combat it extends to all those in authority in society. Judges and prosecutors, given their role in upholding the rule of law, have a particular responsibility to help prevent acts of torture and ill-treatment by promptly and effectively investigating such acts, prosecuting and punishing those responsible and providing redress to the victims. Preventing and investigating alleged acts of torture poses particular problems for judges and prosecutors, and for the administration of justice, because the crime is usually committed by the same public officials who are generally responsible for upholding and enforcing the law. This makes it more difficult to deal with than other forms of criminality. Nevertheless, judges and prosecutors have a legal duty to ensure that the integrity of their profession and the justice they uphold are not compromised by the continued tolerance of torture, or other forms of ill-treatment.

Health professionals should understand that medical documentation of torture and ill-treatment is one of many critical prevention and accountability measures. The following obligations on governments to ensure protection against torture as recognised in international treaties and customary international law\(^{21}\) illustrates the context within which medical documentation occurs. These prevention and accountability measures also demonstrate a range of advocacy activities in which health professionals can and should consider for the prevention of torture and ill-treatment.

2.1 Prevention

\(^{21}\) In particular the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Articles 7 and 10 of the International Covenant on Civil and Political Rights, Article 3 of the European Convention on Human Rights, Article 5 of the African Charter on Human and Peoples’ Rights, Article 5 Of the American Convention on Human Rights and the Inter-American Convention to Prevent and Punish Torture. Torture is also prohibited under international humanitarian law, in particular common Article 3 to the four Geneva Conventions of 1949, and constitutes an international crime, both in its own right and as an element of genocide, crimes against humanity and war crimes. See on the obligations of states parties under the Convention against Torture, REDRESS, Bringing the International Prohibition of Torture Home: National Implementation Guide for the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, January 2006.
To take effective legislative, administrative, judicial or other measures to prevent acts of torture, for example, by:

- Establishing effective monitoring mechanisms to prevent torture in all places of detention;
- Ensuring that any statement that is established to have been made as a result of torture shall not be invoked as evidence in any proceedings, except against a person accused of torture as evidence that the statement was made;
- Ensuring that the prohibition of torture is included in training of law enforcement and medical personnel, public and other relevant officials;
- Not expelling, returning, extraditing or otherwise transferring a person to a country when there are substantial grounds for believing that the person would be tortured (non-refoulement).

To ensure that general safeguards against torture exist in places of detentions such as:

- Granting detainees prompt and unrestricted access to a lawyer and a doctor of their choice;
- Informing family members or friends about the person’s detention;
- Providing detainees access to family members and friends;
- Not holding persons in incommunicado detention;
- Enabling detainees to promptly challenge the legality of their detention before a judge.

2.2 Accountability

(i) To effectively investigate allegations of torture by:

- Putting into place an effective complaints procedure, such as providing adequate victim and witness protection;
- Ensuring that the relevant authorities undertake a prompt and impartial investigation whenever there are reasonable grounds to believe that torture has been committed;
- Guaranteeing that all allegations of torture are effectively investigated.

(ii) To ensure that alleged perpetrators are subject to criminal proceedings by:

- Criminalising acts of torture, including complicity or participation, and excluding the defences of necessity or superior orders;
- Ensuring that the alleged perpetrators are subject to criminal proceedings if an investigation establishes that an act of torture appears to have been committed;
- Imposing punishments that reflect the seriousness of the crime;
- Enshrining the principle of universal jurisdiction, enabling the investigation and prosecution of torturers irrespective of the place where the torture was committed and the nationality of either the victim or the perpetrator; and
- Making torture an extraditable offence and providing assistance to other national governments seeking to investigate and/or prosecute persons accused of torture.

2.3 Reparation

(i) To ensure that victims of torture have the right to an effective remedy and adequate reparation by:
• Ensuring that victims of torture have effective procedural remedies, both judicial and non-judicial, to protect their right to be free from torture in law and practise;
• Guaranteeing that domestic law reflects the different forms of reparation recognised under international law and that the reparations afforded reflect the gravity of the violation(s).

3. International Supervisory Machinery and Complaints Procedures

3.1 The Human Rights Committee

The Human Rights Committee is established as a monitoring body by the International Covenant on Civil and Political Rights (ICCPR). The Committee comprises 18 independent experts elected by the states parties to the Covenant. It examines reports which states parties are obliged to submit periodically and issues concluding observations that draw attention to points of concern and make specific recommendations to the state. The Committee can also consider communications from individuals who claim to have been the victims of violations of the Covenant by a state party. For this procedure to apply to individuals, the state must also have become a party to the first Optional Protocol to the Covenant. The Committee has also issued a series of General Comments, to elaborate on the meaning of various Articles of the Covenant and the requirements that these place on states parties. The General Comment regarding Article 7 is contained in Appendix One of this manual.

3.2 The UN Committee against Torture

The Committee against Torture is a body of ten independent experts established under the Convention against Torture. It considers reports submitted by States Parties regarding their implementation of the provisions of the Convention and issues concluding observations. It may examine communications from individuals, if the state concerned has agreed to this procedure by making a declaration under Article 22 of the Convention. There is also a procedure, under Article 20, by which the Committee may initiate an investigation if it considers there to be ‘well-founded indications that torture is being systematically practised in the territory of a State Party’.

A new Optional Protocol was adopted by the UN General Assembly in December 2002. This established a complementary dual system of regular visits to places of detention in order to prevent torture and ill-treatment. The first of these is an international visiting mechanism, or a ‘Sub-Committee’ of ten independent experts who will conduct periodic visits to places of detention. The second involves an obligation on states parties to set up, designate or maintain one or several national visiting mechanisms, which can conduct more regular visits. The international and national mechanisms will make recommendations to the authorities concerned for the purposes of improving the treatment of persons deprived of their liberty and the conditions of their detention.

3.3 Regional mechanisms
A number of regional human rights treaties have also been developed within the Council of Europe (CoE), the Organisation of American States (OAS) and the African Union (AU). The rights protected by these treaties derive from, and are similar to, those of the Universal Declaration of Human Rights, but each treaty has developed unique approaches when seeking to implement them. The principal instruments referred to here are:

- the European Convention on Human Rights
- the European Convention for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment
- the American Convention on Human Rights
- the Inter-American Convention to Prevent and Punish Torture

The European Court of Human Rights, the Inter-American Commission on Human Rights, the Inter-American Court of Human Rights, the African Commission on Human Rights and the (soon to be established) African Court on Human Rights are responsible for monitoring state-compliance with their respective treaties. These bodies examine allegations of torture on the same level as other alleged human rights violations. However, the CoE has also created a specific body for preventing torture in its member states.

The European Committee for the Prevention of Torture (CPT) was set up under the 1987 Council of Europe European Convention for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment. It is composed of as many independent and impartial members as there are states parties to the Convention and may be assisted by ad hoc experts. Currently all members of the CoE have also ratified the European Convention for the Prevention of Torture. The CPT conducts periodic and ad hoc visits in any places under the jurisdiction of a contracting state where persons are deprived of their liberty by a public authority. States parties are obliged to provide the CPT with access to its territory and the right to travel without restriction; full information on the places where persons deprived of their liberty are being held; unlimited access to any place where persons are deprived of their liberty, including the right to move inside such places without restriction; and other information which is necessary for the CPT to carry out its task. The CPT is also entitled to interview, in private, persons deprived of their liberty and to communicate freely with anyone whom it believes can supply relevant information. The report on the visit and detailed recommendations sent to the government are confidential unless the government concerned decides that they can be published. In practice, most reports have been made public.

3.4 Other monitoring mechanisms

A number of other mechanisms have been developed by the UN Commission on Human Rights (since 2006, the UN Human Rights Council) to look at specific types of human rights violations wherever in the world they occur. These country-specific and thematic mechanisms include special rapporteurs, representatives and independent experts or working groups. They are created by resolution in response to situations that are considered to be of sufficient concern to require an in-depth study. The procedures report publicly to the Commission on Human Rights each year and some also report to the UN General Assembly.

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22 Formerly the Organisation for African Unity (OAU).
23 Article 8, European Convention for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment 1987.
The main thematic mechanisms of relevance for this manual are: the Special Rapporteur on Torture, the Special Rapporteur on Violence Against Women, the Special Rapporteur on the Independence of Judges and Lawyers, the Working Group on Enforced or Involuntary Disappearances, and the Working Group on Arbitrary Detention. A number of other thematic mechanisms also exist. The work of these bodies is not mutually exclusive and they may make either joint or separate interventions in connection with the same allegation.

3.5 The UN Special Rapporteur on Torture and other Cruel, Inhuman and Degrading Treatment or Punishment

Established in 1985 by the UN Commission on Human Rights, this mandate is a non-treaty, “UN Charter-based” body, the purpose of which is to examine international practise relating to torture in any state regardless of any treaty the state may be bound by. On the basis of information received, the Special Rapporteur can communicate with governments and request their comments on cases that are raised. He or she can also make use of an “urgent action” procedure, requesting a government to ensure that a particular person, or group of persons, are treated humanely. The Special Rapporteur can also conduct visits if invited, or given permission, by a state to do so. The reports of these missions are usually issued as addenda to the main report of the Special Rapporteur to the UN Commission on Human Rights.

The Special Rapporteur reports annually and publicly to the UN Commission on Human Rights and to the UN General Assembly. The reports to the Commission contain summaries of all correspondence transmitted to governments by the Special Rapporteur and of correspondence received from governments. The reports may also include general observations about the problem of torture in specific countries, but do not contain conclusions on individual torture allegations. The reports may address specific issues or developments that influence or are conducive to torture in the world, offering general conclusions and recommendations.

3.6 International criminal courts and tribunals

National criminal courts are primarily responsible for the investigation and prosecution of crimes of torture and other criminal forms of ill-treatment. A number of ad hoc international criminal tribunals have been established in recent years – including the International Criminal Tribunal for the former Yugoslavia (ICTY) and the International Criminal Tribunal for Rwanda (ICTR). Crimes of torture as crimes against humanity and war crimes are included in the Statute of ICTY,24 ICTR25 and the Rome Statute of the International Criminal Court (ICC).26 The Statute of the ICC was agreed in 1998 and received the 60 ratifications necessary for it to come into effect in 2002. The ICC will, in future, be able to prosecute some crimes of torture when national courts are unable or unwilling to do so.

3.7 The International Committee of the Red Cross (ICRC)

The ICRC is an independent and impartial humanitarian body with a specific mandate assigned to it under international humanitarian law, particularly the four Geneva Conventions. It actively provides many forms of protection and assistance to victims of armed conflict, as well as situations of internal strife. In cases of international armed conflict between states party to the Geneva Conventions, the ICRC is authorised to visit all places of

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24 Article 5, ICTY.
25 Article 3, ICTR.
26 Articles 7 and 8, ICC.
internment, imprisonment and labour where prisoners of war or civilian internees are held. In cases of non-international armed conflicts, or situations of internal strife and tensions, it may offer its services to the conflicting parties and, with their consent, be granted access to places of detention. Delegates visit detainees with the aim of assessing and, if necessary, improving the material and psychological conditions of detention and preventing torture and ill-treatment. The visit procedures require access to all detainees and places of detention, that no limit be placed on the duration and frequency of visits, and that the delegates be able to talk freely and without witness to any detainee. Individual follow-up of the detainees’ whereabouts is also part of ICRC standard visiting procedures. Visits and the reports made on them are confidential – although the ICRC may publish its own comments if a state publicly comments on a report or visit.

4. Safeguards Against Torture for Those Deprived of Their Liberty

It is important for clinicians who conduct medical evaluations of torture and ill-treatment to be familiar with legal safeguards against torture for those deprived of their liberty. Everyone has the right to liberty and security of person – including the right to be free from arbitrary arrest or detention. When the state deprives a person of liberty, it assumes a duty of care to maintain that person’s safety and to safeguard his or her welfare. Detainees are not to be subjected to any hardship or constraint other than that resulting from the deprivation of liberty. These rights are guaranteed by Article 7 and 10(1) of the International Covenant on Civil and Political Rights (ICCPR) which, respectively, prohibit torture and ill-treatment and safeguard the rights of people deprived of their liberty. The prohibition on torture and ill-treatment apply to all people all the time. Certain rights in the treaties, such as the right not to be subject to arbitrary detention, may under certain circumstances be restricted in a public emergency, but safeguards necessary for the prohibition of torture, such as limiting periods in which people can be held in incommunicado detention, must continue to apply.

Individuals may be at risk of torture or ill-treatment before they are subject to legal formalities such as arrest and charge. Indeed the European Committee for the Prevention of Torture (CPT) has stressed that it is during the period immediately following deprivation of liberty that the risk of torture and ill-treatment is at its greatest. The following international standards, therefore, apply from the moment that someone is deprived of his or her liberty.

27 Article 9 (1) International Covenant on Civil and Political Rights; Article 5 European Convention on Human Rights; Article 6 African Charter of Human and People’s Rights; Article 7 American Convention on Human Rights.
30 European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment, the CPT Standards, Substantive Sections of the CPT’s General Reports, Council of Europe, October 2001, CPT/Inf/E(2002), p.12, para. 41.
4.1 Notifying people of their rights

Everyone deprived of liberty has the right to be given a reason for the arrest and detention. Article 9(1) of the ICCPR states that: 'Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law.'

4.2 Use of officially recognised places of detention and the maintenance of effective custody records

The Human Rights Committee has stated that ‘to guarantee the effective protection of detained persons, provisions should be made for detainees to be held in places officially recognised as places of detention and for their names and places of detention, as well as for the names of persons responsible for their detention, to be kept in registers readily available and accessible to those concerned, including relatives and friends. The European Court of Human Rights has stated that the unacknowledged detention of an individual is a ‘complete negation’ of the guarantees contained in the European Convention against arbitrary deprivations of the right to liberty and security of the person.

The CPT recommends that there should be a complete custody record for each detainee which should record “all aspects of custody and action taken regarding them (when deprived of liberty and reasons for that measure; when told of rights; signs of injuries, mental illness, etc; when next of kin/consulate and lawyer contacted and when visited by them; when offered food; when interrogated; when transferred or released, etc). Further, the detainee’s lawyers should have access to such a custody record.”

The UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment state that the authorities must keep and maintain up-to-date official registers of all detainees, both at each place of detention and centrally. The information in such registers must be made available to courts and other competent authorities, the detainee, or his or her family. Further to this, these principles state that “in order to supervise the strict observance of relevant laws and regulations, places of detention shall be visited regularly by qualified and experienced persons appointed by, and responsible to, a competent authority distinct from the authority directly in charge of the administration of the place of detention or imprisonment. A detained or imprisoned person shall have the right to communicate freely and in full confidentiality with the persons who visit the places of detention or imprisonment . . . subject to reasonable conditions to ensure security and good order in such places.”

4.3 Avoiding incommunicado detention

32 Çakici v Turkey, ECtHR, Judgment 8 July 1999, para. 104.
34 Principle 12.
35 Ibid.
36 Principle 29.
International standards do not expressly prohibit incommunicado detention – where a detainee is denied all contact with the outside world – in all circumstances. However, international standards provide and expert bodies have maintained that restrictions and delays in granting detainees access to a doctor and lawyer and to having someone notified about their detention are permitted only in very exceptional circumstances for very short periods of time.

The Human Rights Committee has found that the practise of incommunicado detention is conducive to torture and may itself violate Article 7 or Article 10 of the ICCPR. It has stated that provision should also be made against incommunicado detention as a safeguard against torture and ill-treatment.

The UN Commission on Human Rights has stated that "prolonged incommunicado detention may facilitate the perpetration of torture and can in itself constitute a form of cruel, inhuman or degrading treatment." The UN Special Rapporteur on Torture has stated that "torture is most frequently practised during incommunicado detention. Incommunicado detention should be made illegal, and persons held incommunicado should be released without delay."

4.4 Humane conditions of detention

The Human Rights Committee has stated that the duty to treat detainees with respect for their inherent dignity is a basic standard of universal application. States cannot claim a lack of material resources or financial difficulties as a justification for inhumane treatment. States are obliged to provide all detainees and prisoners with services that will satisfy their essential needs. Failure to provide adequate food and recreational facilities constitutes a violation of Article 10 of the ICCPR, unless there are exceptional circumstances. The Committee has also stated that prolonged solitary confinement may amount to a violation of the prohibition against torture and ill-treatment in Article 7 of the ICCPR.

The Basic Principles for the Treatment of Prisoners provide that states should undertake efforts to abolish solitary confinement as a punishment or to restrict its use. The Standard Minimum Rules for the Treatment of Prisoners specify that 'corporal punishment, punishment by placing in a dark cell, and all cruel, inhuman or degrading punishments shall be completely prohibited as punishments for disciplinary offences.' The CPT has stressed that solitary confinement can have "very harmful consequences for the person concerned" and that, in certain circumstances, solitary confinement can "amount to inhuman and degrading treatment" and should, in all circumstances, be applied for as short a period as possible.

4.5 Limits on interrogation

39 Human Rights Committee General Comment 20, para.11.
40 Resolution 1997/38, para. 20.
42 Human Rights Committee General Comment 20, para. 6.
43 Principle 7 of the Basic Principles for the Treatment of Prisoners.
44 Rule 31.
45 CPT/Inf/E (2002) 1, p.20 para. 56(2).
Article 11 of the Convention against Torture requires states to keep under systematic review interrogation rules, instructions, methods and practises as well as arrangements for the custody and treatment of persons under arrest, detention or imprisonment. The Human Rights Committee has stated that: 'keeping under systematic review interrogation rules, instructions, methods and practises as well as arrangements for the custody and treatment of persons subjected to any form of arrest, detention or imprisonment is an effective means of preventing cases of torture and ill-treatment.' The Committee has also stated that, 'the wording of Article 14(3)(g) – i.e. that no one shall be compelled to testify against himself or to confess guilt – must be understood in terms of the absence of any direct or indirect physical or psychological pressure from the investigating authorities on the accused, with a view to obtaining a confession of guilt. A fortiori, it is unacceptable to treat an accused person in a manner contrary to Article 7 of the Covenant in order to extract a confession.'

### 4.6 Access to a lawyer and respect for the functions of a lawyer

The general right of those who have been arrested and detained to have access to legal advice is recognised in Article 14 of the ICCPR and a variety of other instruments relating to the right to a fair trial. The promptness of access to a lawyer is also most important from the point of view of preventing torture and ill-treatment. The Human Rights Committee has stressed that the protection of the detainee requires prompt and regular access to be given to doctors and lawyers and that 'all persons arrested must have immediate access to counsel’ for the more general protection of their rights. Counsel must communicate with the accused in conditions giving full respect for the confidentiality of their communications. The authorities must also ensure that lawyers advise and represent their clients in accordance with professional standards, free from intimidation, hindrance, harassment, or improper interference from any quarter.

### 4.7 Access to a doctor

The Human Rights Committee has stated that the protection of detainees requires that each person detained be afforded prompt and regular access to doctors.

The Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment state that 'a proper medical examination shall be offered to a detained or imprisoned person as promptly as possible after his admission to the place of detention or imprisonment, and thereafter medical care and treatment shall be provided whenever necessary. This care and treatment shall be provided free of charge. Detainees have the right to request a second medical opinion by a doctor of their choice, and to have access to

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46 Human Rights Committee General Comment 20, para. 11.
48 Human Rights Committee General Comment 20, para. 11.
51 Ibid.
52 Human Rights Committee General Comment 20, para. 11.
their medical records.\textsuperscript{54} The UN Standard Minimum Rules for the Treatment of Prisoners state that detainees or prisoners needing special treatment must be transferred to specialised institutions or civil hospitals for that treatment.\textsuperscript{55}

### 4.8 The right to challenge the lawfulness of detention

Article 9 (3) of the ICCPR states that: ‘Anyone arrested or detained on a criminal charge shall be brought promptly before a judge or other officer authorized by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release.’ The Human Rights Committee has stated that the right to challenge the legality of detention applies to all persons deprived of their liberty and not just to those suspected of committing a criminal offence.

### 4.9 Safeguards for special categories of detainees

All detained people have the right to equal treatment without discrimination on the grounds of race, colour, sex, sexual orientation, language, religion, political or other opinion, national or social origin, property, birth or other status. Particular allowances should, however, be made for the rights and needs of special categories of detainees including women, juveniles, elderly people, foreigners, ethnic minorities, people with different sexual orientation, people who are sick, people with mental health problems or learning disabilities, and other groups or individuals who may be particularly vulnerable during detention. Some groups may be targeted for discriminatory abuse by the staff of the institution where they are detained. They may also be vulnerable to abuse from other detainees.

#### Women in detention

The Human Rights Committee has expressed concern at the practise of allowing male prison officers access to women’s detention centres, which has led to serious allegations of sexual abuse of women and the invasion of their privacy.\textsuperscript{56} It has also stated that female staff should be present during the interrogation of female detainees and prisoners and should be solely responsible for conducting body searches.\textsuperscript{57}

The Standard Minimum Rules for the Treatment of Prisoners state that women in custody should be supervised by female members of staff.\textsuperscript{58} They should also either be held in separate institutions, or segregated within an institution, under the authority of female staff. No male staff should enter the part of the institution set apart for women unaccompanied by a female member of staff.\textsuperscript{59} In institutions where women are held in custody, facilities for pre-natal and post-natal care and treatment must be provided.\textsuperscript{60} Whenever possible, arrangements should be made for children to be born in a hospital outside the institution.\textsuperscript{61} The UN Special Rapporteur on Torture has recommended that

\begin{itemize}
\item [54] Principle 25.
\item [55] Rule 22(2) of the Standard Minimum Rules.
\item [56] Observations of the Human Rights Committee: USA, UN Doc. CCPR/C/79/Add.50, 7 April 1995, para.20.
\item [58] Standard Minimum Rules 8(a) and 53.
\item [59] Ibid.
\item [60] Rule 23.
\item [61] Ibid.
\end{itemize}
states should provide gender-sensitive training for judicial and law enforcement officers and other public officials.62

**Juvenile detainees**

Some specific obligations with respect to the use of pre-trial detention in cases involving children are found in the Convention on the Rights of the Child. The Convention applies to children up to the age of 18, who would normally be regarded as juveniles within most criminal justice systems. Article 37 emphasises that the detention of children – pre-trial or any other form – should be a measure of last resort and used for the shortest appropriate period of time. It requires due account to be taken of the needs of children who are deprived of their liberty and that they should be kept separately from adults unless it is considered in their best interest not to do so. Article 39 obliges states, *inter alia*, to promote physical and psychological recovery and social reintegration of a child victim of torture or any other form of cruel, inhuman or degrading treatment or punishment as well as any form of neglect, exploitation, or abuse.

**People with mental health problems**

The Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care state that: 'All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.'63 'All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.'64

The Standard Minimum Rules for the Treatment of Prisoners also state that people with mental health problems shall not be detained in prisons and 'shall be observed and treated in specialized institutions under medical management.'65

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63 Principle 2.
64 Principle 3.
65 Standard Minimum Rules para. 82.
MODULE 2

Istanbul Protocol Standards for Medical Documentation of Torture and Medical Ethics

OBJECTIVES

- To familiarize students with the purpose, history, significance of the Istanbul Protocol
- To review the overall content of the Istanbul Protocol
- To be aware of the limitation and possible misuse of the Istanbul Protocol
- To understand Istanbul Protocol standards for procedural safeguards relevant to the medical documentation of torture and ill-treatment
- To understand the medical ethical principles relevant to the medical investigation and documentation of torture and ill-treatment
- To identify the duties of health professionals in the process of investigating and documenting torture and ill-treatment
- Review current, country-specific rules and regulations regarding medical documentation of torture and ill-treatment [to be provided by Instructors]
- To identify country-specific challenges in applying international ethical standards to the effective investigation and documentation of torture and ill-treatment

CONTENT

- Review of the International Standards for the Effective Investigation and Documentation of Torture and Ill-treatment, the Istanbul Protocol
  - Purpose
  - History
  - International recognition of the Istanbul Protocol
  - Overview of Istanbul Protocol content
  - Misuse of the Istanbul Protocol
- Medical Ethics relevant to the investigation and documentation of torture and ill-treatment
  - Duties of the health professional
    - International codes
    - Ethical rules prohibiting torture
    - Primary loyalty to the patient
    - Dual Obligations
    - The treatment of prisoners and detainees
    - Issues surrounding examinations of individuals in the presence of security forces
    - Abusive medical treatment
    - Consent and Confidentiality
    - Security
    - Involvement of health professionals in torture
    - Seeking further information and support
    - UN Committee against Torture
- Country-specific legal responsibilities of the health professionals for forensic documentation of torture and ill-treatment [to be provided by instructors]
- General guidelines for gathering evidence
DISCUSSION TOPICS
- Discuss the value of the Istanbul Protocol for the effective medical investigation and documentation of torture and ill-treatment and its potential for misuse
- Compare and contrast international medical ethical standards for torture documentation and country-specific legal responsibilities of the health professionals for forensic documentation of torture and ill-treatment and provide recommendations for any conflicts identified
- Discuss international and country-specific strategies to address potential personal risks to health professionals who document torture and ill-treatment
- Discuss how health personnel in international and national professional organisations, academics and governmental and non-governmental organisations can work together for the effective investigation and prevention of torture
- Discuss the role of alternative (non-governmental) medical reports. Discuss how have they been used internationally and locally and what their effect has been.
- Discuss the relationship between health and human rights and whether health professionals have a duty to protect and promote human rights, including freedom from torture and ill-treatment

TEACHING FORMATS
- **Group Activity:**
  - Divide the class into several groups and assign each group with one or more (or all) of the Discussion Topics.
  - A facilitator should be identified to moderate the discussion and rapporteur should be identified to record the group’s findings and report them when the class reconvenes.
  - After 20-30 minutes of group discussion, the entire class should reconvene
  - Rapporteurs should briefly report on their group’s findings
  - Open class discussion
- **Individual Research/Assignment:**
  - Conduct literature research on the complicity of medical personnel in torture and write a 2-page essay developing a series of country-specific policy recommendations for the government, medical licensing board and national medical association.
  - Develop of country-specific list of organisations and bodies relevant to torture and ill-treatment
  - If not discussed in class, research the legal status of alternative (non-governmental) forensic medical reports. Indicate how have they been used internationally and locally and what their effect has been.
- **Journal Entry:** (Instructor to assign) Write a few paragraphs -- no more than a page
  - Respond to one or more of the Discussion Topics
  - Do health professionals have a duty to protect and promote human rights? Explain
why or why not.  
- How can and should health professionals document torture and ill treatment when they (or their family members) face the risk of reprisals?

**PRIMARY RESOURCES**

- *The Istanbul Protocol, Chapter II- Relevant Ethical Codes*
- *Medical Investigation and Documentation of Torture: A Handbook for Health Professionals*
- *Trainers’ Guidelines for Health Professionals: Training of Users*
- *Psychological Evaluation of Torture Allegations: An International Training Manual*
- *Action Against Torture: A Practical Guide to the Istanbul Protocol for Lawyers*

### 1.1 The Istanbul Protocol

The Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, commonly known as the Istanbul Protocol, outlines international, legal standards on protection against torture and sets out specific guidelines on how effective legal and medical investigations into allegations of torture should be conducted.

The Istanbul Protocol is an important source as it both reflects existing obligations of States under international treaty and customary international law and aids States to effectively implement relevant standards. It became a United Nations official document in 1999. The Istanbul Protocol is intended to serve as a set of international guidelines for the assessment of persons who allege torture and ill-treatment, for investigating cases of alleged torture, and for reporting such findings to the judiciary and any other investigative body. The investigation and documentation guidelines also apply to other contexts, including human rights investigations and monitoring, assessment of individuals seeking political asylum, the defence of individuals who "confess" to crimes during torture, and assessment of needs for the care of survivors of torture. In the case of health professionals who are coerced to neglect, misrepresent, or falsify evidence of torture, the manual also provides an international point of reference for health professionals and adjudicators alike.
The documentation guidelines apply to individuals who allege torture and ill-treatment, whether the individuals are in detention, applying for political asylum, refugees or internally displaced persons, or the subject of general human rights investigations. The guidelines provided cover a range of topics including:

- Relevant international legal standards
- Relevant Ethical Codes
- Legal Investigation of Torture
- General Considerations for Interviews
- Physical Evidence of Torture
- Psychological Evidence of Torture

Many procedures for a torture investigation are included in the manual, such as how to interview the alleged victim and other witnesses, selection of the investigator, safety of witnesses, how to collect alleged perpetrator’s statement, how to secure and obtain physical evidence, and detailed guidelines on how to establish a special independent commission of inquiry to investigate alleged torture and ill-treatment. The manual also includes comprehensive guidelines for clinical examinations to detect physical and psychological evidence of torture and ill-treatment.

The Istanbul Protocol also outlines minimum standards for state adherence to ensure the effective documentation of torture in its Principles on the Effective Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, or "Istanbul Principles". The guidelines contained in the Istanbul Protocol are not designed to be fixed, rather, they represent an elaboration of the minimum standards contained in the Istanbul Principles and should be applied in accordance with a reasonable assessment of available resources.

The Istanbul Protocol is a non-binding document. However, international law obliges governments to investigate and document incidents of torture and other forms of ill-treatment and to punish those responsible in a comprehensive, effective, prompt and impartial manner. The Istanbul Protocol is a tool for doing this.

1.2 Brief History

The Istanbul Protocol was the result of three years of analysis, research, and drafting undertaken by more than 75 forensic doctors, physicians, psychologists, human rights monitors, and lawyers who represented 40 organisations and institutions from 15 countries, including the International Rehabilitation Council for Torture Victims (IRCT). The development of the Istanbul Protocol was initiated and coordinated by Physicians for Human Rights-USA (PHR), the Human Rights foundation of Turkey (HRFT), and Action for Torture Survivors (HRFT-Geneva). The project was conceived in March, 1996, after an international symposium on "Medicine and Human Rights" held at the Department of Forensic Medicine, Cukurova University Medical Faculty, in Adana, Turkey by the Turkish Medical Association. The drafting process culminated at a meeting in Istanbul in March, 1999, when the manual reached its final form and subsequently submitted to the United Nations High Commissioner for Human Rights (OHCHR) on the 9th of August 1999. In 2001, the Office of the OHCHR published the Istanbul Protocol in its Professional Training Series in the six official UN languages.

1.3 International Recognition of the Istanbul Protocol
The Istanbul Principles have been recognised by a number of human rights bodies as a point of reference for measuring the effectiveness of torture investigations. Such recognition represents a significant factor in the widespread use and acceptance of Istanbul Protocol standards in medico-legal contexts.

Both the UN General Assembly and the then UN Commission on Human Rights (since 2006, the UN Human Rights Council) have strongly encouraged states to reflect upon the Principles in the Protocol as a useful tool to combat torture in their resolutions 55/89 on the 4th of December 2000, following the recommendation of the United Nations Special Rapporteur on Torture during the fifty-sixth session, on the 2nd of February 2000.

The UN Special Rapporteur on Torture stressed in his General Recommendations of 2003 the importance of the Istanbul Principles in the context of establishing independent national authorities for investigation; promptness and independence of investigations; independence of forensic medical services by governmental investigatory bodies and obtaining forensic evidence.

On the 23rd of April 2003, the UN Commission on Human Rights, in its resolution on human rights and forensic science, drew the attention of governments to these principles as a useful tool in combating torture. Likewise, reference was made to the Istanbul Protocol in the resolution on the competence of national investigative authorities in preventing torture.

In addition to recognition by the UN system, the Istanbul Protocol has also been adopted by several regional bodies.

The African Commission on Human and Peoples’ Rights deliberated on the importance of the Istanbul Protocol during its 32nd ordinary session in October 2002 and concluded that investigations of all allegations of torture or ill-treatment, shall be conducted promptly, impartially and effectively, and be guided by the Istanbul Principles.

The European Union has referred to the Istanbul Protocol in its Guidelines to EU Policy towards Third Countries on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment adopted by the General Affairs Council in 2001. The EU guidelines mention that states should “conduct prompt, impartial and effective investigations of all allegations of torture in accordance with the Istanbul Rules annexed to CHR resolution 2000/43” and should “establish and operate effective domestic procedures for responding to and investigating complaints and reports of torture and ill-treatment in accordance with the Istanbul Rules.”

Other institutions and organisations have reiterated the UN and other bodies’ recommendations in their reports, statements, and comments (including the Advisory Council of Jurists and the Asia Pacific Forum of National Human Rights Institutions). These references can roughly be summarised into three categories:

- References that cite the Istanbul Protocol as a useful tool in the efforts to combat torture and strongly encourage governments to reflect upon the principles contained in the Protocol;
- References that stress that all investigations and documentation of torture allegations should be conducted promptly, impartially and effectively, and be guided by the Istanbul Principles;
• References that say that states should establish and operate effective domestic procedures for the investigation and documentation of torture allegations in accordance with the Istanbul Protocol.

2. An Overview of the Istanbul Protocol

The Istanbul Protocol is a set of guidelines for the effective investigation and documentation of torture and ill-treatment. These international standards help both legal and forensic experts to investigate and document torture and ill-treatment. The medical guidelines, in particular, help forensic experts to assess the degree to which medical findings correlate with individual allegations of abuse and to effectively communicate the findings and interpretations to the judiciary or other appropriate authorities.

Medical experts involved in the investigation of torture must conform to the highest ethical standards, including obtaining informed consent before any examination is undertaken. The examination must conform to established standards of medical practise. In particular, examinations shall be conducted in private under the control of the medical expert and outside the presence of security agents and other government officials. The medical expert should promptly prepare an accurate written report which includes at least the following: case-specific, identifying information; a detailed record of the subject's allegations of torture and/or ill-treatment, including all complaints of physical and psychological symptoms; a record of all physical and psychological findings on clinical examination; an interpretation as to the probable relationship of the physical and psychological findings to possible torture and ill-treatment; recommendations for any necessary medical and psychological treatment and/or further examination; and the identify those carrying out the examination. The report should be confidential and communicated to the subject or his or her nominated representative.

According to the Istanbul Protocol, the following guidelines should be applied with due consideration to the purpose of an individual evaluation:

1. Relevant Case Information
2. Clinician’s Qualifications
3. Statement Regarding Veracity of Testimony
4. Background Information
5. Allegations of Torture and Ill-treatment
6. Physical Symptoms and Disabilities
7. Physical Examination
8. Psychological History/Examination:
9. Photographs
10. Diagnostic Test Results
11. Consultations
12. Interpretation of Physical and Psychological Findings
13. Conclusions and Recommendations
14. Statement of Truthfulness (for judicial testimonies)
15. Statement of Restrictions on the Medical Evaluation/Investigation (for subjects in custody)
16. Clinician’s Signature, Date, Place
17. Relevant Appendices
As the Istanbul Protocol makes clear, the absence of physical and/or psychological evidence in a medical evaluation does not rule-out the possibility that torture or ill-treatment was inflicted.

2.1 Legal Investigation of Torture

According to the Istanbul Protocol, investigations into torture should seek to establish the facts of alleged incidents in an effort to identify and facilitate the prosecution of perpetrators and/or secure redress for the victims. When possible, forensic experts should obtain detailed information on the following topics: 1) the circumstances leading up to the torture; 2) the approximate dates and times when the torture occurred; 3) detailed physical descriptions about the people involved in the arrest, detention and torture; 4) the contents of what was asked of or told to the victim; 5) a description of the usual routine in the place of detention; 6) details about the methods of torture and/or ill-treatment used; 7) any instances of sexual assault; 8) resulting physical injuries; 9) weapons or physical objects used; and 10) the identity of any witnesses.

When designing commissions of inquiry, states or organisations should be very clear in defining the scope of the investigation. By framing the inquiries in a neutral manner (without predetermined outcomes), allowing for flexibility, and being clear about which events and/or issues are under investigation, the proceedings can achieve greater legitimacy among both commission members and the general public.

Commissions should be given the authority to obtain information by compelling testimonies under legal sanction, ordering the production of State documents, including medical records, and protecting witnesses. In addition, the commissions should be granted the power to conduct on-site visits and issue a public report.

Perhaps most crucial to the legitimacy of any medico-legal investigation is their impartiality. According to the Istanbul Protocol, “...[c]ommission members should not be closely associated with any individual, State entity, political party or other organisation potentially implicated in the torture. They should not be too closely connected to an organisation or group of which the victim is a member, as this may damage the commission’s credibility.”

In addition, commissions should, whenever possible, rely on their own investigators and expert advisers, especially when examining misconduct by members of the government.

Following the inquiry, the commission should issue a public report, with minority members filing a dissenting opinion. These reports should include: the scope of inquiry and terms of reference, as described above; the procedures and methods of evaluation; a list of all testifying witnesses—except for those whose identities are protected—with their age and gender; the time and place that each sitting occurred; all relevant political, social and economic conditions that may have influenced the inquiry; the specific events that occurred and supporting evidence; the commissions’ conclusions; and finally, a set of recommendations. In response to these reports, the State should issue a public statement describing how it plans to heed the commission’s recommendations.

The Istanbul Protocol also includes obligations of governments to ensure minimum standards for the effective investigation and documentation of torture and ill-treatment as stipulated in the Istanbul Principles as mentioned above.

2.2 General Considerations for Interviews
The Istanbul Protocol outlines some specific guidelines for forensic examiners to use when conducting evaluations. The purpose is to elicit information in a humane and effective manner. During the evaluation, examiners should pay attention to the psychosocial history of the alleged victim. Relevant psychosocial history may include inquiries into “…the person’s daily life, relations with friends and family, work or school, occupation, interests, future plans and use of alcohol and drugs.” Information about any prescription drugs is important, since the discontinuation of any medications during custody could affect the detainee’s health. Health professionals should be aware of the following considerations in the course of conducting their medical evaluations (see Module 3 for a detailed discussion):

- **Informed Consent:** Health professionals must ensure that individuals understand the potential benefits and potential adverse consequences of an evaluation and that the individual has the right to refuse the evaluation.
- **Confidentiality:** Health professionals and interpreters have a duty to maintain confidentiality of information and to disclose information only with the alleged victim’s consent.
- **Setting:** The location of the interview and examination should be as safe and comfortable as possible, including access to toilet facilities. Sufficient time should be allotted to conduct a detailed interview and examination.
- **Control:** The professional conducting the interview/examination should inform the alleged victim that he or she can take a break if needed or to choose not to respond to any question or to stop the process at any time.
- **Earning Trust:** Trust is an essential component of eliciting an accurate account of abuse. Earning the trust of one who has experienced torture and other forms of abuse requires active listening, meticulous communication, courtesy, and genuine empathy and honesty.
- **Translators:** Professional, bicultural interpreters are often preferred, but may not be available.
- **Preparation for the Interview:** Health professionals should read relevant material in order to understand the context of the alleged abuse and to anticipate regional torture practices.
- **Interview Techniques:** Initially, questions should be open-ended, allowing a narration of the trauma without many interruptions. Closed questions are often used to add clarity to a narrative account or to carefully redirect the interview if the individual wanders off the subject.
- **Past Medical History:** The health professional should obtain a complete medical history, including prior medical, surgical or psychiatric problems. Be sure to document any history of injuries before the period of detention or abuse, and note any possible after-effects.
- **Trauma History:** Leading questions should be avoided. Inquiries should be structured to elicit a chronological account of the events experienced during detention. Specific historical information may be useful in corroborating accounts of abuse. For example, a detailed account of the individual’s observations of acute lesions—and the subsequent healing process—often represents an important source of evidence in corroborating specific allegations of torture or ill-treatment. Also, historical information may help to correlate individual accounts of abuse with established regional practices. Useful information may include descriptions of torture devices, body positions, and methods of restraint; descriptions of acute and chronic wounds and disabilities; and information about perpetrators’ identities and place(s) of detention.
- **Review of Torture Methods:** It complements the trauma history to explore abuses that could have been forgotten or avoided by the alleged victim due to their nature.
(e.g. rape). The review is not intended to be an exhaustive checklist; it should be individually tailored according to the trauma history or to the relevant regional or local practises.

- **Pursuit of Inconsistencies:** An alleged victim’s testimony may, at first, appear inconsistent unless further information is gathered. Factors that may interfere with an accurate recounting of past events may include: blindfolding, disorientation, lapses in consciousness, organic brain damage, psychological *sequelae* of abuse, fear of personal risk or risk to others, and lack of trust in the examining clinician.

- **Nonverbal Information:** Include observations of nonverbal information such as affect and emotional reactions in the course of the trauma history and note the significance of such information.

- **Transference and Counter-transference Reactions:** Health professionals who conduct medical evaluations should be aware of the potential emotional reactions that evaluations of trauma may elicit in the interviewee and interviewer. These emotional reactions are known as transference and counter-transference. For example, mistrust, fear, shame, rage, and guilt are among the typical transference reactions that torture survivors experience, particularly when asked to recount details of their trauma. In addition, the clinician’s emotional responses to the torture survivor, known as counter-transference (eg, horror, disbelief, depression, anger, over-identification, nightmares, avoidance, emotional numbing, and feelings of helplessness and hopelessness), may affect the quality of the evaluation. Considering survivors’ extreme vulnerability and propensity to re-experience their trauma when it is either recognised or treated, it is critical that health professionals maintain a clear perspective in the course of their evaluations.

The Istanbul Protocol also provides a series of guidelines to ensure procedural safeguards for medical evaluations of detainees alledging torture and ill-treatment (see Procedural Safeguards for Detainees below).

### 2.3 Physical Evidence of Torture

Indispensable to compliance with the guidelines prescribed in the Istanbul Protocol is an understanding that “the absence of...physical evidence should not be construed to suggest that torture did not occur, since such acts of violence against persons frequently leave no marks or permanent scars.” As a matter of fact, survivors of torture and/or ill-treatment often to not have physical evidence of torture as most lesions heal in approximately 6 weeks. As stated in the Istanbul Protocol, “a detailed account of the patient’s observations of acute lesions and the subsequent healing process often represent an important source of evidence in corroborating specific allegations of torture or ill-treatment.” (*IP, §171*) Physical manifestations of torture may involve all organ systems. Some effects are typically acute while other may be chronic. Symptoms and physical findings will vary in a given organ system over time, though psychosomatic and neurologic symptoms are typically chronic findings. Musculoskeletal symptoms are commonly present in both acute and chronic phases. A particular method of torture, its severity, and the anatomical location of injury often indicate the likelihood of specific physical findings. For example:

- Beating the soles of the feet (*falanga*) may result in subcutaneous fibrosis and a compartment syndrome of the feet.
- The use of electricity and various methods of burning may also leave highly characteristic skin changes.
- Whipping may also produce a highly characteristic pattern of scars.
- Different forms of body suspension and stretching of limbs may result in characteristic musculoskeletal and nerve injuries.
Other forms of torture may not produce physical findings, but are strongly associated with other conditions. For example, beatings to the head that result in loss of consciousness are particularly important to the clinical diagnosis of organic brain dysfunction. Also, trauma to the genitals is often associated with subsequent sexual dysfunction.

Before conducting the physical examination, the Istanbul Protocol states that health professionals should interview individuals in an effort to compile background information, asking individuals to describe both acute and chronic symptoms and disabilities. Health professionals should ask examinees about any injuries resulting from the alleged abuse, documenting instances where the examinees’ ability to describe injuries may be compromised by any after-effects of the torture. Typical acute symptoms include bleeding, bruising, burns from cigarettes, heated instruments or electricity, musculoskeletal pain, numbness, weakness, and loss of consciousness. Some common chronic systems are headache, back pain, gastrointestinal symptoms, sexual dysfunction, and muscle pain. In addition, many alleged victims suffer from chronic psychological effects, which can include depression, anxiety, insomnia, nightmares, flashbacks, and memory difficulties. Physicians should inquire about the intensity, frequency, as well as duration of each reported symptom.

After gathering background information, forensic experts should conduct a physical examination looking for findings or the lack of them that correlate with the allegations of torture and/or ill-treatment. In general, these examinations include an assessment of the following organs or systems: a) skin, b) face, c) chest and abdomen, d) musculoskeletal system, e) genitourinary system, and f) central and peripheral nervous system. The examiner should note all pertinent positive and negative findings, using body diagrams and photographs to record the location and nature of all injuries. Although genital exams can provide crucial corroborating evidence, these are to be performed only with the alleged victim’s consent. In the case that the physician differs in gender from the alleged victim, a chaperone must be present in the examination room. While diagnostic tests are not an essential part of the clinical assessment, there are some circumstances in which such tests may provide valuable supporting evidence.

2.4 Psychological Evidence of Torture

According to the Istanbul Protocol, the psychological impacts can vary depending on a variety of factors: “…the psychological consequences of a mock execution are not the same as those due to a sexual assault, and solitary confinement and isolation are not likely to produce the same effects as physical acts of torture. Likewise, one cannot assume that the effects of detention and torture on an adult will be the same as those on a child.” Despite this variation, certain psychological reactions have been documented in torture survivors with some regularity, and these evaluations remain key by “…provid[ing] useful evidence for medico-legal examinations, political asylum applications, establishing conditions under which false confessions may have been obtained, understanding regional practises of torture, identifying the therapeutic needs of victims and as testimony in human rights investigations.”

Although there may be considerable variability in psychological effects, torture and ill-treatment often result in profound, long-term psychological trauma. According to the Istanbul Protocol, the most common psychological problems are posttraumatic stress disorder (PTSD) and major depression, but may include the following:

- Re-experiencing the trauma
- Avoidance and emotional numbing
- Hyperarousal symptoms
- Symptoms of depression
- Damaged self-concept and foreshortened future
- Dissociation, depersonalisation, and atypical behaviour
- Somatic complaints
- Sexual dysfunction
- Psychosis
- Substance abuse
- Neuropsychological impairment

As with physical injuries, the absence of a definite mental health syndrome or condition, such as PTSD or depression, does not rule out torture and/or ill-treatment. Whether an individual presents with mental health problems depends on multiple factors, including but not limited to age, gender, mental preparedness, personality traits, degree of psychological trauma, and cultural/religious values.

Such psychological symptoms and disabilities can last many years or even a lifetime. It is important to realize that the severity of psychological reactions depends on the unique cultural, social, and political meanings that torture and ill-treatment have for each individual, and significant ill effects do not require extreme physical harm. Seemingly benign forms of ill-treatment can and do have marked, long-term psychological effects.

The psychological examination should elicit background information about the victim’s life both preceding and following the alleged torture or ill-treatment. Components of the psychiatric evaluation should include: a) history of torture and ill-treatment, b) current psychological complaints, c) post-torture history, d) pre-torture history, e) medical history, f) psychiatric history, g) substance use and abuse history, h) mental status examination, i) assessment of social function, j) psychological testing and the use of checklists and questionnaires, and k) clinical impression. Such information enables examiners to assess the presence of significant psychological symptoms and its relationship to the alleged trauma and other possible causes.

2.5 Interpretation of Findings and Referrals

The forensic examiner should correlate allegations of abuse with the findings of the physical and psychological evaluation and indicate his or her level of confidence in the correlations (e.g., inconsistent, consistent with, highly consistent with, or pathognomonic). A final statement of opinion regarding all sources of evidence (physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practises of torture, consultation reports, etc.) and the possibility of torture should be included. The examiner also should provide any referrals or recommendations for further evaluation of and care for the interviewee.

Unfortunately, it is a common misconception among evaluators, attorneys and adjudicators that psychological evidence is of lesser value than “objective” physical findings. The aim and effect of torture is largely psychological. The psychological evaluation is critical in assessing the level of consistency between the alleged trauma and individual psychological responses. In some cases, the symptoms may be either attenuated or exacerbated depending on the meaning assigned to individual experiences.
2.6 Misuse of the Istanbul Protocol

As the Istanbul Protocol makes clear, the absence of physical and/or psychological evidence in a medical evaluation does not rule-out the possibility that torture or ill-treatment was inflicted.

The Istanbul Protocol was developed to prevent torture and ill-treatment and to promote accountability. Governments must ensure that its official representatives do not engage in misuse or misrepresentation of the Istanbul Protocol to exonerate police who are accused of abuses or for any other purpose, as has been noted in a recent report by Physicians for Human Rights (PHR).66

Recent statements by Mexican authorities to the press67 relating to the highly publicized case of Víctor Javier García Uribe, alias ‘El Cerillo’, demonstrate a fundamental misunderstanding of the purpose, nature and limitations of the Istanbul Protocol (Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment). The Istanbul Protocol is not a diagnostic test or tool that can be used to assure, with certainty, the presence or absence of torture, nor is it a U.N. treaty or instrument that can be ratified by member States as has been suggested by Governor José Reyes Baeza.68

The Istanbul Protocol is a set of guidelines for the effective investigation and documentation of torture and ill-treatment. When used appropriately, these international standards help forensic experts to assess the degree to which medical findings correlate with the individual allegation of abuse and to effectively communicate the findings and interpretations to the judiciary or other appropriate authorities. As the Istanbul Protocol makes clear, the absence of physical and/or psychological evidence in a medical evaluation does not rule-out the possibility that torture or ill-treatment was inflicted.


67 Rubén Villalpando, Rechaza PGJE de Chihuahua Tortura a Supuesto Asesino, JORNADA, Aug. 12, 2005 (“La Procuraduría General de Justicia del Estado (PGJE) confirmó que Víctor García Uribe, El Cerillo, no fuesometido a tortura en noviembre de 2001 para que se confesara culpable de asesinar a 11 mujeres, de acuerdo los criterios periciales del Protocolo de Estambul.”)[The Office of the State Attorney General confirmed that according to the expert opinion based on the Istambul Protocol, Víctor García Uribe, alias the Match, was not subjected to torture with the purpose of forcing a confession of the 11 women murdered in November 2001]; Protocolo de Estambul no halla evidencias de tortura vs Cerillo, DIARIO , Aug. 12, 2005.

68 “Al afirmar que la aplicación del Protocolo de Estambul no está en entredicho, el gobernador José Reyes Baeza, indicó que ‘siempre las detenciones de cualquier presunto responsable estarán sujetas al respeto irrestricto de los derechos humanos, y con ello evitar el señalamiento, la inquietud y la molestia por parte de la comunidad, en torno a este tipo de detenciones’.” [“Confirming that there was no question about whether an evaluation according to the Istambul Protocol had been performed, the Governor José Reyes Baeza, said that ‘detentions are always subject to the utmost respect for the human rights of the person, thus avoiding questioning, uncertainty and anger within the community around such type of detentions’.”], available at www.nortedeciudadjuarez.com, (last visited August 17, 2005).
Such misrepresentation of the Istanbul Protocol may explain why, in the PHR study, the majority of the forensic physicians working for the Federal Attorney General’s Office wrongly equated the lack of forensic findings with “proof” that the alleged torture and ill-treatment did not occur.

2.7 Procedural Safeguards for Detainees

Ensuring procedural safeguards for detainees is essential in conducting effective medical investigation and documentation of torture and ill-treatment. Failure to ensure such safeguards may, in fact, result in the possibility of administrative and/or criminal sanctions against the medical expert responsible for forensic documentation of torture and ill-treatment. The Istanbul Protocol provides a series of guidelines to ensure procedural safeguards for medical evaluations of detainees alleging torture and ill-treatment as follows:

Forensic medical evaluations of detainees by all clinicians should be conducted in response to official written requests by public prosecutors or other appropriate officials. Requests for medical evaluations by law enforcement officials are to be considered invalid unless they are requested by written orders of a public prosecutor. Detainees themselves, their lawyer or relatives, however, have the right to request a medical evaluation to seek evidence of torture and ill-treatment. The detainee should be taken to the forensic medical examination by officials other than soldiers and police since torture and ill-treatment may have occurred in the custody of these officials and, therefore, that would place unacceptable coercive pressures on the detainee or the physician not to effectively document torture or ill-treatment. The officials who supervise the transportation of the detainee should be responsible to the public prosecutors and not to other law enforcement officials. The detainee’s lawyer should be present during the request for examination and post-examination transport of the detainee. Detainees have the right to obtain a second or alternative medical evaluation by a qualified physician during and after the period of detention.

Each detainee must be examined in private. Police or other law enforcement officials should never be present in the examination room. This procedural safeguard may be precluded only when, in the opinion of the examining doctor, there is compelling evidence that the detainee poses a serious safety risk to health personnel. Under such circumstances, security personnel of the health facility, not the police or other law enforcement officials, should be available upon the medical examiner’s request. In such cases, security personnel should still remain out of earshot (i.e. be only within visual contact) of the patient. Medical evaluation of detainees should be conducted at a location that the physician deems most suitable. In some cases, it may be best to insist on evaluation at official medical facilities and not at the prisoner jail. In other cases, prisoners may prefer to be examined in the relative safety of their cell, if they feel the medical premises may be under surveillance, for example. The best place will be dictated by many factors, but in all cases, investigators should ensure that prisoners are not forced into accepting a place they are not comfortable with.

The presence of police officers, soldiers, prison officers or other law enforcement officials in the examination room, for whatever reason, should be noted in the physician’s official medical report. The presence of police officers, soldiers, prison officials or other law enforcement officials during the examination may be grounds
for disregarding a “negative” medical report. The identity and titles of others who are present in the examination room during the medical evaluations should be indicated in the report. Medico-legal evaluations of detainees should include the use of a standardized medical report form.

The original, completed evaluation should be transmitted directly to the person requesting the report, generally the public prosecutor. When a detainee or a lawyer acting on his or her behalf requests a medical report, they must be provided with the report. Copies of all medical reports should be retained by the examining physician. A national medical association or a commission of inquiry may choose to audit medical reports to ensure that adequate procedural safeguards and documentation standards are adhered to, particularly by doctors employed by the State. Reports should be sent to such an organisation, provided the issues of independence and confidentiality have been addressed. Under no circumstances should a copy of the medical report be transferred to law enforcement officials. It is mandatory that a detainee undergo a medical examination at the time of detention and an examination and evaluation upon release. Access to a lawyer should be provided at the time of the medical examination. An outside presence during examination may be impossible in most prison situations. In such cases, it should be stipulated that prison doctors working with prisoners respect medical ethics, and they must be capable of carrying out their professional duties independently of any third party influence. If the forensic medical examination supports allegations of torture, the detainee should not be returned to the place of detention, but rather should appear before the prosecutor or judge to determine the detainee’s legal disposition.

3. Medical Ethics

3.1 Introduction

The term, ‘medical ethics,’ broadly describes the moral framework in which health professionals are bound to carry out their work. Many of the rules and principles of medical ethics have been adopted as professional codes of conduct. While ethics must guide every action of health professionals in their work, in the process of investigating and documenting allegations of torture, there are three areas in which the health professional must be particularly cognizant of specific ethical considerations. The first is the duty to the patient, the second is the clinical independence of the health professional and the third is in the production of medical records, reports and testimony.

There are certain ethical issues which are more likely to come to the fore depending on the various situations in which health professionals may encounter those alleging or showing signs of torture. This section points out the particular ethical considerations raised by situations such as the examination of an individual who is brought to a hospital or clinic still in the custody of the police, military or other security forces, and difficulties encountered by health professionals employed by the police, military or prison authorities.

3.2 Duties of the health professional

Health professionals have a duty to treat all patients without any form of discrimination and to provide treatment based only upon medical criteria without outside influence. In cases where torture or other ill-treatment is suspected, the health professional must keep in mind that these are crimes under international law, and probably domestic law. Therefore, irrespective of what the individual may be suspected, charged or convicted, the health professional’s duty is to document objectively any psychological or physical findings and, where pertinent, provide treatment or referral to colleagues for treatment. Thus those who become aware of torture have a duty to act, both to relieve the suffering and to document the evidence. To do nothing may be seen as acquiescence and as compounding the abuse. On the other hand, when choosing a course of action, consideration also needs to be given to the torture victim’s situation and how the risk of reprisals can be avoided or minimised.

3.3 International codes

Many UN documents address the specific ethical obligations of doctors and other health professionals, for example in Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment; Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment; Standard Minimum Rules for the Treatment of Prisoners; and the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol). These documents stress that it is a gross contravention of health care ethics to participate, actively or passively, in torture or other ill-treatment, or condone it in any way. Medical services must be provided for all patients without discrimination. They reinforce the ethical obligations of health professionals to act in the best interests of patients.

3.4 Ethical rules directly prohibiting involvement in torture

A number of international ethical standards deal directly with the obligations of health professionals with regard to torture and other ill-treatment. The World Medical Association’s 1975 Declaration of Tokyo, Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment, contains an unequivocal prohibition on any form of active or passive participation of a doctor in torture or other ill-treatment. According to the Tokyo Declaration:

- The doctor shall not countenance, condone or participate in the practise of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedure is suspected, accused or guilty, and whatever the victim's belief or motives, and in all situations, including armed conflict and civil strife.
- The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practise of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment
- The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment are used or threatened.

Tokyo Declaration was revised in 2006 to include the provision that: “

“The physician shall not use nor allow to be used, as far as he or she can, medical knowledge or skills, or health information specific to individuals, to facilitate or otherwise aid any interrogation, legal or illegal, of those individuals.”
Principles of medical ethics apply not only to doctors, but to all health care professionals. Nurses may also find themselves faced with patients who are survivors of torture or other ill-treatment, and the Position Statement on Nurses’ Role in the Care of Prisoners and Detainees, of the International Council of Nurses, has stressed the fundamental obligation of the nurse to restore the health and alleviate the suffering of the patient, including prisoners, and to protect them from abuse and ill-treatment. Similarly, the World Psychiatric Association has issued specific guidance which prohibits any participation of psychiatrists in torture (Declaration of Madrid 1996).

‘Participation’ in torture refers to some action at the time of the abuse or later, or by omission. It includes evaluating an individual’s capacity to withstand ill-treatment; being present at, supervising or inflicting ill-treatment; resuscitating individuals for the purposes of further ill-treatment; providing medical treatment on the instructions of those likely to be responsible for torture (rather than on the basis of clinical judgement); or providing professional medical knowledge or individuals’ personal health information to torturers. Omission includes the deliberate withholding of medical treatment so as to aggravate suffering intentionally or neglecting evidence. The failure to report cases of ill-treatment or torture that a health professional has noted is, at the least, acquiescence in torture, and the falsifying of medical notes or reports is a form of complicity in the abuse.

3.5 Primary loyalty to the patient

The principles of medical ethics make it clear that the primary loyalty of the health professional is to the patient. While the health professional may feel bound towards the state as an employer or for ideological reasons, their first and foremost obligation is always to the patient. According to the Tokyo Declaration ‘...the doctor’s fundamental role is to alleviate the distress of his or her fellow men, and no motive whether personal, collective or political shall prevail against this higher purpose.

In fact, according to the World Medical Association’s Declaration on the Rights of the Patient, “whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or to restore them.”

3.6 Dual obligations

Many health professionals have dual obligations (also referred to as ‘dual loyalties’), in that they owe a primary duty to the patient to promote his or her best interests and often a separate duty to employers. There is also a general duty to society to ensure that violations of human rights are prevented, and that the interests of . The dilemmas arising from dual obligations are particularly acute, however, for health professionals working with the police, military, and other security services or in the prison system. In these situations, either through the fact of their employment or ideological reasons, the obligations to their employer (the State) as well as the interests of their employer and their non-medical colleagues may all be in conflict with the best interests of their patients. A military doctor, for example, may belong to the very same government forces to which suspected perpetrators belong, thus interposing the loyalty to their comrades, military unit and military objectives, due to a separate obligation to the individual patient. A military or prison doctor may be under pressure to ignore allegations, or not conduct proper examinations and/or to falsify any record of their findings.
However, health professionals hold a particular duty to act impartially and to document and report any suspected ill-treatment through the appropriate channels. Health professionals must only document that which they have personally verified themselves, and they must document this truthfully, fully and accurately. Health professionals must be able to make clinical decisions independently from employers, governments, and other bodies in order to act in the best medical interests of their patients. They cannot be obliged by contractual or other considerations to compromise their professional independence.

There are various situations in which dual obligations and other ethical and legal issues may arise:

- They could be asked to perform a medical examination prior to interrogation in order to verify that the individual will be able to withstand physical torture or other ill-treatment
- They could be asked to revive or treat an individual during an abusive interrogation to enable further interrogation
- They may be asked to provide medical knowledge or individual medical information concerning physical health or to identify psychological weaknesses or fears, that can be exploited in order to facilitate interrogation, or to develop new methods
- Health professionals could be asked to be complicit in the falsifying of medical reports in order to cover up any indications of abuse.

Health professionals undertaking the above tasks may be guilty of playing an active or passive role in the abuse of an individual. In all these cases the health professional must abide by the rules of medical ethics and retain their primary loyalty to the patient, refusing to participate in or condone torture or other ill-treatment, and doing all they can to end the abuse, including the full and accurate documentation of any possible psychological or physical sequelae.

It should be kept in mind that in addition to the principles of medical ethics, health professionals working for the state are also bound by the rules of international law and which could, in certain cases, lead to individual criminal responsibility of the health professional for participation in torture. Obeying the orders of a superior would not provide a defence to a charge of participation in torture.

Forensic doctors may have a different relationship with individuals they examine. In their usual function, forensic doctors have a duty to the courts, to which they provide independent medical expert opinion, even though they may be paid by one or other party. Before beginning any examination, forensic doctors must explain their role to the individual and make clear that medical confidentiality is not a usual part of their role, as it would be in a therapeutic context, as their primary duty is to objectively document evidence that can be presented to a court. However, forensic doctors should not examine individuals without making clear the nature of their role and gaining specific consent. If consent is refused, this must be noted and respected. Depending on the jurisdiction, following such refusal by the subject, a court order may be required before any examination or taking of samples can proceed. The forensic doctor should seek to include in their findings and report, only that medical information that is relevant to the case, and should leave out that medical information which can remain confidential to the patient (e.g. if HIV status is not relevant to the case, then it should not be raised in the findings). They must not falsify their reports but provide impartial evidence, including making clear in their reports any evidence of ill-treatment.
There is consensus in international and national declarations of ethical precepts that other imperatives, including the law, cannot oblige health professionals to act contrary to medical ethics and to their conscience. In such cases, health professionals must decline to comply with the law or a regulation rather than compromise basic ethical precepts. Whatever the circumstances of their employment, all health professionals owe a fundamental duty to care for the people they are asked to examine or treat. They cannot be obliged by contractual or other considerations to compromise their professional independence. They must make an unbiased assessment of the patient’s health interests and act accordingly.

3.7 The treatment of prisoners and detainees

The rules of medical ethics and medical professional codes do not allow for discrimination in the provision of health care to prisoners and detainees. Individuals under arrest or any form of detention must have access to a standard of health care and services, and compassionate care, which are equivalent to that of the surrounding general population. This applies to health professionals who work directly in prisons or other detention centres, and equally to health professionals working in the national health services to whom prisoners may be referred. One consequence of neglect of detainee is that they learn to mistrust doctors, leading to them to avoid seeking medical help after imprisonment. There may be other reasons for prisoners not to trust the prison doctor. Doctors working in prisons are often underpaid, ill-considered by their superiors, and receive no training on prison health issues. As a result they are not very motivated in performing their jobs, which leads the prisoners to mistrust their services. Prison doctors in situations where torture is a reality will also be, rightly or wrongly, seen as accomplices of “the system” and also be mistrusted.

Hunger strikes are a particularly difficult situation for doctors to deal with. Most fasting prisoners do so for two or three weeks, and those on strikes rarely suffer any harm. As they go on longer, the risks to the hunger striker increase. In an ideal situation, an independent doctor will have explained the risks of prolonged hunger strike, and taken instructions on what the person wants to happen if he or she ceases to be capable of rational thought. This should happen in an environment where the patient’s confidentiality can be respected, and where he or she can be protected from undue pressure from political colleagues. In cases where prison doctors have been following hunger strikers before and during the fast, and know what the patients’ positions and convictions are, physicians should respect the principles stated in the Declaration of Malta on hunger strikes. This declaration allows physicians to act in the best perceived interests of their patients, while respecting autonomy. If a physician is called upon to take care of a hunger striker already in a comatose state, he or she will have no choice and will have to provide reanimation. A physician should not rely on what amounts to “hearsay” in such cases. The opinions of the immediate family should be taken into consideration, but are not paramount. Neither the opinions of the authorities nor those of the patient’s political colleagues should be given any weight.

3.8 Issues surrounding examinations of individuals in the presence of security forces

Health professionals, whether working in places of detention, called to visit a police station or other place of detention, or working in national health services, may well be presented with detainees to examine in the presence of security forces. The reasons for such examination may include a statutory initial medical examination upon arrival in a place of

detention, complaint of illness or ill-treatment by a detainee, or routine referral for medical treatment. When faced with a detainee, the health professional must apply their usual ethical principles in any assessment and treatment. The detainee must give informed consent to any examination, procedure or treatment, and this should include an explanation of who will have access to any findings, and how these findings may be used. Informed consent requires that the consenting individual:

- Is mentally competent
- Receives full disclosure of information, i.e. risks vs. benefits
- Understands the information provided
- Gives his/her consent voluntarily
- Provides authorisation for his/her consent

Two further points of particular importance in the examination of detainees must be highlighted: the maintenance of medical confidentiality and the use of restraints (such as handcuffs) on detainees. Medical ethics dictates that consultations and the information gained therein should be confidential between the doctor and the patient. In the case of prisoners, the security forces (police, military or prison guards) will often maintain that they must remain present during any consultation, the most common reason being that it is for the protection of the health professionals. In some circumstances, the security personnel might insist that the detainee remain in restraints (handcuffs, ankle-cuffs) and even with a hood or blindfold during the consultation. Thus there is an immediate conflict between security and medical concerns.

As stated above, health professionals have a duty to observe their usual ethical practise in their treatment of detainees. In brief, there can be no blanket rule that dictates that all detainees are dangerous and merit, in all circumstances, the presence of security personnel and/or restraints. If escape is an issue, health professionals can conduct consultations with the security personnel outside the door, or as a less acceptable alternative, with the door open and the personnel out of range of hearing. Further, security concerns can be addressed by conducting the consultation in a room that has only one entrance, and either no windows or barred windows.

The routine use of restraints during medical consultation or treatment is also contrary to medical ethics and international standards on treatment of prisoners. Health professionals must not accept such practises. Restraints not only interfere with the proper diagnosis, management and treatment of patients, but they also run contrary to the inherent dignity of all human beings. The only possible acceptable justification for use of restraints is as a last resort when there is substantiated reason to believe that this particular detainee presents an immediate and current violent threat to himself or others. Health professionals can and should question the use of restraints if they have reason to doubt such a risk exists. In the exceptional circumstances that restraints are used, they should be as minimal as possible.

The use of hoods or blindfolds during any contact between a detainee and health professionals is absolutely unacceptable under any circumstances. The use of hoods or blindfolds has in itself been found to be a form of ill-treatment. In the health setting hoods or blindfolds not only impair any meaningful contact with the patient, they also prevent the identification of any health professionals and may thus add to a perception of impunity in any cases of ill-treatment.

### 3.9 Abusive medical treatment
Health professionals should also be wary of any attempts (from officials) to ask them to administer treatment or medication that are not aimed at benefiting the physical or mental health of the patient, but only at assisting an interrogation or the management of a patient or detainee.

The individual need not be in prison, or in detention at all, to be tortured. Health professionals must be aware that they might be considered responsible for ill-treatment in settings where patients do not have freedom of movement, for example, those detained under mental health legislation or in facilities for the elderly. Inappropriate use of medical treatment, such as overuse of sedatives, may also be ill-treatment.


3.10 Consent and confidentiality

It is a principle of ethical practise that patients must understand what is happening to them and consent to it. This is extremely important in working with torture survivors who have been in the situation of having no control over any aspect of their lives. It is essential that they do not feel powerless in the subsequent clinical setting. This is particularly true of medico-legal work in which the documentation will be in the public domain. As stated above, for consent to be valid, the patient must understand how the data gained from the examination will be used, how it will be stored and who will have access to it.

While all statements emphasise the obligation to act in the best interests of the individual being examined or treated, this presupposes that health professionals know what the patient’s interests are. A fundamental idea in modern medical ethics is that patients are the best judges of their own interests. This requires that health professionals should normally give precedence to the competent adult patient’s wishes. Where the patient is unconscious or otherwise incapable of giving valid consent, health professionals must make a judgement about how that person’s best interests can be protected and promoted. Nurses and doctors are expected to act as advocates of their patients’ well-being and this is made clear in professional statements.

Conflicts arise where health professionals are pressured or required by law to disclose information to third parties about patients without consent. This may include an obligation to report torture or serious crimes (possibly including torture itself). A health professional may receive an allegation of torture on the patients’ understanding that they are only seeking treatment and that the information will not be disclosed to others for fear of reprisals or other reasons. The health professional must contemplate the risks to the patient, and indeed to themselves, in disclosing such information, and the potential benefits to society as a whole (e.g. potentially avoiding further harm to others), before acting. Whatever decision is reached, the health professional should endeavour to gain consent. In such cases, the fundamental ethical obligations to respect autonomy and to act in the best interests of the patient are more important than other considerations. Health professionals should make clear to any authority requesting information that they are bound by professional duties of confidentiality. Health professionals responding in this way are entitled to the support of their professional association and colleagues.
The Geneva Conventions give particular protection to doctor-patient confidentiality in periods of international armed conflict, for example, requiring that doctors should not be compelled to disclose information about their patients to the opposing side.

### 3.11 Security

The security of the individual who may complain of or show signs of ill-treatment is closely related to the issues of consent and confidentiality described above. In examining or treating these individuals, the health professional must keep in mind the security of both the patient and him or herself. Often, the patient may have the impression that the health professional can provide an element of physical protection, and even prevent further arrest or ill-treatment. This sense of protection may be even more commonplace when health professionals visit the individual while they are still detained (particularly if it is a visit by an international team) since it is assumed that the fact of having access to the place of detention invests them with greater powers.

The security of the individual extends to how any information collected is used or to whom it is divulged. Clearly the release of any information is governed by the issues of consent and of confidentiality since identifiable information may itself lead to recriminations for the individual, or their family, or indeed the health personnel. Health professionals thus have a duty to ensure that individuals are aware of the limits of their ability to protect them, and must ensure that no information is released or passed on that may put interviewees at risk. All documentation must be stored safely.

### 3.12 Involvement of other health professionals in torture

Health professionals may at times have concerns that other health professionals might be participating directly or indirectly in the torture or other ill-treatment of individuals. The appropriate course of action in such cases can depend on the particular circumstances, for instance, whether the concerned health professional is working within the same institution as those he or she suspects; whether he or she is a local practitioner or part of an international visiting team; and the assessment of level of risk that may be involved in various courses of action. In some cases, a private discussion with trusted colleagues may be enough to clarify and bring about positive change. In other cases, there may be a need to turn (sometimes discreetly) to outside bodies, national or international (such as medical associations or human rights bodies), in order to seek advice.

### 3.13 Seeking further information and support

Health professionals who encounter any of the above situations, and have concerns on how to act, can seek information and support from a variety of bodies, national and even international, who may be able to provide more specific guidance. If there are ethics bodies within the police, military or prison medical services, then this could be one avenue for support. Such bodies, however, may be unable to work impartially, or the health professional may feel that turning to these bodies could present a risk of personal security to him or herself or the patient. Other bodies the health professional could perhaps turn to include national medical associations, national human rights bodies, or, if these are not available, relevant international bodies, in particular the World Medical Association (WMA).

### 3.14 Country-specific legal responsibilities of the health professionals for forensic documentation of torture and ill-treatment
Country-specific national legislation and regulations relevant to medical documentation vary considerably and are beyond the scope of this Curriculum. Instructors who use the Model Curriculum should consider adding country-specific information:

- Rights, obligations and restrictions of the physician according to national legislation concerning the preparation of forensic reports
  - criminal procedures
  - administrative procedures
  - disciplinary procedures
- Possible consequences of false reports for the patient and for the physician
- Best practice of medical reporting and its impact in practice.
- Legal status of alternative (non-governmental) reports
- The problem of dual obligation
- Ethical and legal responsibilities of the physician according to the above mentioned international codes
- The similarities and differences between the international (ethical and legal) and national codes.
- Qualification of health professionals to conduct psychological and physical evaluations
- The differences between national legislation and practice
- Regulations that apply specifically to gender-based violence against women

4. General Guidelines for Gathering Evidence and Documenting Findings

The primary goal of documenting allegations of human rights violations is to create an accurate, reliable and precise record of events. The uses to which this record may be put are varied, but all rely on the quality of the record that has been established. A description of a typical documentation team is given, detailing the different roles and functions carried out by each member. A general overview of documentation is provided, to illustrate for the health professional how the medical evidence fits into the wider picture of documentation and evidence. It also covers essential information needed in any investigation of allegations, including types of evidence which the health professional should attempt to gather when the lawyer is prevented from doing so. General guidelines are given on the types of evidence needed, what essential information should be collected, how to ensure the quality of information, and various considerations to be taken into account in the gathering of evidence.

4.1 The aims and goals of investigation

Torture and other ill-treatment are prohibited in international law and are likely also to be a crime under national law. International law requires not only that torture not be used, but also that any allegation of torture be investigated, and that those responsible be brought to justice.

Effective investigation, including the aspect of medical documentation, is a vital component in the struggle to eradicate the practise of torture. Legal bodies, domestic and international alike, rely on factual evidence to reach their conclusions and uphold justice.
By shedding light on cases of torture and other ill-treatment, effective investigation and documentation can assist in the achievement of a number of important goals:

- Raising awareness of the infliction of torture and its absolute prohibition
- Battling impunity: bringing torture into the public eye assists in calling states to account for their actions and having them fulfill their legal obligations. On a different level, torture reporting can also help to cast light on the individuals who carry out such practises, to make sure that they cannot continue to engage in such behaviour without negative consequences
- Redress for the survivor: there are a number of remedies and objectives that may assist the individual survivor of torture, for example:
  - Preventing and ending ongoing abuse: in certain cases, allegations of torture may be raised by a person who is still in custody of the authorities. Effective and swift investigation can help put an end to the suffering. In other cases, the individual may be seeking protection from abuse in another country, and the determination of whether the individual was a survivor of torture and is personally at risk can prevent the person being deported back into the hands of their torturers.
  - Compensation and other forms of restitution: survivors of torture may, for example, be able to claim compensation for monetary loss, physical and mental harm, and other damage caused by the torture.
  - Rehabilitation: many torture survivors are in need of rehabilitation services, including medical treatment, both physical and psychological, legal assistance, and social services. Effective investigation and documentation can assist in diagnosis, treatment (including rehabilitation) and prognosis of the patient.
  - Official and public acknowledgement of their suffering can also be important in the recovery process of survivors of torture.
- Reform: drawing attention to a situation is not just about seeking condemnation or holding a state accountable. Even more importantly, it is about seeking constructive and long-term improvements in a country, which will contribute to the ultimate elimination of torture. This will often require changes both in the legislative framework and in official attitudes to torture. The eradication of torture is a fundamental and necessary step for any society aspiring to protect human rights and care for its people.

4.2 Multidisciplinary approach to documentation

Although straightforward allegations of torture can be documented by a health professional on his or her own, the investigation and documentation of torture is ideally a joint effort to be carried out by a number of actors with expertise in different fields. These usually include a lawyer, health professional and human rights monitor. Others who play an important part in the effort are judges, the police, the media, and of course the individuals and their families.

4.3 Role of the health professional in the team

Health professionals who encounter survivors of torture may do so in different capacities, and they may thus have slightly different but convergent duties:
The health professional who is asked to examine an individual expressly for the purpose of providing a medical opinion in a report for a court or other judicial body will be fulfilling a forensic (medico-legal) role.

A health professional who is acting as a care giver to an individual and who in the course of routine work notes signs and symptoms of ill-treatment, or to whom the individual complains of being previously subjected to ill-treatment, may need to make an accurate medical record of the findings in the medical notes.

A health professional who forms part of a team visiting places of detention may record findings of ill-treatment in individuals, but this information may be used more generally in a report on the place of detention without actually forming part of a medico-legal report.

Health professionals in primary care or emergency departments to whom the individual complains of ill-treatment or who note signs of torture. In such cases the health professional may not necessarily have to write a report, but may just need to know how to make a proper examination and a good set of medical notes, which document the care.

Health professionals in hospitals or clinics who may be asked by, for example, police or military, to examine a detainee.

Health professionals examining individuals in a specialist centre for survivors of torture.

The first and foremost concern for the health professional is the immediate health and well-being of the torture survivor. Health professionals may have a therapeutic role in treating the patient, or a forensic role in establishing the possible causes and origins of injuries and trauma. There are concerns that having a dual role may create the perception of bias in the reporting. The health professional should therefore ensure that the individual is receiving any necessary medical care, taking into account that:

- Care includes immediate treatment and long-term rehabilitation for survivors of torture.
- Forms of torture may be used that are psychological or otherwise leave no persisting physical signs. It must always be emphasised that the absence of physical or psychological findings can never be considered to be evidence that ill-treatment did not occur.
- A psychological assessment of the individual should take place, noting any psychological effects that may be the result of torture or other ill-treatment.
- The strongest evidence supporting the allegation of torture is often of a medical or psychological nature. The health professional should record any external or physical evidence of injury or abuse and any psychological symptoms and signs.

4.4 Role of the lawyer in the team

Lawyers are key interlocutors for survivors of torture seeking justice and other forms of reparation. Equally, they may play a vital role in persuading governments to comply with their international obligations to refrain from acts of torture and to implement preventative measures. If lawyers are familiar with the applicable international standards, they may seek to interpret and apply domestic law in light of these standards, and may cite such standards in their legal argument, pleadings and complaints.

The Istanbul Protocol states that lawyers have a duty in carrying out their professional functions to promote and protect human rights standards and to act diligently in accordance
with law and recognised standards and ethics of the legal profession. Other human rights instruments, such as the “UN Basic Principles on the Role of Lawyers”,\textsuperscript{72} set out the duty of lawyers to assist clients “in every appropriate way” and to take legal action to protect their interests.

International standards to investigate torture are primarily formulated as obligations of States, as reflected in Chapter III of the Istanbul Protocol. However, lawyers play a crucial and active role in the documentation and investigation of torture, in particular by:

(i) documenting torture for use in legal or other proceedings, including future proceedings where national mechanisms at the time are unavailable or ineffective;

(ii) collecting evidence of torture that may prompt authorities to open or reopen an investigation;

(iii) providing evidence of torture that supports ongoing investigations or prosecutions at the national or international level;

(iv) recording the failure to investigate in spite of the availability of evidence or the shortcomings of any investigations undertaken with a view to prompting further investigations, including by taking cases to regional or international human rights bodies;

(v) collecting evidence to support reparation claims brought at the national or international level before judicial or administrative bodies.

The Istanbul Protocol highlights the important role of medical professionals in the documentation of torture and sets out detailed guidelines on methodology for obtaining medical evidence, including the recommended content of medical reports.

It is important for lawyers working with torture survivors to know how torture can be medically documented and how to recognise the physical and psychological symptoms of torture. This will not only help them to better understand their clients and assist them but equally, such insights are extremely important when lawyers lodge complaints of torture or other forms of ill-treatment on the survivors’ behalf. As recognised in the Istanbul Protocol, lawyers and doctors need to work closely together to effectively investigate and document acts of torture. Medical evidence may convincingly demonstrate that torture has occurred. It will also assist lawyers to determine victims’ claims for reparations (e.g., restitution, compensation and rehabilitation). Similarly, lawyers will need to assess whether the official investigation undertaken by the police or other competent body took into account proper medical evidence or whether they need to arrange for independent medical examinations to attest to the victim’s version of the events.

\textbf{4.5 Role of the NGO member in the team}

Experience over the past decades has shown that human rights NGOs vary in mandate, focus, and methods, but some can contribute in important ways to the documentation of torture and subsequent legal action:

- They can assist individuals to gain advice, services and treatment, from the legal and medical professions, through lawyers and health professionals who are part of the NGO or by referral to others.
- NGOs are often best placed to handle the case of the individual in the international arena, for example by assisting and advising in making complaints to international courts and other mechanisms.
- The information held by the NGO on other similar cases and the research conducted on torture and other ill-treatment domestically and internationally, can provide valuable support to the case of the individual. Their knowledge of local circumstances can be very important. In certain cases it may be possible to combine a number of cases into joint complaints and petitions.
- NGOs often have the expertise for any necessary work to be done through public advocacy or with the media.
- NGOs can assist in the prevention of abuse, for example, by circulating information about those who have been recently arrested.

Although the circumstances vary considerably between countries, generally it is better for an NGO to be open about its activities in helping survivors of torture and to develop links with relevant regional and international bodies; this makes it easier to seek protection from intimidation by the national authorities.

4.6 Role of Judges and prosecutors

Judges and prosecutors have a responsibility to ensure that they do not themselves, unintentionally or otherwise, collude with acts of torture while carrying out their official functions. In some legal systems, prosecutors may be directly involved in conducting interrogations in which coercive methods of extracting confessions and information are used. In some situations, prosecutors may rely on information or confessions, when conducting cases, without ensuring that the information was not obtained by coercive means.

Sometimes judges and prosecutors fail to ensure that the laws and procedures designed to protect people in detention, and prevent acts of torture and other forms of ill-treatment, are upheld. They may also fail to require that a person making a statement or confession does so in their presence; fail to explore for signs of physical or mental distress on a detainee who is brought before them; return a detainee to the custody of law enforcement officials where there is reason to believe that the detainee will suffer ill-treatment; fail to react to signs which indicate that a person may have been ill-treated even in the absence of a formal complaint; fail to sufficiently take complaints of ill-treatment seriously; fail to investigate such allegations with a view to bringing proceedings against the perpetrators; and fail to exercise their powers to carry out thorough inspections of places of detention.

Conversely, judges and prosecutors may exercise their powers to prevent and investigate acts of torture. They may demand that a suspect be brought before them at the earliest opportunity and check that he or she is being properly treated. Where they have discretion, they may interpret the balance of proof, with respect to allegations of torture and the admissibility of evidence obtained through it, in ways that discourage law enforcement officers, and those in charge of places of detention, from carrying out, or permitting others to carry out, torture and other forms of ill-treatment. They may also stay alert to all possibilities that their own courts or tribunals do not conform to the highest possible standards with respect to preventing and investigating torture.
While international law provides a basic minimum, there are also examples from different countries that can be drawn on when developing standards of good practice. The case studies contained in this manual, which only represent a brief snapshot of such cases drawn from around the world, are intended to illustrate how judges and prosecutors have sought to combat torture within their own national jurisdictions.

5. Documenting the allegations

5.1 The aim of medical documentation

Medical documentation may be critical to legal investigations of torture through the following means:

- Producing a contemporaneous record (a record as close in time as possible to the event) of signs and symptoms of ill-treatment when an individual presents to any health professional for treatment after the event – the examining health professional may not be called upon to produce a report, but in the future an expert may be asked to use this record to form an opinion of events at the time
- Providing detailed understanding of the case so that the person can be referred for the appropriate treatment and rehabilitation in a specialised centre or by other specialists
- The production of a medico-legal report for submission to a judicial or administrative body:
  - for judicial enquiries or court cases aimed at the prosecution of perpetrators
  - for a judicial process which decides on the responsibility of the state
  - for a judicial process which decides upon compensation/reparations for survivors
  - in individual cases where a medico-legal report may be used as part of a court application to end on-going abuse while the person is still in detention
  - for the case of asylum seekers when medical evidence may be used as part of the evidence (e.g. in hearings) to show a history of ill-treatment in another country and the physical and psychological consequences thereof.
- The documentation of patterns of widespread abuse. Courts, NGOs, and inter-governmental mechanisms, can all have need for knowledge of the existence of widespread abuse. Assessment of the prevalence of torture and other ill-treatment, relies upon well-documented individual allegations
- The production of supporting material during visits to places of detention. Medical documentation may not necessarily lead to the production of a medico-legal report on specific cases, but the medical findings can be used more generally to support allegations of conditions and treatment amounting to torture or other ill-treatment.

5.2 Types of evidence

Medical evidence is one of many types of substantiation given to allegations of torture and other ill-treatment, and will often be used in conjunction with other forms of evidence. These will commonly include:

- The individual’s statement
- Witness statements
- Other forms of third party evidence, such as the testimony of a forensic scientist or other expert
• Objective evidence of a widespread occurrence of torture in the circumstances referred to
• Anything else which can help to support and prove an allegation.

5.3 Medical evidence

Medical evidence is a very important type of evidence as it can add strong support to witness testimony. It is rare for medical evidence to be conclusive - prove with certainty that torture occurred - because:

• Many forms of torture leave very few traces, and even fewer leave long-term physical signs that they ever occurred.
• Injuries or marks which are alleged to have resulted from torture cannot always be distinguished with a high degree of certainty from the effects of other causes.

What medical evidence usually can do is demonstrate that injuries or other clinical findings recorded in the alleged survivor are consistent with or highly consistent with the torture described. Where there is a combination of physical and psychological evidence compatible with an allegation, this will strengthen the overall value of the medical evidence.

When obtaining medical evidence, it is important to be aware of the difference between therapeutic (treating a patient’s symptoms) and forensic (legal) medicine. The objective of forensic medicine is to assist the courts and other appropriate authorities in medico-legal matters, for example, by establishing the causes and origins of injuries. Sometimes both therapeutic and forensic functions are carried out by the same health professionals but, where possible, they should be separated to avoid a possible conflict between the two roles. Failing that, the possible conflict should be recognised and discussed by the clinical evaluator.

5.4 Gathering of evidence

The medical evidence will be used in combination with the other types of evidence mentioned above. Detailed guidelines on gathering medical evidence, including the interviewing of alleged victims, physical and psychological examinations, and writing medical reports, are addressed in the following Modules.

Health professionals engaged in the documentation and investigation of torture ought also, however, to be aware of certain non-medical aspects of evidence gathering. In ideal circumstances, there will be a number of people responsible for collection of evidence, and other members of the team, particularly the lawyers or NGO professionals, will coordinate the collection and ensure that all requisite details have been gathered. However, in some circumstances not all members of the team will have access to the alleged victim, and it is therefore crucial that each member is aware of the necessary details essential for the substantiation of alleged abuse. In other circumstances, health professionals may participate in human rights investigations and monitoring. The level of proof and detail may vary depending on the purpose of documentation: for example, a criminal trial requires higher standards of proof than a civil hearing or administrative procedures determining potential risk in case of deportation. If the health professional is the only person with access to the alleged victim or other source of information, it is vital that he or she attempts to collect, or ensures that others collect, key information, beyond the purely medical evidence.

5.5 Essential information
In all cases, in addition to the medical evidence and information, the following non-medical details should be viewed as useful and often crucial information regardless of the purpose of documentation:

**Identity of the victim.** This should include full name, gender, age, occupation, and address. Date of birth is a useful identifier when the name is a common one; often the year is known although it might not correspond to the age given. Additional useful information would be a description of appearance, a photograph, and any relevant records that may exist on the individual, such as medical files from the time before the alleged abuse.

**Identity of the perpetrators.** This might include the identification of a particular individual or individuals. However, to establish responsibility of the state for a violation, it might be enough to show the connection with the state. Relevant information would detail whether they were members of a specific security force such as police or military and, if possible, their names and rank. If unsure, then a description of uniforms, vehicles, weapons or any identifying characteristics will assist in the determination. Note, for legal and human rights reasons, great care should be taken in making allegations that particular individuals have been involved in torture. These are, after all, allegations of serious criminality.

**Description of how the individual came into the hands of the perpetrators.** This should include whether the person was officially arrested, what reason was given for taking the person into custody, the time and date this took place, and whether there was use of violence or restraints.

**Description of the location where the abuse took place.** This may have been a prison, a police detention facility, a military installation, or any other institution or location, even an outdoor space. Additional useful information would be a description of the conditions in which the individual was held, including size, content of the room, lighting, hygiene, presence of others, and access to lawyers, visitors, and medical care.

**Description of the form of abuse.** Where did it occur? What happened? When? By whom? How often? How long did it last? And what effects did it have on the immediately and later? There should be a detailed description of exactly what occurred, and how frequently. Presence of anyone else in the room during the interview, whether detainees, security personnel or others, should be mentioned. Any instruments used should be noted. What were the immediate and long-term effects of the abuse? If the alleged victim received medical attention, or requested it and the request was denied, directly before, during, or after the abuse, this should all be detailed.

**Possible witnesses.** Were there others present at the time of the abuse. Who were they? What was their role (for example, other detainees)? Did others see the individual immediately after the ill-treatment (for example, cellmates or prison medical staff)?

### 5.6 Quality of information

The primary goal of documenting allegations of human rights violations is to create an accurate, reliable and precise record of events. The uses to which this record may be put are varied, but all rely on the quality of the record which has been established. Factors which contribute to the quality of information are:
The source of the information. Was the information obtained directly from the victim? The further away from the alleged victim or incident the information comes, the less reliable it is likely to be.

The level of detail. Is the allegation very detailed? Are there unexplained gaps in the account? The more detail obtained, the better, because it helps others to understand what happened, and it also helps to prevent allegations of fabrication. Psychological and/or organic explanations for gaps should be kept in mind.

The absence or presence of contradictions. Minor inconsistencies are common and should not affect the overall quality of the information, but major inconsistencies or contradictions should prompt seeking further clarification of the information.

The absence or presence of elements which support (corroborate) or disprove the allegation. Are there witness statements, medical certificates or any other supporting information? The more supporting documentation that is provided, the more likely it is that the allegation will be found credible, but its absence is not evidence that the ill-treatment did not occur.

The extent to which the information demonstrates a pattern. Is the allegation one of a number alleging similar facts? Where there is evidence of a practise, there may be a greater presumption that the information is true.

The age of the information. Is the information very recent? Does it relate to facts which occurred several years previously? The fresher the information, the easier it is to investigate or verify the facts alleged.

5.7 Comparing records

Different members of the team might have notes or memories that emphasise different aspects of the individual’s account. This is particularly true when the team comprises members with different professional backgrounds. Interviews should be reviewed and notes compared before one member is delegated to write up the relevant interview. All notes should be retained. It is important to note that a team approach may be more appropriate for documentation in a therapeutic context than a medico-legal context. In the case of medico-legal documentation, it is advisable to discuss with the client’s attorney potential benefits and liabilities before proceeding with a team approach.

As the team comes together, it may be able to identify patterns of a general nature, especially if several teams are working together, and not every team member is aware of the information gathered by the others. Evidence that appeared incomprehensible or implausible might be clarified by the understanding of evidence gathered by other team members or teams. They can then discuss how to take the work forward, for example by de-identifying data and analysing them in groups.
MODULE 3

Interview Considerations

OBJECTIVES

- To understand the key role of the interview in conducting medical evaluations of torture allegations
- To be familiar with conditions necessary for an effective interview
- To understand and develop interview process skills such as empathy and earning trust
- To learn effective and appropriate techniques of questioning
- To understand the effect of the interviewing style on the interview process and the alleged victim
- To develop the capacity to elicit a detailed narrative account of alleged experiences
- To be familiar with possible difficulties of recalling and recounting elements of torture experiences
- To understand how and why difficulties may arise during an interview
- To be familiar with possible transference and counter-transference reactions
- To develop awareness to possible vicarious traumatisation and burnout and discuss strategies to address their effects
- To examine individual reactions to hearing a recording of an interview with a survivor of torture

CONTENT

- Preliminary Considerations
  - Purpose of medical evaluations
  - Interview settings
  - Trust
  - Informed consent
  - Confidentiality
  - Privacy
  - Empathy
  - Objectivity
  - Safety and security
  - Procedural Safeguards for Detainees
  - Risk of Re-traumatisation
  - Gender Considerations
  - Interviewing Children
  - Cultural and Religious Awareness
  - Working with Interpreters
  - Transference and Counter-Transference Reaction
- Conducting Interviews
  - Types of Questions
  - Cognitive Techniques
  - Summarising and Clarifying
  - Difficulties Recalling and Recounting
  - Assessing Inconsistencies
- Interview Content
  - Identification and Introduction
  - Psychosocial History- Pre-Arrest
### DISCUSSION TOPICS

- Play audiotape (MP 3 file) of interview with Sr. Diana Ortiz. National Public Radio. 1996 (about 15 minutes) and discuss relevant interview considerations: confidentiality, informed consent, privacy, safety, objectivity, impartiality, creating a climate of trust, courtesy, honesty, empathy, the effects of interviewing style, appropriate use of open-ended and closed questioning, the risks of re-traumatisation and how to minimize the risk of re-traumatisation.
- Discuss individual responses to the interview with Sr. Diana Ortiz and discuss strategies for managing such reactions and limiting secondary trauma and “burn-out”
- Discuss what you find most challenging about interviewing survivors of torture and ill treatment

### TEACHING FORMATS

- **Group Activity:**
  - Listen to the audiotape (MP 3 file) of interview with Sr. Diana Ortiz. National Public Radio. 1996 (about 15 minutes) as a class.
  - Divide the class into several groups and have each group address the first two Discussion Topics above
  - A facilitator should be identified to moderate the discussion and rapporteur should be identified to record the group’s findings and report them when the class reconvenes.
  - After 20-30 minutes of group discussion, the entire class should reconvene
  - Rapporteurs should briefly report on their group’s findings
  - Open class discussion

- **Individual Research/Assignment:**
  - Research ways in which clinicians who work with survivors of torture deal with secondary trauma. Write a series of recommendations for colleagues who conduct medical evaluations of alleged torture victims on a regular basis, but are unaware of counter-transference issues
  - **Journal Entry:** (Instructor to assign Write a few paragraphs -- no more than a page)
  - Consider your response to the audiotape of interview with Sr. Diana Ortiz. Provide a series of recommendations to effectively address these reactions and possibly others.
  - Discuss what you find most challenging about interviewing survivors of torture and ill treatment

### PRIMARY RESOURCES

- *The Istanbul Protocol*
- *The Medical Documentation of Torture*
- *Medical Investigation and Documentation of Torture: A Handbook for Health Professionals*
- *Psychological Evaluation of Torture Allegations: An International Training Manual*
- *Audiotape of interview National Public Radio with Sr. Diana Ortiz*
1. Preliminary Considerations

The documentation of torture and other ill-treatment depends on the gathering of detailed and accurate information from the individual on the circumstances of the alleged events, including details of any arrest, detention, conditions of detention and specific treatment while under interrogation. The interview should be structured and conducted according to the guidelines defined in “the general considerations for the interview”, “procedural safeguards” and “medical ethics” chapters of the Istanbul Protocol. These considerations apply to all persons carrying out interviews whether they are lawyers, medical doctors, psychologists, psychiatrists, human rights monitors or members of any other profession. Interview considerations that pertain specifically to the documentation of physical and psychological evidence of torture are included in Modules 5 and 6 respectively.

Torture is usually both physical and psychological in nature. It is important, therefore, for each clinician to elicit and relate physical and psychological information in their evaluations. It should be noted that, with appropriate training, physicians may become qualified to conduct psychological evaluations. Those who are not qualified, should refer the alleged victim to a qualified psychological expert (i.e. psychologist, psychiatrist, clinical social worker). Medical doctors should carefully consider the potential benefits and possible difficulties of qualifying as a psychological expert. It may be helpful to seek the advice of attorneys to better understand country-specific requirements to qualify as an expert witness on psychological evidence of torture.

The degree of detail gathered during an interview with an alleged victim of torture depends on several factors, such as the aim of the interview/examination (producing a note in a medical record of incidental findings during a routine medical visit, versus being asked to provide a medical report for a judicial body), the location and circumstances of the interview (for example in a health clinic, in a police station or prison, or in a rehabilitation centre for survivors of torture) and the degree of access to the individual and amount of time available. This being said, the principles on interviewing can be adapted and applied to the various circumstances in which an individual alleging torture may be encountered.

Clinicians should not assume that the individual, such as the asylum applicant’s attorney, requesting a medico-legal evaluation has related all the material facts. It is the clinician’s responsibility to discover and report upon any material findings that he or she considers relevant, even if they may be considered irrelevant or adverse to the case of the party requesting the medical examination. Findings that are consistent with torture or other forms of ill-treatment must not be excluded from a medico-legal report under any circumstance.

1.1 Purpose of Medical Evaluations

According to the Istanbul Protocol, the broad purpose of the medical evaluation is to establish the facts related to alleged incidents of torture (*IP, §120*). The purpose of the written or oral testimony of the physician is to provide expert opinion on the degree to which medical findings correlate with the patient’s allegation of abuse and to communicate effectively the physician’s medical findings and interpretations to the judiciary or other appropriate authorities. In addition, medical testimony often serves to educate the judiciary, other government officials and the local and international communities on the physical and
psychological *sequelae* of torture. The examiner should be prepared to do the following (IP, §121):

- Assess possible injury and abuse, even in the absence of specific allegations by individuals, law enforcement or judicial officials;
- Document physical and psychological evidence of injury and abuse;
- Correlate the degree of consistency between examination findings and specific allegations of abuse by the patient;
- Correlate the degree of consistency between individual examination findings with the knowledge of torture methods used in a particular region and their common after-effects;
- Render expert interpretation of the findings of medico-legal evaluations and provide expert opinion regarding possible causes of abuse in asylum hearings, criminal trials and civil proceedings;
- Use information obtained in an appropriate manner to enhance fact-finding and further documentation of torture.

### 1.2 Interview Settings

Medical evaluations of torture allegations should be conducted at a location that the clinician deems most suitable. The clinician should ensure that the interviewee, particularly if the interviewee is a detainee, is not forced into accepting a place which is not comfortable and safe. In many situations it is not possible to control the environment of the interview (for example in police stations and prisons), and the interviewer will have to make the best of less than ideal conditions. However, the basic principles on interviewing should be adapted and applied as far as possible to the different contexts. The clinician should make sure to explore all opportunities to establish a setting which is as private, safe and comfortable as possible. Attention should be paid to arrange the room in a way that it is not reminiscent of an official surrounding and the process of interrogation.

Sufficient time should be allotted for the interview and arranged in advance. A two-to-four hour interview may be insufficient to conduct an evaluation for physical or psychological evidence of torture. A second, and possibly a third, interview may be needed to be scheduled to complete the evaluation. If the evaluation is taking place under time constraints, the information gathered and the outcome of the interview might be limited. Such constraints and limitations should be noted in a medical evaluation.

If possible:
- The room should have appropriate physical conditions (light, ventilation, size, temperature).
- There should be access to toilet facilities and refreshment opportunities. It would be good to have water and tissues within the reach of the interviewee.
- The seating should allow the interviewer and interviewee to be equally comfortable and at an appropriate distance, to establish eye contact, and see each others’ faces clearly.

### 1.3 Trust

Trust is an essential component of eliciting an accurate account of abuse. Earning the trust of someone who has experienced torture or other forms of abuse requires active listening, meticulous communication, courtesy and genuine empathy and honesty. Clinicians must have the capacity to create a climate of trust in which disclosure of crucial, though perhaps
very painful or shameful, facts can occur. It is important to be aware that those facts are sometimes intimate secrets that the person may reveal at that moment for the first time.

Clinicians should explain what to expect in the evaluation. The clinician should also be mindful of the tone, phrasing and sequencing of questions (sensitive questions should be asked only after some degree of rapport has been developed) and should acknowledge the interviewee’s ability to take a break if needed or to choose not to respond to any question.

### 1.4 Informed Consent

Clinicians must ensure that informed consent is based on adequate disclosure and understanding of the potential benefits and adverse consequences of a medical evaluation and that consent is given voluntarily without coercion by others, particularly law enforcement or judicial authorities. The interviewee has the right to refuse the evaluation. In such circumstances, the clinician should document the reason for refusal of an evaluation. According to the Istanbul Protocol:

> "Medical experts involved in the investigation of torture or ill-treatment shall behave at all times in conformity with the highest ethical standards and, in particular, shall obtain informed consent before any examination is undertaken.” (Istanbul Principle 6(a))

From the outset, the alleged victim should be informed of: the nature of the process, why his/her evidence is being sought, how the information given by the person would be used and possible consequences.

As stated in Module 2, Informed consent requires that the consenting individual:

- Is mentally competent
- Receives full disclosure of information, including risks, benefits, and clarification of the limits of confidentiality that may be imposed by State or judicial authorities.
- Understands the information provided
- Gives his/her consent voluntarily
- Provides authorisation for his/her consent

### 1.5 Confidentiality

Clinicians have a duty to maintain confidentiality of information and to disclose information with only the interviewee’s informed consent. The clarification of confidentiality and its limits are of paramount importance for a well-conducted interview. The interviewee should be clearly informed of any limits on the confidentiality of the evaluation and of any legal obligations for disclosure of the information gathered by means of the interview and medical/psychological examination at the beginning of the interview.

Individuals may fear that information revealed in the context of an evaluation cannot be safely kept from being accessed by persecuting governments. Fear and mistrust may be particularly strong in cases where physicians or other health workers were participants in the torture. In many circumstances, the evaluator will be a member of the majority culture and ethnicity, whereas the patient, in the situation and location of the interview, is likely to belong to a minority group or culture. This dynamic of inequality may reinforce the perceived and real imbalance of power and may increase the potential sense of fear, mistrust and forced submission in the interviewee.
1.6 Privacy

Examinations must be conducted in private under the control of the clinician. Privacy during the interviews is not only necessary for ethical reasons, but also when talking about sensitive issues that may be embarrassing or shameful for the person being evaluated. The clinician should establish and maintain privacy during the entire interview (IP, §83, 124). Police or other law enforcement officials should never be present in the examination room. The presence of police officers, soldiers, prison officers or other law enforcement officials in the examination room, for whatever reason, should be noted in the clinician’s report. Their presence during the examination may be grounds for disregarding a negative medical report (IP, §124, 125). If any other persons are present in the interview room during the interview, the identity, titles, affiliations of those persons should be indicated in the report (IP, §125).

1.7 Empathy

Empathy and human contact may be the most important thing that people still in custody receive from the investigator. The investigation itself may contribute nothing of specific benefit to the person being interviewed, as in most cases their torture will be over. The meagre consolation of knowing that the information may serve a future purpose will however be greatly enhanced if the investigator shows appropriate empathy. While this may seem self-evident, all too often investigators in actual prison visits are so concerned about obtaining information that they fail to empathize with the prisoner being interviewed.

1.8 Objectivity

Conducting an objective and impartial evaluation should not preclude the evaluator from being empathic. It is essential for clinicians to maintain the professional boundaries and at the same time to acknowledge the pain and distress that they observe. The clinician should communicate their understanding of the individual’s pain and suffering and adopt a supportive, non-judgmental approach. Clinicians need to be sensitive and empathic in their questioning while remaining objective in their clinical assessment.

1.9 Safety and Security

Clinicians should carefully consider the context in which they are working, take necessary precautions and provide safeguards accordingly. If interviewing people who are still imprisoned or in similar situations in which reprisals are possible, all precautions should be taken to ensure that they do not place the detainee in danger (or in additional difficulty). Promises must not be made, for example, to provide security for the witness or for relatives who might be at risk, unless the interviewer is certain that they can be fulfilled. Witnesses might believe that international organisations or others investigating allegations of torture have more power to protect them than is the case. It is part of the informed consent process that individuals are aware of all the issues before they agree for a clinician to make a formal report. If the risk of harm from reprisals is a virtual certainty, conducting a medical evaluation may be considered unethical even if informed consent is obtained. This may be the case in the context of documenting human rights violations in places of ongoing conflict.

Whether or not certain questions can be asked safely will vary considerably and depends on the degree to which confidentiality and security can be ensured. When necessary, questions about forbidden activities should be avoided.
If the forensic medical examination supports allegations of torture, the detainee should not be returned to the place of detention, but rather should appear before the prosecutor or judge to determine the detainee’s legal disposition (see Procedural Safeguards below).

An interviewer will make notes of the interview, and may use other recording devices. The reasons for this should be explained to the interviewee who should be reassured as to how the notes and other records will be used and asked for consent. The way in which any records of such interviews are stored can be important in protecting the security of the interviewer and the interviewee. In many countries where torture is prevalent, the police have been known to raid clinics and search or confiscate medical records. In order to protect patients, therefore, in such conditions records should have no obvious identifying information on any document inside (such as initials or date of birth), and the files themselves being numbered with a register kept in a secure place elsewhere. Patients can be given cards with the identifying number so that treatment can be continued even if the register is not available. In some circumstances it may be necessary to hold records at a different location or even in a third country to ensure their security.

If information about an individual needs to be transmitted to another body, fax transmission is generally safer than e-mail as a copy of the latter may be stored on the sending computer or held on the server of the internet service provider. In some countries the authorities routinely screen all outgoing messages.

1.10 Procedural Safeguards for Detainees

Ensuring procedural safeguards for detainees is essential for the safety and security of detainees, to earn the detainees trust, respect his or her privacy, and ensure confidentiality (See Procedural Safeguards for Detainees, Module 2). Disregard for certain procedural safeguards may not only result in inaccurate medical evaluation, but also the possibility of administrative and/or criminal sanctions against the medical expert responsible for forensic documentation of torture and ill-treatment. As described in Module 2, procedural safeguards for detainees can be summarised as follows:

- Forensic medical evaluation of detainees should be conducted in response to official written requests by public prosecutors or other appropriate officials.
- Detainees themselves, their lawyers or relatives have an independent right to request a medical evaluation to seek evidence of torture and ill-treatment.
- It is mandatory that detainees undergo a preliminary medical examination at the time of detention; a further examination and evaluation should be made upon their release.
- The detainee should be taken to the forensic medical examination by officials other than soldiers or police working in the unit where the detainee is held.
- The officials who supervise the transportation of the detainee should be responsible to the public prosecutors and not to other law enforcement officials.
- The detainee must be:
  - independently and thoroughly examined by a qualified doctor, and, without any police officer being present.
- The presence of police, soldier, warden, or other law enforcement officers in the examination room, for whatever reason, should be noted in the physician’s official medical report. Notation of police, soldier, prison officer, or other law enforcement official’s presence during the examination may be grounds for disregarding a "negative" medical report.
• Medico-legal evaluations of detainees should include the use of a standardized medical report form.
• The report must include the story, details of injuries and psychological findings that may be attributable to torture or ill-treatment together with explanations of the patient and the opinion of the doctor.
• Under no circumstances should a copy of the medical report be transferred to law enforcement officials; instead it should be transmitted to the official requesting the report, generally the public prosecutor.
• If the forensic medical examination supports allegations of torture or ill-treatment, the detainee should not be returned to the place of detention, but should instead be presented to the competent prosecutor or judge for purposes of determining the detainee's legal disposition.
• Access to the lawyer should be provided at the time of the medical examination.
• The medical examination should be free of charge.
• Forensic medical services should be under judicial or an independent authority and not under the same governmental authority as the police and prison system.
• Detainees have the right to obtain a second or alternative medical evaluation by a qualified physician also during his/her detention.

1.11 Risk of Re-traumatisation

Physical and psychological examinations by their very nature may re-traumatise an individual by provoking and/or exacerbating psychological distress and symptoms by eliciting painful memories. The interview must be structured so as to minimise the risk of re-traumatisation. According to the Istanbul Protocol:

"Several basic rules must be respected (see chapter III, sect. C.2 (g). Information is certainly important, but the person being interviewed is even more so, and listening is more important than asking questions." (IP, §134)

The clinician needs to balance two important requirements which should be complementary, but may sometimes conflict: the need to obtain a useful account, and the importance of respecting the needs of the person being interviewed. The primary goal of documenting allegations of torture is to create an accurate, reliable, precise and detailed record of events by taking into account the personal situation and the psychological condition of the individual.

Interviewers should show sensitivity in their questioning and watch out for signs of tiredness or distress. A subjective assessment has to be made by the clinician about whether and to what extent pressing for details is necessary for the effectiveness of the report in court, especially if the interviewee demonstrates obvious signs of distress.

1.12 Gender Considerations

Ideally, an investigation team should contain specialists of both genders, permitting the person who says that they have been tortured to choose the gender of the investigator and, where necessary, the interpreter. This is particularly important when a woman has been detained in a situation where rape is known to happen, even if she has not, so far, complained of it. Even if no sexual assault takes place, most torture has sexual aspects. The re-traumatisation can often be worse if she feels she has to describe what happened to a person who is physically similar to her torturers, who will inevitably have been mostly or entirely men. In some cultures, it would be impossible for a male investigator to question a
female victim, and this must be respected. However, in most cultures, if there is only a male physician available, many women would prefer to talk to him rather than a female of another profession in order to gain the medical information and advice that she wants. In such a case, it is essential that the interpreter, if used, be female. Some interviewees may also prefer that the interpreter be from outside their immediate locality, both because of the danger of being reminded of their torture and because of the perceived threat to their confidentiality. If no interpreter is necessary, then a female member of the investigating team should be present as a chaperone throughout at least the physical examination and, if the patient wishes, throughout the entire interview.

When the individual is male and has been sexually abused, the situation is more complex because he too will have been sexually abused mostly or entirely by men. Some men would, therefore, prefer to describe their experiences to women because their fear of other men is so great, while others would not want to discuss such personal matters in front of a woman.

1.13 Interviewing Children

Children have the rights to have their consent and confidentiality respected. Except in emergency they should not be given medical treatment without a parent or guardian present. Similarly, a detailed account of the cause of injuries should only be taken from a child in the presence of a parent or guardian or, if they are not available, someone else representing the child’s best interests.

Older children may be tortured to suppress political activity. They should be treated in the same way as young adults, and the approach needs to be very sympathetic. Torture of younger children is generally performed to put pressure on parents. Where possible, the family should be treated together and the child’s injuries should be documented and managed by pediatric specialists.

A child, in particular, needs to be in an environment in which he or she feels comfortable before being willing to disclose sensitive information. In discussing traumatic events, a child may prefer to draw a picture and then to explain it. Children’s attention spans can be quite short, so it may be necessary to break the interview frequently. See additional considerations in Module 6, Children and Torture.

1.14 Cultural and Religious Awareness

The clinician should attempt to understand mental suffering in the context of the interviewee’s circumstances, beliefs, and cultural norms rather than rush to diagnose and classify. Awareness of culture specific syndromes and native language-bound idioms of distress is of paramount importance for conducting the interview and formulating the clinical impression and conclusion. When the interviewer has little or no knowledge about the interviewee’s language and culture, the assistance of an interpreter is essential. An interpreter from the interviewee’s country of origin will facilitate an understanding of the language, customs, religious traditions, and other beliefs that will need to be considered during the evaluation.

In addition, interviewers should make sure to conduct him or herself in a manner that does not offend cultural or religious sensibilities. A lack of such awareness risks alienating the individual and/or causing them to feel uneasy, leading to a less effective interview.

1.15 Working with Interpreters
Good interpreters, particularly those from the same background as the individual, are able not only to interpret the words, but also to identify and explain relevant cultural, historical and social factors as well as linguistic idioms to the interviewer. Beware, however, of over-reliance on interpreters, as they are not experts in areas outside their own field.

Interpreters are an important part of the inquiry team. They need to be trained to work with survivors of torture and other ill-treatment even if they have considerable experience of interpreting in other contexts. Most professional interpreters have their own code of ethics. If not, they must be advised that what they hear and interpret in interviews is strictly confidential.

Professionals working with interpreters need to remind themselves that, if they do not share a language with the individual, the quality of the interpreter used will impact on all aspects of their interview, examination and report.

**Second and third languages**

In situations where the health professional is seeing the individual in their routine practise, they will usually speak the same language. In situations where there are several ethnic groups within a country, there may be language barriers within the population. Sometimes the one will speak some of the other’s language, or they may share a third language. The danger is that if one person’s command of this second or third language is weak, this may lead to inaccuracies and inconsistencies in the report. There may also be difficulties associated with interpreters of a different ethnicity or from a different region from that of the individual. The accent and vocabulary might differ.

**Gender and age of interpreters**

In many cases, it is necessary to use an interpreter for some, or all, of the interview. The issues of gender may be even more important in this situation as the interviewee may relate more to the interpreter than to the interviewer. Some individuals are less concerned about the gender of the interviewer than they are about that of the interpreter. Age may also be relevant. A young male individual may be able to discuss sexual torture with an older woman to whom he may relate as to an aunt, but not to a woman of his own age. Similarly, a young female individual may find an older man easier to talk to than one who is of a similar age to her torturer. Bear in mind, however, for women, having a female interviewer and interpreter is the best practise.

**Local and international interpreters**

When an international team makes a visit to a country it might include interpreters, or it may choose to employ local interpreters. There are two issues to keep in mind in such cases. Firstly it must be made clear to the local interpreter that he or she may be putting him- or herself into danger by working with visiting interviewers when documenting torture. Secondly, the individual may not trust a local interpreter and not give a complete account of what happened.

**Using an interpreter**

Interviewers should remember to talk to the individual and to keep eye contact with him or her even though there is a natural tendency to speak to the interpreter. It helps to pose questions directly to the first person, for example: ‘What did you do then?’ rather than
indirectly through the interpreter, for example: ‘Ask him what happened next.’ Observing body language, gestures and facial expressions, as well as non-verbal communication, is essential both to enhance the amount of information gained and to give the individual confidence that the health professional is interested in what is being said. Above all, it helps the individual to understand that he or she has been heard. When the individual is providing a long, unbroken account, the health professional should pause the interview regularly to note the information. This helps the interpreter not to forget key points and allows the health professional to clarify points when they are still fresh in the individual’s mind.

**Family members**

As a rule, family members and friends must not be used for interpretation for two reasons. First, the quality of interpreting is generally inadequate, and second, there may be topics that the individual will not discuss in front of a family member, and therefore the risk of a failure to disclose torture is greatly increased. Many parents, for example, will not reveal details of their torture in front of their child. Furthermore, revealing such details in their presence may even lead to psychological harm for the child.

**1.16 Transference and Counter-Transference Reactions**

Clinicians who conduct physical and psychological evaluations should be aware of the potential emotional reactions that evaluations of severe trauma may elicit in the interviewee and interviewer. These emotional reactions are known as transference and countertransference.

**Transference**

Transference refers to the feelings a survivor has towards the clinician that relate to past experiences but which are misunderstood as directed towards the clinician personally. Common transference considerations may include the following:

- A clinical interview may induce mistrust on the part of the torture survivor and possibly remind him or her of previous interrogations thereby “re-traumatizing” him or her. To reduce the effects of re-traumatisation, the clinician should communicate a sense of empathy and understanding.
- The survivor may suspect the clinician of having voyeuristic and sadistic motivations or may have prejudices towards the clinician because he/she hasn't been tortured.
- The clinician is a person in a position of authority and for that reason may not be trusted with certain aspects of the trauma history.
- Alternatively, individuals still in custody may be too trusting in situations where the clinician cannot guarantee that there will be no reprisals for speaking about torture.
- Torture survivors may fear that information that is revealed in the context of an evaluation cannot be safely kept from being accessed by persecuting governments.
- Fear and mistrust may be particularly strong in cases where physicians or other health workers were participants in the torture.
- In the context of evaluations conducted for legal purposes, the necessary attention to details and the precise questioning about history is easily perceived as a sign of doubt on the part of the examiner. Under these pressures, survivors may feel overwhelmed with memories and affect or mobilize strong defences such as withdrawal and affective flattening or numbing during evaluations.
- If the gender of the clinician and the torturer is the same, the interview situation may be perceived as resembling the torture more than if the genders were different.
On the other hand, it may be much more important to the survivor that the interviewer is a physician regardless of gender so as to ask specific medical questions about possible pregnancy, ability to conceive later, and future of sexual relations between spouses.

**Counter-transference**

The clinician’s emotional response to the torture survivor, known as counter-transference, also may affect the psychological evaluation. When listening to individuals speak of their torture, clinicians should expect to have emotional responses themselves. Understanding these personal reactions is crucial because they can have an impact on one’s ability to evaluate and address the physical and psychological consequences of torture. Counter-transference reactions may include:

- Avoidance, withdrawal and defensive indifference in reaction to being exposed to disturbing material. This may lead to forgetting some details and underestimating the severity of physical or psychological consequences;
- Disillusionment, helplessness, hopelessness and overidentification that may lead to symptoms of depression or vicarious traumatisation, such as nightmares, anxiety and fear;
- Omnipotence and grandiosity in the form of feeling like a saviour, the great expert on trauma or the last hope for the survivor’s recovery and well-being;
- Feelings of insecurity about professional skills when faced with the gravity of the reported history or suffering. This may manifest as lack of confidence in the ability to do justice to the survivor and unrealistic preoccupation with idealized medical norms;
- Feelings of guilt over not sharing the torture survivor’s experience and pain or over the awareness of what has not been done on a political level may result in overly sentimental or idealized approaches to the survivor;
- Anger and rage towards torturers and persecutors are expectable, but may undermine the ability to maintain objectivity when they are driven by unrecognised personal experiences and thus become chronic or excessive;
- Anger or repugnance against the victim may arise as a result of feeling exposed to unaccustomed levels of anxiety. This may also arise as a result of feeling used by the victim when the clinician experiences doubt about the truth of the alleged torture history and the victim stands to benefit from an evaluation that documents the consequences of the alleged incident;
- Significant differences between the cultural value systems of the clinician and the individual alleging torture may include belief in myths about ethnic groups, condescending attitudes and underestimation of the individual’s sophistication or capacity for insight. Conversely, clinicians who are members of the same ethnic group as a victim might form a non-verbalized alliance that can also affect the objectivity of the evaluation.

Most clinicians agree that many countertransference reactions are not merely examples of distortion but are important sources of information about the psychological state of the torture victim. The clinician’s effectiveness can be compromised when counter-transference is acted upon rather than reflected upon. Clinicians engaged in the evaluation and treatment of torture victims are advised to examine counter-transference and obtain supervision and consultation from a colleague, if possible. Individual and group support may also help to prevent and/or mitigate secondary traumatisation and/or burn-out reactions that are commonly experienced by clinicians.
2. Conducting Interviews

2.1 Types of Questions

If possible, the individual should be asked to give a chronological account of the incident(s) in question. Generally, open-ended questions should be used, for example: ‘Can you tell me what happened?’ or ‘Tell me more about that.’ The individual should be allowed to tell his or her story with as few interruptions as possible. Further details can be elicited with appropriate follow-up questions, such as: ‘How big was the cell?’, ‘Was there any lighting?’ and ‘How could you go to the toilet?’ Asking too many questions too quickly might confuse the individual, or even remind him or her of being interrogated.

Leading questions are avoided wherever possible, because individuals may answer with what they think the health professional wants to hear. This is especially important when interviewing for medico-legal purposes, where the testimony may be challenged in court. Closed questions, which provide the interviewee with a limited number of options and, particularly, list questions, can cause confusion in the individual and might create unnecessary inconsistencies. For example, an individual might be asked, ‘Were you arrested by the police or the army?’ limiting the answer to a choice between the two. If he or she was arrested by a special task force of soldiers and policemen working together, it would be difficult to give an accurate answer without appearing to contradict the health professional. This could in turn create inconsistencies between statements.

The pace of the interview must be dictated by the individual. Even if there is limited time for the interview (such as in a police station or prison), the interviewee should not feel rushed. It is better to focus on a few specific points than to try to cover too much ground in too little time. If there are many interviewees to be seen over several days, each should be seen once or twice for a substantial period of time, rather than several shorter sessions.

In a clinical setting, the interviewer should allow enough time between appointments to allow for this and for sufficient time to write up his or her notes. It is good practise to write up the notes of each interview at the end of that session, as various aspects of the individuals’ accounts may become confused if the interviewer attempts to write up all the interviews in a later single session, and details may be forgotten.

2.2 Cognitive techniques

Psychological research has shown that the ability to recall important incidents can be enhanced by using some basic cognitive techniques. Having established rapport with the individual, he or she should be allowed to give a free narrative about the events. The interviewer should allow the individual, as much as possible, the time to describe what happened in his or her own words. Clarification of points is permissible but not direct questioning which might break the individual’s recall. Only after the individual has finished his or her narrative should direct questions be asked to clarify points. The survivor of torture should know that it is acceptable to say: ‘I don’t understand the question,’ or ‘I don’t know the answer.’

The quality of the information gained can be improved by some specific techniques. Firstly, in a clinical setting in which time allows it, the individual should be told to describe everything surrounding the time of ill-treatment (for instance describing the events and process of being taken into detention), even if it does not appear directly relevant to him or her. This might relate to events that could be more important than the individual realises.
Secondly, as he or she relates them, this can bring other events that are more relevant into his or her mind. It helps if he or she is encouraged to recall the context in which the events happened.

Having encouraged the interviewee to describe the events in a free narrative, in chronological order, the interviewer can seek more detail by asking questions in a different order. For example, by reversing the order: ‘You were telling me ..., what happened just before that?’

Another tool is changing the perspective, which means trying to describe the events from another point of view, for example if the interviewee is sufficiently well-educated the interviewer could ask: ‘How would a tailor describe what the man was wearing?’ or ‘When you were arrested at the demonstration, what would a spectator have seen?’

It is important to remember that different cultures have different concepts of what is normal behaviour in an interview. In some societies it is considered polite not to look directly into the eyes of someone in a position of relative authority (such as an interviewer), whereas in other cultures such behaviour is considered to be a sign of dishonesty. People from some cultures find constant hand movements a normal part of communication, whereas those from others find them distracting. Personal space varies between and within cultures, and what might be normal between colleagues could feel too close in an interview setting. This could make the individual feel anxious, and behave in a way that the interviewer perceives as uncooperative.

2.3 Summarising and clarifying

During the interview, it is often helpful to clarify points, in order to ensure that the information is accurate. For example: ‘When you say that you were suspended by your arms, in what position were they?’ Alternatively the individual can be asked to recreate the position, but it should be borne in mind that doing so could provoke uncomfortable feelings or other reactions in the individual.

At the end of each session, it generally helps to summarise the key points, to ensure that they are clear. This sometimes has the additional benefit of getting the individual to remember details that add to the narrative.

In medico-legal cases, it may be helpful to have an opportunity to meet with the individual again to review any questions or inconsistancies. This also provides an opportunity to follow up any clinical problems that may have been identified in the evaluation.

2.4 Difficulties Recalling and Recounting

Torture survivors may have difficulties in recalling and recounting the specific details of the torture experience and other parts of the history for several important reasons. Clinicians should be familiar with such factors as they commonly manifest as inconsistencies in the interview. Difficulty recalling and recounting may be related to:

- Factors directly related to the torture experience
  - Factors during torture itself, such as blindfolding, drugging, lapses of consciousness, etc.
  - Disorientation in time and place during torture due to the nature of torture or extreme stress experienced during torture.
Neuro-psychiatric memory impairment resulting from head injuries, suffocation, near drowning, starvation, hunger strikes or vitamin deficiencies.

Experiencing repeated and similar events may also lead to difficulties in recalling clearly the details of specific events.

Factors related to the psychological impact of torture
- PTSD-related memory disturbances recalling the traumatic event or intrusive memories, nightmares and the inability to remember important details of the event.
- Denial and avoidance, which can be protective coping mechanisms, in these particular circumstances.
- High emotional arousal and impaired memory secondary to trauma-related mental illnesses, such as depression and post-traumatic stress disorder.
- Other psychological symptoms such as concentration difficulties, fragmentation or repression of traumatic memories, confusion, dissociation, amnesia.
- Feelings of guilt or shame.

Cultural factors
- Cultural differences in the perception of time.
- Culturally prescribed sanctions that allow traumatic experiences to be revealed only in highly confidential settings.

Factors related to interview conditions or barriers of communication
- Fear of placing oneself or others at risk.
- Lack of trust in the examining clinician and/or interpreter.
- Lack of feeling safe during the interview.
- Environmental barriers such as lack of privacy, comfort of interview setting, inadequate time for the interview.
- Physical barriers such as pain or other discomforts, fatigue, sensory deficits.
- Socio-cultural barriers such as the gender of the interviewer, language and cultural differences.
- Barriers due to transference/counter-transference reactions during the interview.
- Inadequately conducted and/or poorly structured interviews.

2.5 Assessing Inconsistencies

Inconsistencies in a person’s story may arise from any or all of these factors. If possible, the investigator should ask for further clarification. These possibilities should be explored in detail. When clarification is not possible, the investigator should look for other evidence that supports or refutes the story. A network of consistent supporting details can corroborate and clarify the person’s story. Although the individual may not be able to provide the details desired by the investigator, such as dates, times, frequencies and exact identities of perpetrators, a broad outline of the traumatic events and torture will emerge and stand up over time.

If, on the other hand, the clinician suspects fabrication (sometimes called “simulation”), the clinician should try to identify potential reasons for exaggeration or fabrication, keeping in mind that fabrications may require detailed knowledge about trauma-related symptoms and findings that individuals rarely possess. It may be helpful to refer the individual to another clinician for a second opinion. If the suspicion of fabrication persists, it should be documented by both clinicians.

3. Interview Content
3.1 Identification and Introduction

Interviews for medical evaluations usually begin with the clinician introducing himself or herself followed by:

- Explanation of the purpose of the evaluation
- Reviewing the conditions of the evaluation, i.e.
  - Independence of the evaluator
  - Confidentiality of the clinician’s findings and limits thereof
  - Right to refuse answering questions
  - Importance of detail and accuracy of information
  - Acknowledge likely difficulty of recalling certain events
  - Ability to take breaks
  - Access to refreshments and toilet facilities
- Statement on the overall content of the interview including: detailed questions on events before during and after the alleged torture, followed by a physical examination, should this be the case, and the possibility of photographs
- Discussing the likely benefits and risks of the evaluation
- Addressing any questions or concerns that the individual may have
- Obtaining consent to proceed with the evaluation.

For forensic evaluations, the clinician should establish the identity of the subject. As previously mentioned, law enforcement officials should not be present during the evaluation. If such officials refuse to leave the examination room, it should be noted in the clinician’s report or and/or the evaluation may be cancelled.

When the medical evaluation is being conducted by more than one clinician, i.e. one for physical evidence and another for psychological evidence, the content of the interview should focus on the information most relevant to their expertise.

3.2 Psychosocial History (Pre-Arrest)

The examiner should inquire into the person's daily life, relations with friends and family, work/school, occupation, interests, and use of alcohol and drugs, prior to the traumatic events. Inquiries into prior political activities and beliefs and opinions are relevant insofar as they help to explain why the person was detained and/or tortured, but such inquiries are best made indirectly by asking the person what accusations were made, or why they think they were detained and tortured. The psychosocial history is particularly important in understanding the meaning that individuals assign to traumatic experiences.

The occupation of the individual is sometimes relevant to the documentation of torture because it might affect the differential diagnosis of any lesions. Occupation can also be a marker of educational attainment, and so can be evidence of a change in cognitive and/or psychosocial functioning. Statements from former colleagues, or documentation of work appraisals, can act as corroboration of this point.

The social background can also be relevant. If the individual has some educational achievements documented, these can be used as indicators of the premorbid intellectual state (the psychological condition the individual was in prior to the trauma). They can then be compared with the evaluation of the individual’s present level of functioning, and judgements can be made about changes, and any possible causation.
3.3 Past Medical History

Obtain a complete medical history, including prior medical, surgical and/or psychiatric problems. Be sure to document any history of injuries before the period of detention and any possible after-effects. Knowledge of prior injuries may help to differentiate physical findings related to torture from those that are not.

3.4 Summary of Detention(s) and Abuse

Before obtaining a detailed account of events, elicit summary information, including dates, places, duration of detention, frequency and duration of torture sessions. A summary will help to make effective use of time. In some cases where survivors have been tortured on multiple occasions, they may be able to recall what happened to them, but often can not recall exactly where and when each event occurred. In such circumstances, it may be advisable to elicit the historical account by methods of abuse rather than as a series of events during specific arrests.

Similarly, in taking a history it may often be useful to have "what happened where" documented as much as possible. "Holding places" are often operated by different security/police/armed forces, and what events happened in different places may be useful to get a full picture of the torture system. Obtaining a map of where the torture occurred may be useful in piecing together different histories from different people. This will often prove very useful for the overall evaluation.

3.5 Circumstances of Detention(s)

If there has been an arrest or any period of detention, the description should include details of the conditions of detention, especially the nature of the accommodation (including size, shape, space, natural and artificial light, temperature, ventilation, and hygiene), the daily routine, and access to water, food, sanitation, health care and the open air. All of these elements of arrest and detention can produce physical and psychological manifestations (e.g. malnutrition, vector-borne disease, anxiety, etc).

Consider the following questions: What time was it? Where were you? What were you doing? Who was there? Describe the appearance of those who detained you. Were they military or civilian, in uniforms or in plain clothes? What type of weapons were they carrying? What was said? Were there any witnesses? Was this a formal arrest, administrative detention, or disappearance? Was violence used, threat spoken? Was there any interaction with family members? Note the use of restraints or blindfold, means of transportation, destination, and names of officials, if known.

3.6 Prison/Detention Place Conditions

Include access to and descriptions of food and drink, toilet facilities, lighting, temperature, ventilation. Also, document any contact with family, lawyers or health professionals, conditions of overcrowding or solitary confinement, dimensions of the detention place, and whether there are other people who can corroborate his/her detention. Consider the following questions: What happened first? Where were you taken? Was there an identification process (personal information recorded, fingerprints, photographs)? Were you asked to sign anything? Describe the conditions of the cell/room (note size, others present,
light, ventilation, temperature, presence of insects, rodents, bedding, and access to food, water and toilet). What did you hear, see and smell? Did you have any contact with people outside, or access to medical care? What was the physical layout of the place where you were detained?

3.7 Allegations of Torture and Ill-treatment

The interviewer should then take a detailed description of specific methods of ill-treatment employed during periods of questioning, interrogation or indeed at any time while they are in the control of the authority. It cannot be over-emphasised that it is not sufficient to document only physical ill-treatment and any resulting injuries or scars. Psychological methods must also be accurately noted since these will often produce both psychological reactions and physical symptoms.

In obtaining historical information on torture and ill-treatment, one should be cautious about suggesting forms of abuse that a person may have been subjected to. This may help to separate potential embellishment from valid experiences. However, eliciting negative responses to questions about various forms of torture also may help to establish the credibility of the interviewee.

Questions should be designed to elicit a coherent narrative account. Consider the following questions: Where did the abuse take place, when and for how long? Could you see? Why not? Before discussing forms of abuse, note who was present (give names, positions). Describe the room/place. What objects did you observe? If possible, describe each instrument of torture in detail; for electrical torture, the current, device, and number and shape of electrodes. Ask about clothing/disrobing/change of clothing. Record quotations of what was said during interrogation, insults to one’s identity, etc. What was said among the perpetrators?

For each form of abuse note: body position/restraint, nature of contact, including duration, frequency, anatomical location, and the area of the body affected. Was there any bleeding, head trauma, or loss of consciousness? Was the loss of consciousness due to head trauma, asphyxiation, or pain? One should also ask about how was the person’s condition at the end of the “session.” Could he or she walk? Did s/he have to be helped back or carried back to the cell? Could s/he get up the next day, eat, use the toilet, or walk up or down stairs? How long did the feet stay swollen? All this gives a certain completeness to the description, which a "check list" of methods does not.

Asking detailed questions about specific torture allegations will aid physicians in their efforts to assess correlations between allegations of abuse and presence or absence of medical findings. For example, questions related to allegations of suspension may include: the duration and frequency of the alleged torture (Note: time estimates are subjective, and may not be accurate since disorientation of time and place are common effects of torture), a description of the form of suspension (“crucifixion,” “Palestinian,” etc.), the use of cloth restraints vs. rope, wire or other material, whether weights or pulling was used to increase the pain of the suspension, and whether there was any loss of consciousness, or any other acute or chronic symptoms or disabilities. Such details may be critical in corroborating physical evidence and allegations. For example, a history of brief or partial suspension (some of the individual’s weight supported by his/her feet) with the use of non-abrasive cloth restraints may help to explain the absence of any acute or chronic physical findings on examination. Alternatively, allegations of prolonged and repeated “Palestinian” using ropes
would be highly consistent with evidence of a brachial plexus injury and circumferential wrist abrasions on examination.

In order to assess psychological evidence of torture, it is important for the clinician to assess thought content, affect, and psychological symptoms during and after the period of detention (see Module 6).

As previously mentioned, an individual’s narrative account should be open-ended. In the course of eliciting a detailed history of torture and ill-treatment it may be helpful for the clinician to consider possible categories of abuse. A survivor may have forgotten, for instance, that he or she was subjected to a mock execution. The following list of torture methods is not meant to be used by clinicians as a “check list”, nor as a model for listing torture methods in a report. A method-listing approach may be counterproductive, as the entire clinical picture produced by torture is much more than the simple sum of lesions produced by methods on a list. Furthermore, it is important to recognise that the distinction between physical and psychological methods is artificial.

Torture methods to consider include, but are not limited to:

- **Blunt trauma**, such as a punch, kick, slap, whipping, a beating with wires or truncheons or falling down;
- **Positional torture**, using suspension, stretching limbs apart, prolonged constraint of movement, forced positioning;
- **Burns** with cigarettes, heated instruments, scalding liquid or a caustic substance;
- **Electric shocks**;
- **Asphyxiation**, such as wet and dry methods, drowning, smothering, choking or use of chemicals;
- **Crush injuries**, such as smashing fingers or using a heavy roller to injure the thighs or back;
- **Penetrating injuries**, such as stab and gunshot wounds, wires under nails;
- **Chemical exposure** to salt, chili pepper, gasoline, etc. (in wounds or body cavities);
- **Sexual violence** to genitals, molestation, instrumentation, rape;
- **Crush injury or traumatic removal** of digits and limbs;
- **Medical amputation** of digits or limbs, surgical removal of organs;
- **Pharmacological torture using** toxic doses of sedatives, neuroleptics, paralytics, etc.;
- **Conditions of detention**:
  - Such as a small or overcrowded cell
  - Solitary confinement
  - Unhygienic conditions
  - No access to toilet facilities
  - Irregular or contaminated food and water
  - Exposure to extremes of temperature
  - Denial of privacy
  - Forced nakedness;
- **Deprivation of**:
  - Normal sensory stimulation, such as sound, light, sense of time, isolation, manipulation of brightness of the cell,
  - Physiological needs, restriction of sleep, food, water, toilet facilities, bathing, motor activities, medical care,
  - Social contacts, isolation within prison, loss of contact with the outside world (victims are often kept in isolation in order to prevent bonding and mutual identification and to encourage traumatic bonding with the torturer);
• Humiliation, such as verbal abuse, performance of humiliating acts;
• Threats of death, harm to family, further torture, imprisonment, mock executions;
• Threats of attack by animals, such as dogs, cats, rats or scorpions;
• Psychological techniques to break down the individual, including forced “betrayals,” learned helplessness, exposure to ambiguous situations or contradictory messages;
• Violation of taboos;
• Behavioural coercion, such as:
  o Forced engagement in practises against the religion of the victim (e.g. forcing Muslims to eat pork)
  o Forced harm to others through torture or other abuses
  o Forced destruction of property
  o Forced betrayal of someone placing them at risk of harm;
• Forcing the victim to witness torture or atrocities being inflicted on others.

The above examples do not by any means constitute a definitive list. There are many other forms of abuse that have been witnessed in the past, and there will probably be new forms in the future. International definitions of torture deliberately avoid providing a list of methods that are seen as torture. One of the reasons for this is that such a list may imply that it is exhaustive, and those engaged in such practises would simply devise methods that do not appear on the list, in an attempt to circumvent the definition. Torture is a complex phenomenon; it cannot be simply reduced to a list of acts.

A review of common torture methods and their physical and psychological sequelae is included in Module 4.

### 3.8 Review of Symptoms

After eliciting a detailed narrative of the alleged torture and ill-treatment, it is important to document subsequent symptoms and disabilities that may be related to the alleged abuse. The clinician should obtain a detailed review of physical and psychological symptoms and disabilities at the time of the abuse and subsequently, up to the present time. All complaints of the alleged torture victim are of significance; although there may or may not be a correlation with the physical findings, they should be reported. Acute and chronic symptoms and disabilities associated with specific forms of abuse and the subsequent healing processes should be documented. Specific information acute and chronic symptoms and disabilities are included in Module 5 (Physical Evidence of Torture) and Module 6 (Psychological Evidence of Torture).

### 3.9 Psychosocial History (post-arrest)

It is also important to obtain information concerning the individual’s post-detention/torture psychosocial history, including any difficulties the individual may have experienced such as continued harassment/persecution by authorities, fear for his/her own safety as well as the safety of family/friends following release from detention, inability to return to work or school. Obtain summary information concerning the events of the individual fleeing his/her country of origin and arrival in subsequent locations.

### 3.10 Assessments of Physical and Psychological Evidence

The content of interviews varies among clinicians who conduct separate medical evaluations of physical and psychological evidence of torture. Additional interview considerations for these components of a medical evaluation are included in Modules 5 and 6.
3.11 Physical Examination

The physical examination, and any related photographs of physical findings, is usually conducted after all other interview components, including the psychological evaluation if the examiner is conducting both the physical and psychological assessments. Information on the physical examination is included in Module 5.

3.12 Closing

To conclude the medical evaluation, the clinician should review the next steps in the process of medical documentation, for example, that the clinician will forward a copy of his or her report to the individual’s attorney, or that the clinician is recommending additional tests or consultations. The clinician should consider acknowledging the emotional difficulty of the interview and thank the interviewee for his or her time and effort. During the psychological examination, the clinician may have reassured the individual that their symptoms are normal reactions to extreme experiences. This is particularly helpful when the individual feels that their symptoms are a sign of “going crazy.” The clinician may consider reviewing this point with the individual at the end of the interview.

3.11 Indications for Referral

Wherever possible, examinations to document torture for medico-legal reasons should be combined with an assessment for other needs, whether referral to specialist physicians, psychologists, physiotherapists or those who can offer social advice and support. Investigators should be aware of local rehabilitation and support services. The clinician should not hesitate to insist on any consultation and examination that he or she considers necessary in a medical evaluation. In the course of documenting medical evidence of torture and ill-treatment, physicians are not absolved of their ethical obligations. Those who appear to be in need of further medical or psychological care should be referred to the appropriate services.

NOTE: Online course available on “Caring for Torture Survivors” offered by the Boston Center for Refugee Health and Human Rights. See http://www.bcrhhr.org/pro/course/course_index.html#
MODULE 4

Torture Methods and their Medical Consequences

OBJECTIVES

- To provide in-depth information on specific torture methods, how they are applied and possible acute and chronic physical findings associated with them
- To develop an understanding of the extent to which physical findings corroborate specific allegations of torture and ill-treatment
- To be able to describe and identify physical findings, likely causes of injury and opinion regarding the possibility of torture/ill-treatment
- To understand common psychosocial consequences of torture and ill-treatment
- To be familiar with factors which may affect the variability of psychological evidence of torture and ill-treatment

CONTENT

- The subjective element of suffering
- Torture methods
  - Beating
  - Falanga
  - Ear trauma
  - Eye trauma
  - Restraint, shackling and positional torture
  - Suspension
  - Crushing and stretch Injuries
  - Burning
  - Electrical injuries
  - Asphyxiation
  - Violent shaking
  - Sexual assault
  - Sexual humiliation
  - Prolonged isolation and sensory deprivation
  - Sleep deprivation
  - Temperature manipulation
  - Sensory bombardment
  - Threats of harm
- Psychological consequences of torture
  - The Paradox of Psychological Consequences of Torture
  - The Psychological Consequences of Torture
  - Social, Political and Cultural Context
  - Risk factors for Trauma and Torture-Related Disorders
  - Psychological Symptoms

DISCUSSION TOPICS

- Students should work in groups or individually on answering questions contained in Self-Assessment 4

Additional Discussion Topics:
- Discuss the overall value of physical evidence of torture and limitations thereof
- Consider relationships between physical and psychological evidence of torture. Provide
examples of interrelated findings.
• What patterns of physical injury support the allegation of torture?
• Discuss possible interpretations of the absence of physical evidence of torture and ill-treatment

TEACHING FORMATS

• **Group Activity:**
  - Divide the class into several groups and have each group work on answering questions contained in Self-Assessment 4
  - A facilitator should be identified to moderate the discussion and rapporteur should be identified to record the group’s findings and report them when the class reconvenes.
  - After 20-30 minutes of group discussion, the entire class should reconvene
  - Rapporteurs should briefly report on their group’s findings
  - Open class discussion

Alternative Option:
  - Divide the class into several groups and assign each group with one or more (or all) of the Discussion Topics
  - Follow the usual sequence for conducting group activities as outlined above

**Individual Research/Assignment:**
  - Individual students should answer all questions contained in Self-Assessment 4
  - **Journal Entry:** (Instructor to assign Write a few paragraphs -- no more than a page)
  - Respond to one or more of the Discussion Topics

PRIMARY RESOURCES

• *The Istanbul Protocol, Chapters V and VI*
• *The Medical Documentation of Torture*
• *Medical Investigation and Documentation of Torture: A Handbook for Health Professionals*
• *Examining Asylum Seekers*
• *Medical Physical Examination of Alleged Torture Victims: A Practical Guide to the Istanbul Protocol for Medical Doctors*
• *Dermatologic Findings after Alleged Torture (PowerPoint file). Lis Danielsen and Ole Vedel Rasmussen, IRCT 2004-2005.*
• *İşkence Atla: İşkencenin Tibbi Olarak Belgelendirilmesinde Muayene ve Tanısal İnceleme Sonuçlarının Kullanılması*
• *Trainers’ Guidelines for Health Professionals: Training of Users*

1. Introduction

Effective medical investigation and documentation of torture and ill-treatment require clinicians to have a detailed understanding of torture methods and their physical and psychological *sequelae*. This Module provides a review of common torture methods and their medical consequences. It is important to keep in mind that it is difficult to separate physical from psychological torture, as each has a component of the other; for example, hooding not only impedes normal breathing, but also produces disorientation and fear. In addition, physical forms of torture and ill treatment will generally produce both physical and psychological *sequelae*, and psychological forms of torture and ill-treatment often result in psychological *sequelae*, but may also produce physical *sequelae* as well.

The methods of torture and ill-treatment included in this module are not exhaustive. The actual methods that a survivor experiences are only limited by the imagination and cruelty
of his or her torturers. As mentioned in Module 1, it is important to realize that, although there is much similarity of torture methods around the world, there can be regional and country-specific variations. Instructors and students who use this Model Curriculum should be aware of regional, country-specific, and local practises and adapt them to the Model Curriculum materials accordingly with reliable and current human rights reports.

Although physical torture as practised around the world has many features in common, almost invariably including beating, slapping and kicking, more sophisticated techniques have been developed in many areas. In countries whose authorities wish to disguise the fact that torture takes place, methods are devised, sometimes with the help of doctors, that produce maximum pain with minimum external evidence. This must be recognised by the examiner if the after-effects of these techniques are not to be missed, especially after the passage of time. Documentation of special methods of torture alleged by an individual requires that the examiner has a detailed knowledge of torture techniques used in the country where the torture was alleged to have taken place. With this knowledge the interviewer can take an informed and detailed history (taking care to avoid using leading questions). This helps to give a precise picture of such details of torture as the victim’s posture, clothing, blindfolding or hoarding, the implements used, duration of assault and his or her condition at the end of the session – whether he or she could walk or whether there were any bleeding wounds. It cannot be emphasised too strongly that such a detailed history is essential to ensure that, during the subsequent physical examination, signs in the relevant areas of the body are not missed and that a correct differentiation from accidental or self-inflicted injury is made. For this reason it is necessary to review, at length, some of the techniques employed in different countries before outlining the symptoms and signs to be expected during history-taking and physical examination. Of particular value in assessing the severity of the attack is a history of loss of consciousness, though this should be elaborated by questions aimed at finding out whether unconsciousness was caused by blows to the head, asphyxiation, unbearable pain or exhaustion.

As discussed in Module 3, survivors may be unable to describe exactly what happened to them because they may have been blindfolded, lost consciousness, sustained head injury, or have difficulty recalling or revealing the especially traumatic components of their experience. It is important to realize that torturers often attempt to conceal their deeds. For example, physical evidence of beating may be limited when a wide, blunt objects are used for beatings. Similarly, victims are sometimes covered by a rug, or shoes in the case of falaka, to distribute the force of individual blows. For the same reason, wet towels may be used with electric shocks. In other cases, torturers use methods with the intent of producing maximal pain and suffering with minimal evidence, for example, forced positioning, near asphyxiation, mock executions, temperature manipulation, sensory deprivation, prolonged isolation, threats of harm to the individual and his or her family, and sexual humiliations, among many others.

It is important to understand that some methods on their own may amount to torture; in other cases significance is attached to the use of a combination of methods, which may collectively amount to torture. Also, the length of time over which the individual is subjected to the methods may be decisive. Again, for this reason, it is important to document as accurately and completely as possible all the events to which an individual was exposed and their consequences.

The Subjective Element of Suffering
It is important to keep in mind that, when assessing the degree of suffering involved, one should take into account the identity and background of the alleged victim. For example, certain situations that might be relatively bearable for some people could be degrading and humiliating to those of a particular gender, culture or religious faith. Torture and other ill-treatment can also often go hand-in-hand with discrimination, based on race, religion, gender or other factors, which may exacerbate the distress. In addition, physical and mental suffering can differ amongst categories of victims, for example some tortures may exacerbate pre-existing health problems, and children may experience a higher degree of suffering than adults undergoing similar ill-treatment. All these factors should be taken into account in documenting the alleged victim’s experience.

2. Torture Methods

2.1 Beating

Beating is the most common form of physical torture. When the aim is to disguise its effects, beating may be performed with heavy, flexible implements such as sandbags or lead-filled plastic pipes, which may leave short-lived bruising but no permanent scarring. Sometimes the torturers perform the beating over clothing or folded towels. The impact of the blows is still severe and such beating may cause deep muscle bruising (which may take several days to reach the surface) or internal bleeding. This has been reported to lead to acute renal failure due to release of myoglobin (see Module 5). In many countries, severe beatings, which cause widespread bruising, are discontinued after the first few days of detention so that when the victim is produced to court or released after days or weeks later, all obvious signs of beating will have faded.

*Beating using a metal cable in South Africa [Courtesy of Physicians for Human Rights.]*

2.1 Falanga

*Falanga*, also referred to as *falaka*, can be defined as the applications of blunt trauma to the soles of the feet. The technique has been practised throughout history. It is still very common, particularly in the Middle East, but also in the Indian subcontinent and, according to Amnesty International, in over thirty countries worldwide. In some countries, such as Turkey, it is applied almost as a routine at the time of detention and many torture survivors report having suffered it on numerous occasions.
"Falaka” (beating the soles of the feet). [Courtesy of the Human Rights Foundation of Turkey.]

It may be applied by batons, whips or canes to the bare feet or with shoes still on, and the immediate effect will depend on these variables. Often the victim is made to walk round on rough paving afterwards, sometimes carrying another on his back. This last detail is clearly intended to add to the humiliation as well as the pain.

As with most forms of physical torture, the physical findings associated with falanga change over time. These changes can be summarised as follows:

**Acute Symptoms and Signs**

The immediate effect of falanga is bleeding and oedema in the soft tissues of the feet, as well as severe pain. At clinical examination, changes are also confined to the soft tissues. Swelling of the feet, discoloration of the soles due to haematoma formation and various degrees of skin lesions are typical and diagnostic findings. Extensive ulcerations and gangrene of toes due to ischaemia have been described, but are not common. Fractures of tarsals, metatarsals and phalanxes are described as occurring occasionally. The acute changes disappear spontaneously within weeks, as the oedema and extravasation of blood resolve, but the induced soft tissue lesions may be permanent.

**Symptoms and Signs in the Chronic Phase**
The majority of torture victims submitted to falanga complain of pain and impaired walking. The cardinal symptom is pain in the feet and calves, and two types of pain are usually present:

- A deep, dull cramping pain in the feet, which intensifies with weight bearing and muscle activity spreading up the lower legs
- A superficial burning, stinging pain in the soles, often accompanied by sensory disturbances and frequently also a tendency for the feet to alternate between being hot and cold, suggestive of autonomic instability

Because of the pain, walking is impaired in most falanga victims. Walking speed and walking distance are reduced. Typically, the torture victim is only able to walk a limited distance, during which the pain will increase and make continued muscle activity impossible. At rest, the pain subsides and the victim can resume walking.

**Theories Explaining the Persistent Pain and Foot Dysfunction After Falanga**

The aetiology and pathogenesis of the persistent pain and disability after falanga is not fully understood. Several theories have been put forward, and most likely a combination of trauma mechanisms are responsible.

**Reduced Shock Absorbency in the Heel Pads**

The footpads are situated under the weight-bearing bony structures, at which in particular the heel pads act as the first in a series of shock absorbers. The heel pad is normally a firm elastic structure covering the calcaneus. It has a complex internal architecture consisting of closely packed fat cells surrounded by septa of connective tissue, which also contain the nerve and vessel supply to the tissues. Because of its structure, the heel pad is under constant hydraulic pressure and maintains its shape during weight load in the standing position.

After falanga, the heel pad may appear flat and wide, with displacement of the tissues laterally during weight loading. This is observed at inspection from behind, with the torture victim in the standing position. At palpation, the elasticity in the heel pad is reduced and the underlying bony structures are easily felt through the tissues. The pathophysiology of the reduced elasticity in the heel pad is thought to be tearing of the connective tissue septa, leading to deprivation of blood supply and secondary atrophy of fat cells with loss of the shock absorbing ability.

Damaged footpads are not pathognomonic of falanga, but are also described in connection with other conditions unrelated to torture, e.g. lesions in long-distance runners and patient with fractures of the heel bone. It should also be stressed that normal footpads at clinical examination does not rule out exposure to falanga.

**Changes in the Plantar Fascia**

The plantar fascia springs from the calcaneus and proceeds to the forefoot. It is tightened during foot of supporting the longitudinal arches of the foot, assisting the foot muscles during walking. Changes in the plantar fascia are present in some torture victims after falanga and are probably due to the repeated direct traumas to this superficial structure. After falanga, the fascia may appear thickened with an uneven surface at palpation, and tenderness may be found throughout the whole length of the fascia, from its spring to the insertion. Disruption of the plantar fascia has been reported, based on the finding of increased passive dorsiflexion in the toes at clinical examination.
Closed Compartment Syndrome

The plantar muscles of the foot are arranged in tight compartments – an anatomical arrangement which makes it possible for a closed compartment syndrome to develop. A closed compartment syndrome is defined as a painful ischaemic, circulatory disturbance in connection with an increase in pressure and volume inside a well-defined muscle compartment. In the acute form, with a rapidly increasing pressure, e.g. caused by bleeding inside the compartment, the symptoms are alarming and the consequences severe with necrosis of involved tissues if left untreated.

Chronic compartment syndromes may occur as a result of an increase in the muscle bulk and/or a narrowing of the compartment. Clinically, this condition presents itself with pain that intensifies with load and which finally makes continued muscle activity impossible. The pain subsides after a short period of rest, but recurs if muscle activity is resumed – a picture not unlike that seen in impaired walking after falanga.

In a MRI study comparing torture victims exposed to falanga with healthy volunteers, significant thickening of the plantar fascia was found in all victims. Apart from this, morphological changes were present in the fascia, possibly representing scar tissue formation. No signs of detachment of the plantar fascia, closed compartment syndrome or changes in the heel pads were shown in this study.

Neurogenic Pain

The skin of the soles in the normal foot is apart from the arch area, very thick and firmly tied to the underlying tissues. It is very rich in sensory nerve endings, which register touch and pressure. Peripheral nerve lesion affecting the small nerves of the soles is a very possible consequence of falanga. Neurogenic pain due to nerve lesion is therefore a possible contributing pain mechanism.

Impaired Walking

Deviations from the normal gait pattern are very frequent after exposure to falanga. Many torture victims develop a compensatory altered gait with loading of the lateral border (supinating the foot) or loading of the medial border (pronating the foot) to avoid pain at heel strike. The unwinding of the foot is likewise abnormal. Maximal extension and weight loading of the first toe is typically avoided at take-off.

Stride and walking speed are reduced. The gait is broad, stiff and insecure as seen in patients with peripheral neuropathy from other causes. Postural reflexes are elicited from the soles, and, together with the ability to register distribution of pressure, these reflexes are essential for balance and walking. Nerve lesion influencing the proprioception may therefore also contribute to the overall picture. As a consequence of the altered function of the foot, altered gait and frequently concurrent exposure to other forms of torture involving the lower extremities, a chain reaction of muscular imbalance occurs. The various muscle groups of the lower legs are often painful due to increased muscle tone, tight muscles and fasciae, tender and trigger points, and musculo-tendinous inflammation.

Clinical Examination for Falanga

The clinical examination of torture victims exposed to falanga should include:
1. Inspection and palpation of the soft tissues of the feet: heel pads, plantar fascia, skin
2. Assessment of foot function and gait
3. Examination of soft tissues and joints in the lower extremities
4. Neurological examination

It should be stressed once again that none of the findings at clinical examination in the late phases after falanga are pathognomonic, and that a normal examination of the feet does not rule out the possibility of this specific torture method. Special investigations that may aid in correlating allegations of falanga include x-rays, scintography and MRI (see Module 5). Treatment in the chronic phase often includes gentle massage to the muscles of the feet, calves and thighs, re-education of the walking pattern and supportive footwear, especially designed to offer cushioning of the heels.

2.2 Ear Trauma

Trauma to the ears, especially rupture of the tympanic membrane (eardrum), is a frequent consequence of harsh beatings. The ear canals and tympanic membranes should be examined with an otoscope and injuries described. A common form of torture, known in Latin America as telefono, is a hard slap of the palm to one or both ears, rapidly increasing pressure in the ear canal, thus rupturing the drum. There is often tinnitus for a while. Attacks of otitis media may supervene. Deafness usually gradually improves as the drum repairs itself. Very occasionally there is dislocation of the ossicles which will cause permanent loss of hearing. Even more rarely, a perilymph fistula may lead to vertigo. Few of the long-term signs are specific to torture, but a careful history may make the differentiation from disease possible and an expert may be able to differentiate a perforation resulting from trauma from one caused by infection.

Prompt examination is necessary to detect tympanic membrane ruptures less than 2 millimetres in diameter, which may heal within 10 days. Fluid may be observed in the middle or external ear. If otorrhea (leaking middle ear fluid) is confirmed by laboratory analysis, MRI or CT should be performed to determine the fracture site. The presence of hearing loss should be investigated, using simple screening methods. If necessary, audiometric tests should be conducted by a qualified audiometric technician. The radiographic examination of fractures of the temporal bone or disruption of the ossicular chain is best determined by CT, then hypocycloidal tomography and, lastly, linear tomography.
2.3 Eye Trauma

Direct trauma to the eye is very common, either incidental to general beating about the head or else intentionally aimed. There may be conjunctival or retinal haemorrhage, dislocation of the lens or detachment of the retina. Torturers may force their victims to look at the sun or bright lights for long periods. Conversely, detainees may be kept for months or years in total darkness. Survivors often complain long afterwards of lacrimation (tearing) and photophobia (light sensitivity). However, such cases do not show any detectable physical abnormality and treatment is purely symptomatic.
2.4 Restraint, Shackling and Positional Torture

Some degree of restraint is clearly necessary and legitimate at the time of arrest or during transfer in order to prevent a detainee from escaping. However, once detention has been secured, there can be no legitimate need for artificial restraint. The use of shackles or leg irons is specifically forbidden by Rule 33 of the UN Standard Minimum Rules for the Treatment of Prisoners. In spite of this ruling, extreme and prolonged measures are very often taken. Sometimes an attempt is made to justify its use as preventing escape but usually they are applied to cause humiliation or as a punishment. The restraint may be continued for days or even weeks, far longer than needed for legitimate purposes.

Handcuffs, wrist or ankle ties leave no mark if they are applied properly, and in some countries officers take care to prevent damage. In India, for instance, police often use the detainee's turban cloth to bind the wrists or ankles. Conversely, restraints may cause abrasions or bruising even after a short time if they are of rough or harsh material or are applied too tightly. Thin ligatures tightly applied may cause deep wounds after a few hours. This type of handcuff, which automatically continues to tighten if the prisoner struggles, is particularly dangerous and can cause characteristic lesions.

The use of leg irons is widespread in police stations and prisons. Pakistani prisons are particularly notorious for its use, often for long periods of time. They are used as punishment, as a means of extorting bribes and intimidating or humiliating prisoners. Often the rings round the ankles are roughly finished and cause severe abrasions and scarring which may be highly consistent with allegations of abuse.

There are many forms of positional torture, all of which tie or restrain the victim in contorted, hyperextended or other unnatural positions, which cause severe pain and may produce injuries to ligaments, tendons, nerves and blood vessels. Characteristically, these forms of torture leave few, if any, external marks or radiological findings, despite subsequent frequently severe chronic disability.

Positional torture is directed towards tendons, joints and muscles. The 'five-point tie' is a technique of trussing up a captive used in several African countries. A single fine rope is tied round the wrists, ankles and neck or mouth, holding the trunk tightly in extreme extension. An attempt to relieve the pain by moving one limb tightens it more around the others. If this type of restraint is continued for any length of time there is almost certain to be permanent scarring and perhaps peripheral nerve or vascular lesions.

In China, many forms of shackling are used as punishment and are given nicknames to disguise the appallingly painful methods used. For instance, Su Qin bei jian (literally, 'Su Qin carries a sword on his back') describes the shackling of one arm pulled over the shoulder to the other which is twisted behind the back. Another is liankao, describing various methods of shackling the hands and feet behind the back.

Cramped or distorted postures or prolonged standing are used routinely in many countries. An example is Israel, where 'moderate physical pressure' is permitted by law. Several techniques have been devised by the General Security Service (Shin Bet) and routinely used to put detainees under undue stress. In shabeh the victim is shackled for hours to a low chair whose front legs have been shortened so that the detainee must constantly struggle to
avoid sliding off. *Shabeh* is usually combined with methods of abuse, i.e. placing an often filthy sack over the victim’s head, exposing him or her to loud music and sometimes to extreme temperatures and sleep deprivation.

An illustration of "Shabeh" positional torture. [From the BTSELEM Human Rights Report, 1998.]

In *gambaz* the detainee is forced to crouch on his toes in the 'frog' position for long periods. In *kas‘at tawila* the subject is made to kneel with his back up against a table and his cuffed arms resting on the table behind him while the interrogator’s legs push against his shoulders. A small chamber nick-named 'the refrigerator' is used to keep the victim immobile for hours or days.

An example of positional torture. [Courtesy of the Human Rights Foundation of Turkey]

The UN Committee against Torture has determined that restraining detainees in very painful positions is by itself an act of both torture and cruel, inhuman or degrading treatment.73 It recently determined that the use of "short shackling" by US (United States) personnel constitutes either torture or cruel, inhuman or degrading treatment and has recommended that the method be prohibited.74 In a review of US practises, the UN Special Rapporteur on


74 *Broken Laws, Broken Lives* pp. 100.
Torture has condemned the use of stress positions on detainees by the United States as violating the Convention Against Torture.75

### 2.5 Suspension

Suspension is a common form of torture that can produce extreme pain, but which leaves little, if any, visible evidence of injury. A person still in custody may be reluctant to admit to being tortured, but the finding of peripheral neurological deficits, diagnostic of brachial plexopathy, virtually proves the diagnosis of suspension torture. Suspension may last from 15 to 20 minutes to several hours. Suspension can be applied in various forms:

- Cross suspension or “crusifixion.” Applied by spreading the arms and tying them to a horizontal bar;
- Butchery suspension. Applied by fixation of hands upwards, either together or one by one;
- Reverse butchery suspension. Applied by fixation of feet upward and the head downward;
- “Palestinian” suspension. Applied by suspending the victim with the wrists or forearms bound together behind the back and tied to a horizontal bar or rope.
- “Parrot perch” suspension. Applied by suspending a victim by the flexed knees from a bar passed below the popliteal region, usually while the wrists are tied to the ankles.

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75 *Broken Laws, Broken Lives* pp. 100.
“Palestinian” suspension may produce permanent brachial plexus injury in a short period. There is such an unnatural strain on all the muscles and ligaments of the shoulder girdle that one or both shoulders may dislocate. Victims complain for several days afterwards of inability to raise the arms above the head and sometimes of numbness and weakness of the fingers. For years afterwards they may experience pain on raising the arms, lifting weights or combing the hair. On examination there is usually tenderness in the muscles around the shoulders and scapulae and severe pain on passive movements, especially extension and internal rotation of the shoulders. There is occasionally winging of the scapulae (prominent vertebral border of the scapula) caused by traction on the long thoracic nerve, easily missed unless specially looked for by asking the subject to press against a wall with outstretched arms, and there may be permanent deficit of the lower roots of the brachial plexus, as shown by sensory deficit in an ulnar distribution.

Demonstration of “winged” scapula in a torture victim subsequent to prolonged suspension. [Courtesy of Robert H. Kirschner, M.D.]

The “parrot perch” (pau de arara, the chicken, the bar) is another form of suspension which causes immediate severe pain. It has been commonly used in many Latin American countries but is also seen in Africa. The wrists are bound together in front of the body, the arms passed over the knees and a pole thrust behind the knees. The result may be rupture of the cruciate ligaments of the knees or sensory or vascular damage below the knees. Victims will often be beaten while suspended or otherwise abused. In the chronic phase, it is usual for pain and tenderness around the shoulder joints to persist, as the lifting of weight and rotation, especially internal, will cause severe pain many years later.
There are many other methods of suspension including hanging by the ankles or with the arms tied to a cross-bar as in 'crucifixion'. Whether there will be any immediate or later ill-effects depends on the method used, the posture of restraint and the distribution of bonds, which may have been not only at the wrists and ankles but at any point of the arms, legs or trunk.

Suspension by the hair can avulse the scalp leading to an immediate cephalhaematoma which may persist and be palpable for months or even years as a boggy swelling. In any event, the scalp is likely to remain tender, sometimes with the scalp attached unnaturally firmly to the underlying skull.

In general, complications in the acute period following suspension include weakness of the arms or hands, pain and paraesthesias, numbness, insensitivity to touch, superficial pain and tendon reflex loss. Intense deep pain may mask muscle weakness. In the chronic phase, weakness may continue and progress to muscle wasting. Numbness and, more frequently, paraesthesia are present. Raising the arms or lifting weight may cause pain, numbness or weakness. In addition to neurologic injury, there may be tears of the ligaments of the shoulder joints, dislocation of the scapula and muscle injury in the shoulder region.

Various forms of suspension can result in neurologic injury which is usually asymmetrical in the arms. Brachial plexus injury manifests itself in motor, sensory and reflex dysfunction.

- Motor examination. Asymmetrical muscle weakness, more prominent distally, is the most expected finding. Acute pain may make the examination for muscle strength difficult to interpret. If the injury is severe, muscle atrophy may be seen in the chronic phase;
- Sensory examination. Complete loss of sensation or paraesthesias along the sensory nerve pathways is common. Positional perception, two-point discrimination, pinprick evaluation and perception of heat and cold should all be tested. If at least three weeks later, deficiency or reflex loss or decrease is present, appropriate electrophysiological studies should be performed by a neurologist experienced in the use and interpretation of these methodologies;
• Reflex examination. Reflex loss, a decrease in reflexes or a difference between the two extremities may be present. In “Palestinian” suspension, even though both brachial plexi are subjected to trauma, asymmetric plexopathy may develop due to the manner in which the torture victim has been suspended, depending on which arm is placed in a superior position or the method of binding. Although research suggests that brachial plexopathies are usually unilateral, that is at variance with experience in the context of torture, where bilateral injury is common.

Among the shoulder region tissues, the brachial plexus is the structure most sensitive to traction injury. “Palestinian” suspension creates brachial plexus damage due to forced posterior extension of the arms. As observed in the classical type of “Palestinian” suspension, when the body is suspended with the arms in posterior hyperextension, typically the lower plexus and then the middle and upper plexus fibers, if the force on the plexus is severe enough, are damaged, respectively. If the suspension is of a “crucifixion” type, but does not include hyperextension, the middle plexus fibers are likely to be the first ones damaged due to hyperabduction. Brachial plexus injuries may be categorized as follows:

• Damage to the lower plexus. Deficiencies are localized in the forearm and hand muscles. Sensory deficiencies may be observed on the forearm and at the fourth and fifth fingers of the hand’s medial side in an ulnar nerve distribution;
• Damage to the middle plexus. Forearm, elbow and finger extensor muscles are affected. Pronation of the forearm and radial flexion of the hand may be weak. Sensory deficiency is found on the forearm and on the dorsal aspects of the first, second and third fingers of the hand in a radial nerve distribution. Triceps reflexes may be lost;
• Damage to the upper plexus. Shoulder muscles are especially affected. Abduction of the shoulder, axial rotation and forearm pronation-supination may be deficient. Sensory deficiency is noted in the deltoid region and may extend to the arm and outer parts of the forearm.

Assessing physical evidence following suspension may be complicated by the fact that suspension is often accompanied by beating, so it is impossible to generalise, but if the examiner asks the subject to describe or mime the particular posture and stress he was subjected to, it is possible to decide what areas of skin, joints and muscle groups to concentrate on during physical examination. This entails a detailed search of the skin for marks of bonds, the joints for limitation of movement by pain or, occasionally, tendency to subluxation, and muscle groups for abnormal tension and tenderness as well as a neurological examination for peripheral nerve lesions and the extremities for vascular changes. Abnormalities are likely to be easily found in the immediate aftermath but usually fade with time. Unless the full thickness of skin has been destroyed by tight bonds there is unlikely to be any permanent scarring where bonds have been applied though they must be searched for. Their absence does not negate the allegation. In most cases all signs on the skin fade after a few days, but if abrasions are deep or become infected, there may be permanent scarring, changes in pigmentation or occasionally, only depilation (hair loss). Lesions are usually linear and transverse and most marked over bony prominences. These are suggestive, but only if they are almost completely circumferential round the limbs are they are virtually diagnostic of restraint. Though usually situated at the level of the wrists or ankles, they may be found further up the limbs because bonds may be applied higher or ride higher up. In many cases joint movements remain limited and painful for months or years and tenderness of muscle groups is often persistent. Motor or sensory changes tend to improve with time.
The sooner after injury that treatment can be instituted the better, but it is rare for any professional care to be possible until long after the events. Victims often say that they were treated by traditional methods of massage and exercise, with relief of pain on their release from detention. Late treatment concentrates on physiotherapy with massage, graduated exercises and postural re-education. At first, the therapist must be extremely careful to respect the patient's fear of contact and may not even be able to touch him until a satisfactory rapport has been established.

2.6 Crushing and Stretch Injuries

Many torturers injure their victims by stamping on their hands or feet with heavy boots, leaving scarring and fractures of the digits, which may give a good indication of how the injuries were inflicted. However, it is not usually possible to differentiate nails damaged by trauma from the subjects of previous chronic infection.

“Cheera” is the Punjabi word for tearing. It is the nickname given to a technique common in the northwest of the Indian subcontinent. The victim is seated on the floor, often with an officer behind him with a knee in his back and pulling the head back by the hair. The legs are stretched apart, either suddenly or gradually, until they reach as much as 180 degrees. There is often a sound and sensation of tearing and, of course, the pain is excruciating. Often there is the additional trauma of kicks aimed at the inner aspect of the thighs or the genitals. In extreme cases the femur may fracture. The usual immediate result is the appearance of extensive haematomata in the groins or lower on the inner aspect of the thighs depending on whether the adductors have been torn off their origins or the bellies of the muscles have been disrupted. Naturally, walking is almost impossible for a long time. The late findings are pain on walking long distances, tenderness over the origins or bellies of the muscles and extreme limitation of abduction of the hips by pain. If the legs have been kicked, there are sometimes circular or irregular scars on the inner aspect of the thighs, an unusual site for accidental trauma. It may be impossible to squat, kneel or sit cross-legged for months or years afterwards.

“Cheera” After being disrobed and beaten, this 34 year-old man was restrained in a sitting position with his hands tied behind his back. Two policemen forced his legs apart, causing intense pain and loss of consciousness. The leg stretching was repeated three times. Five days after the torture, physical examination revealed echymosis over the adductor muscles of both lower extremities. There
was pain to palpation of the adductor muscles, especially at points of muscle origin on the pelvis. [Courtesy of Vincent Iacopino, M.D., Ph.D.]

In the same part of the world the ghotna is routinely used in police stations and interrogation centres. It is a traditional domestic implement, a pole about four feet long and four inches in diameter used for grinding corn or spices. In many police stations implements specially made of metal are used instead. These may be filled with concrete and are extremely heavy. The most common method is, with the victim seated or lying supine on the floor, for the ghotna to be rolled up and down the front of the thighs with one or more of the heaviest policemen standing on it. Occasionally, with the victim prone, it is rolled over the buttocks and back of the thighs or calves, but it is usual for bony areas like the shins to be avoided. The immediate effects are extensive bruising and inability to walk and even years later there is usually pain on walking far. On examination there is marked tenderness on palpation of the thigh muscles. Occasionally areas of fat necrosis can be palpated. If a rough or angular log has been used, there may be some scarring of the skin. Sometimes scars are found over the anterior superior spine, the patellae or the shins.

"Ghotna" acute effects: This seventeen year-old man was detained by Indian security forces and a heavy wooden roller was applied to his back, buttocks and posterior thighs. The weight of the roller was amplified by one of the perpetrators standing on it. The torture lasted approximately one hour. He presented to a local hospital with signs of acute renal failure secondary to rhabdomyolysis. The photograph was taken 4 days after the torture and demonstrates marked ecchymoses that extended from the mid-posterior thighs to the upper lumbar region, highly consistent with a crush-type injury resulting from the "roller" method of torture. [Courtesy of Vincent Iacopino, M.D., Ph.D.]

"Ghotna" late effects: A 28 year-old man tortured extensively with a heavy wooden roller applied to anterior aspect of his thighs. The weight of the roller was amplified by one of the perpetrators standing on it. After the torture, he experienced severe pain and swelling in the anterior region of his
thighs and observed dark black and blue discoloration over these areas for several months. A medical evaluation five years later revealed marked atrophy and fibrosis of the quadriceps muscles bilaterally. The normal contour of the thigh was deformed bilaterally, leaving concave depressions measuring 10 cm by 5 cm and about 2 cm deep. [Courtesy of Vincent Iacopino, M.D., Ph.D.]

Another way for the ghotna to be used is, with the victim lying prone, the ghotna to be placed behind the knees and then the legs bent forcibly over it, straining and possibly disrupting the cruciate ligaments. The late effects of this depend on the amount of internal damage to the knee joints that has been caused. If severe, there may be permanent difficulty in walking, tenderness on palpating the joint margins and marked limitation by pain of flexion of the knees. Squatting, kneeling or sitting cross-legged may be extremely painful and impossible to maintain for long periods.

2.7 Burning

The application of heat is frequently employed by torturers. It produces immediate and long-term effects that are similar to those caused accidentally, but it is often possible to determine the deliberate nature of the injury if it is widely distributed in different parts of the body or if there are numerous similar lesions. For this reason it is important to take a detailed history in order to learn the nature of the agents used, the situation and posture of the subject and the duration of the application. Of course, if the victim was blindfolded or hooded during torture, he may not be able to describe the method of burning. In late cases, it is important to enquire as to the immediate effects and appearance of the wounds and how long they took to heal. If there was merely initial erythema or blistering and no infection supervened, it is likely that there will be no permanent scarring but if there was infection, sloughing and delay in healing for a month or more, recognisable scarring would be expected.

The pattern of scarring gives a clue to the method used. Flame burns caused by setting clothing alight leave different patterns from the application of blowlamps or other flames.

Caustic or acid burns may leave a trail indicating the victim’s posture. Scarring tends to be more florid, perhaps with keloid formation than similarly-configured scars caused by scalding with boiling water.

Heated metal rods, branding irons or electrically heated devices such as smoothing irons or soldering irons often leave scars of distinctive shape and if in multiples, they make accidental injury most unlikely.

Melted candle wax or plastic give a characteristic pattern of scarring which indicate the flow of the hot liquid, and burning rubber tyres such as are placed round the neck in “necklacing”, leave burns over the whole upper body.

Cigarettes are a particularly common torture weapon. The scars they leave depend on the way the cigarettes were applied to the skin. If they were touched lightly or simply brushed against the skin they may leave no scar or something that is indistinguishable from a scar from acne, chicken pox or insect bite. On the other hand, if the cigarettes were deliberately stubbed out and held immobile on the skin, the scar is often characteristically circular about one centimetre in diameter, with a hyperpigmented periphery (usually with a relatively indistinct periphery) and an atrophic, hypopigmented, “tissue paper” centre. The feature that corroborates allegations of deliberate infliction of the burns is the presence of patterns on a part of the skin surface that the history indicates would be exposed. Thus, if the victim
was strapped to a chair, there may be a line of scars on the knuckles, up the forearms or on the front of the thighs.

Illustration of cigarette burn injuries. [Courtesy of the Human Rights Foundation of Turkey.]

2.8 Electrical injuries

Electric shocks have been used commonly by torturers for many years because they cause exquisite pain but rarely leave identifiable physical signs. The equipment can be as basic as the magneto of an old military field telephone or a couple of bare wires in an electrical socket to complex stun guns.

Magnetos (generators) are generally hand-cranked devices that provide a direct current (DC) related to the speed at which a rotor is turned – giving an opportunity to threaten the victim further. Main electrical currents can be delivered through bare wires touched against the skin, which might have been previously covered in water. Clips are sometimes used, and these can cause small lacerations when they pull off as the victim jolts with the force of the current. Some torturers have used fixed systems using switches or levers which again can be used to increase the threat of the torture.

Battery operated devices are portable but can still deliver a high voltage which may be alternating current (AC) or DC. Electric shock batons are being superseded by a range of devices including stun shields, remote control stun belts, and tasers, many of which were originally designed for law-enforcement purposes.

Electrical torture instruments. [Amnesty International, 1996]
Electrical torture uses the property of the electrical current to cause pain: in the body the current travels along nerves and blood vessels as they are the paths of lower resistance. As the current travels, it causes contractions to the muscles involved and severe pain. These contractions can cause dislocation of joints and, if the chest muscles are involved, difficulties in breathing. If the current passes through the heart, arrhythmias (irregular heartbeat) can develop, leading to sudden death. Torturers apply electricity to the most vulnerable and intimate parts of the body. Genitals and breasts are often targeted and the victim is threatened on his or her reproductive capacity. When the current involves the muscles controlling urination and defecation those can occur without the victim being able to exercise control. The mouth also is very sensitive and often targeted.

Areas of reddening may persist for weeks. Occasionally the electrodes can leave small burns, probably from sparking. Both tend to be circular and less than 0.5 cm in diameter. These lesions may create hyperpigmentation. However, as these lesions are small, they may be difficult to find. Although non-specific, they can corroborate allegations of electric shock torture, especially if they are in certain parts of the body. Studies have shown distinctive changes to cells beneath the site of the shock on microscopy, but such investigations should only be performed if they are essential to the legal case.

2.9 Asphyxiation

The most common way of inducing asphyxia to near-death is submarino as it is nicknamed in Latin American countries. The head is immersed in water for minutes at a time to the point of drowning, then brought out and immersed again. In some countries the victim is suspended by the ankles and lowered repeatedly into a tank. A variant of submarino is for a plastic bag or similar impervious material filled with liquid to be tied over the head. In all these techniques the water is often contaminated with sewage or chemicals, adding to the immediate distress and increasing the likelihood of permanent ill-effects.
“Waterboarding” is another form of asphyxiation torture that dates back to the Middle Ages and recently practised by the United States. Victims are strapped to a board or made to lie in a supine position with their heads lower than the rest of their bodies, their faces covered with cloth, and water is poured over their mouths to create the sensation of drowning.

Dry submarino is practised with a plastic bag or similar impervious material placed over the head and tied tightly around the neck. Again, there is often contaminated material or an irritant such as chilli powder inside the bag. In Sri Lanka a small amount of petrol is often put in the bag so that there is chemical poisoning as well as asphyxiation.
The immediate effects of these techniques vary according to whether there has been any contamination. If so, there is likely to be severe upper respiratory and perhaps broncho-pulmonary inflammation. Conjunctivitis or otitis media may follow, particularly after *submarino*. Irritants such as petrol or chilli may cause a dermatitis which is indistinguishable from acne. Any long-term effects of these techniques are not easy to assess but many victims attribute their asthma or bronchitis to having been asphyxiated many years previously. If there was no history of pre-existing disability, it may be reasonable to consider this as a possibility.

### 2.10 Violent Shaking

Violent shaking may be haphazard or, as in the case of Israel, systematic and planned. In such cases, bruising may be found on the chest or shoulders where the victim was seized but otherwise there are few outward signs. In the acute phase there is usually headache, disorientation and often a changed mental state. The most severe cases demonstrate all the features, potentially fatal, that have been well documented in shaken infant syndrome – cerebral oedema, subdural haematoma and retinal haemorrhage, the last being the major sign that makes possible a diagnosis before death. It has been named the shaken adult syndrome.

Non-fatal brain trauma from violent shaking can potentially result in more subtle but clinically significant cognitive impairment possibly due to diffuse axonal injury, injury to the brain cells themselves. Non-fatal consequences of shaking may also include recurrent headaches, disorientation and mental status changes, all of which can become chronic. Violent shaking can also produce neck trauma, producing a whiplash mechanism of cervical strain. Cervical spine fracture with spinal cord compression may also occur, resulting in quadriplegia.

### 2.11 Sexual Assault

Sexual torture begins with forced nudity, which in many countries is a constant factor in torture situations. An individual is never as vulnerable as when naked and helpless. Nudity enhances the psychological terror of every aspect of torture, as there is always the potential of abuse, rape or sodomy. Furthermore, verbal sexual threats, abuse and mocking are also part of sexual torture, as they enhance the humiliation and its degrading aspects. The groping of women is traumatic in all cases and is considered to be torture.

Sexual assault is clearly not simply a physical assault on the individual, but in many instances it is the psychological insult that is most injurious. Often, sexual assaults will be accompanied by direct or implied threats. In the case of women, the threat may be one of becoming pregnant. For men, those inflicting the torture may also threaten (incorrectly but usually deliberately) that the victim will become impotent or sterile. For men or women there may be the threat of contracting HIV or other sexually transmitted infections (STIs) and often the threat or fear that sexual humiliation, assault or rape will lead to ostracism from the community and being prevented from ever marrying or starting a family. Sexual assaults can be categorised as:

- Assaults to the genitals
- Electric shocks to the genitals and anus
- Forced sexual acts on themselves or on/with others
- Object inserted into the vagina (in women)
• Object inserted in the urethral meatus (in men)
• Object inserted through the anus
• Penis forced into the mouth
• Penis forced through the anus
• Penis forced into the vagina (in women).

The term ‘rape’ refers to the last of these, but in many jurisdictions it can mean one or more of the others. Thus if the term is used, the act should also be specified.

There are some differences between sexual torture of men and sexual torture of women, but several issues apply to both. Rape is always associated with the risk of developing sexually transmitted diseases, particularly human immunodeficiency virus (HIV). Currently, the only effective prophylaxis against HIV must be taken within hours of the incident, and may not be available in countries where torture occurs routinely. In most cases, there will be a lewd sexual component, and in other cases torture is targeted at the genitals. Electricity and blows are generally targeted on the genitals in men, with or without additional anal torture. The resulting physical trauma is enhanced by verbal abuse. There are often threats of loss of masculinity to men and consequent loss of respect in society. Prisoners may be placed naked in cells with family members, friends or total strangers, breaking cultural taboos. This can be made worse by the absence of privacy when using toilet facilities. Additionally, prisoners may be forced to abuse each other sexually, which can be particularly difficult to cope with emotionally. The fear of potential rape among women, given profound cultural stigma associated with rape, can add to the trauma. Not to be neglected are the trauma of potential pregnancy, which males, obviously, do not experience, the fear of losing virginity and the fear of not being able to have children (even if the rape can be hidden from a potential husband and the rest of society).

Children may also be victims of rape and sexual assault. Even older children may be unaware of what happened to them, and may not be able to give a coherent account of their experience. Using drawings and, if available, dolls may help them explain where they do not have the necessary language or understanding. It is even more important that the examination is performed by someone who is experienced in this field.

If in cases of sexual abuse the alleged victim does not wish the event to be known due to sociocultural pressures or personal reasons, the physician who carries out the medical examination, investigative agencies and the courts have an obligation to cooperate in maintaining the victim’s privacy. Establishing a rapport with torture survivors who have recently been sexually assaulted requires special psychological education and appropriate psychological support. Any treatment that would increase the psychological trauma of a torture survivor should be avoided. Before starting the examination, permission must be obtained from the individual for any kind of examination, and this should be confirmed by the alleged victim before the more intimate parts of the examination. The individual should be informed about the importance of the examination and its possible findings in a clear and comprehensible manner.

**Review of symptoms**

A thorough history of the alleged assault should be recorded. There are, however, some specific questions that are relevant only to an allegation of sexual abuse. These seek to

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elicit current symptoms resulting from a recent assault, for example bleeding, vaginal or anal discharge and location of pain, bruises or sores. In cases of sexual assault in the past, questions should be directed to ongoing symptoms that resulted from the assault, such as urinary frequency, incontinence or dysuria, irregularity of menstruation, subsequent history of pregnancy, abortion or vaginal haemorrhage, problems with sexual activity, including intercourse and anal pain, bleeding, constipation or incontinence.

Ideally, there should be adequate physical and technical facilities for appropriate examination of survivors of sexual violation by a team of experienced psychiatrists, psychologists, gynaecologists and nurses, who are trained in the treatment of survivors of sexual torture. An additional purpose of the consultation after sexual assault is to offer support, advice and, if appropriate, reassurance. This should cover issues such as sexually transmitted diseases, HIV, pregnancy, if the alleged victim is a woman, and permanent physical damage, because torturers often tell victims that they will never normally function sexually again, which can become a self-fulfilling prophecy.

*Illustration of sexual assault – sodomy with a truncheon. [Courtesy of the Human Rights Foundation of Turkey.]*)
Illustration of sexual torture involving squeezing of the testicles. [Courtesy of the Human Rights Foundation of Turkey.]

2.12 Sexual Humiliation

Sexual humiliation usually involves forcing individuals to perform humiliating acts, often in an attempt to exploit cultural and religious stereotypes regarding sexual behavior and induce feelings of shame, guilt and worthlessness.

Sexual humiliation can result in lasting psychological symptoms in the form of posttraumatic stress disorder and major depression, and that individuals often relive the humiliation long after their release through flashbacks and nightmares. Sexually humiliating treatment can also affect an individual’s sense of identity and autonomy. Individuals often experience feelings of intense shame, guilt, grief, fear, and social isolation. Victims who have been forced into humiliating acts can feel “responsible for participating in their own degradation” resulting in intense and long lasting shame.

The UN Special Rapporteur on Torture has found that both depriving detainees of clothing and stripping them naked are psychologically harmful methods used by the United States that constitute torture and ill-treatment.77 The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment has found that even mere threats of sexual humiliation “could be considered to amount to psychological torture.”78

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2.13 Prolonged Isolation and Sensory Deprivation

Prolonged isolation is the denial of contact with other human beings, including through segregation from other prisoners, for prolonged periods of time, i.e. solitary confinement. Sensory deprivation refers to the reduction or removal of stimuli from one or more of the senses for prolonged periods.

Sensory deprivation is a technique that is “calculated to disrupt profoundly the senses” and “the personality.” It tends not only to result in situations of complete dependency on the interrogator but also leads to severe anxiety and often causes hallucinations. Studies have demonstrated that even short-term isolation can result in: an inability to think or concentrate; anxiety; somatic complaints; temporal and spatial disorientation; deficiencies in task performance; hallucinations; and loss of motor coordination.

Solitary confinement can result in include depression, anxiety, difficulties with concentration and memory, hypersensitivity to external stimuli, hallucinations and perceptual distortions, paranoia, suicidal thoughts and behaviour, and problems with impulse control. The UN Committee against Torture has encouraged states to abolish the practise, noting that, outside the interrogation context, solitary confinement “should be applied only in exceptional cases and not for prolonged periods of time.” and has determined that prolonged solitary confinement could constitute cruel, inhuman or degrading treatment or punishment. Furthermore, according to the UN Special Rapporteur on Torture, solitary confinement may impact the psychological “integrity of the prisoner.”

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2.14 Sleep Deprivation

Sleep deprivation of normal sleep for extended periods through the use of stress positions, sensory overload, or other techniques may have profound psychological consequences. It causes significant cognitive impairments including deficits in memory, learning, logical reasoning, complex verbal processing, and decision-making; sleep appears to play an important role in processes such as memory and insight formation. Sleep deprivation may also result in decreases in psychomotor performance as well as alterations in mood. In recent years, a growing body of research has emerged that point to the complex and bidirectional relationships between sleep disturbance and psychiatric disorders. For example, evidence suggests that sleep disturbance is not only a symptom of major depression, but it also independently affects the clinical outcome and the course of the disorder. Moreover, sleep disturbance seems to be associated with an independent increase in the risk of suicidal ideation and actions.

Even sleep restriction of four hours per night for less than a week can result in physical harm, including hypertension, cardiovascular disease, altered glucose tolerance and insulin resistance. Sleep deprivation can impair immune function and result in increased risk of infectious diseases. Further, chronic pain syndromes are associated with alterations in sleep continuity and sleep patterns.

The UN Committee against Torture has noted that sleep deprivation used to extract confessions from suspects is impermissible, and that “sleep deprivation for prolonged periods” constitutes torture.

The UN Committee against Torture has determined that “hooding under special conditions” constitutes both torture and cruel, inhuman or degrading treatment or punishment.

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82 Broken Laws, Broken Lives pp. 104.
84 Broken Laws, Broken Lives pp. 102.
noted that this finding would be “particularly evident” when hooding is used in combination with other coercive interrogation methods.\(^8^5\)

### 2.15 Temperature Manipulation

Temperature manipulation typically involves prolonged periods of exposure to extreme heat or to extreme cold, for example, holding detainees in cells that are deliberately too hot or too cold, forcing detainees to strip down to their underwear in a frigid cell or to stand in cold water, and dousing victims with freezing water.

Exposing a detainee to the cold can have serious health consequences even if the environmental temperature is well above freezing. The body is highly regulated to maintain core body temperature within a narrow range. Maintenance of this core temperature is essential to human survival. Hypothermia can have a number of adverse physical effects. Even moderate cold exposure can lead to significant shifts from the peripheral circulation to the body core, slowing heart function (including arrhythmias, ventricular fibrillation and cardiac arrest). If the body temperature drops below 90\(^\circ\)F, there may be cognitive effects including amnesia. If the body temperature drops below 86\(^\circ\)F, major organs can fail and death can occur.

In addition to immediate effects, hypothermia can result in prolonged adverse health consequences. The neurologic effects of hypothermia include mental slowing, diminished reflexes and eventually flaccid muscle tone. With exposure to temperatures below 32\(^\circ\)C (89.6\(^\circ\)F) patients develop amnesia and below 31\(^\circ\)C (87.8\(^\circ\)F) there may be loss of consciousness. Exposure to heat can result in elevations of core body temperature, particularly when access to water is limited. Heat stroke is a life-threatening condition that can occur when the core temperature rises above 40\(^\circ\)C (104\(^\circ\)F). Heat stroke is characterized as predominant central nervous system dysfunction resulting in delirium, convulsions and coma. Even with aggressive and appropriate treatment, heat stroke is often fatal.

The UN Committee against Torture has found that exposure to extreme temperatures, even in the absence of other forms of abusive interrogation or detention techniques, constitutes both torture and cruel, inhuman and degrading treatment.\(^8^6\) The UN Special Rapporteur on Torture has similarly determined that depriving detainees of clothing and exposing them to extremes of heat or cold constitute torture and ill-treatment.\(^8^7\)

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\(^8^5\) *Broken Laws, Broken Lives* pp. 102.

\(^8^6\) *Broken Laws, Broken Lives* pp. 103.

\(^8^7\) *Broken Laws, Broken Lives* pp. 103.
2.16 Sensory Bombardment

Sensor bombardment is usually practised with exposure to bright lights, flashing strobe lights and/or loud music for extended periods of time. The use of lights and loud music may cause physiologic distress and disorientation. The body can interpret certain noises as danger signals, inducing the release of stress hormones which may increase the risk of acute myocardial infarction (heart attack) among those with pre-existing cardiovascular disease. Loud music can also cause hearing loss or ringing in the ears; these consequences can be both short term and chronic, with chronic tinnitus, or ringing in the ears, being more common.

Sound and light bombardment is used to disorient, cause anxiety, and even contribute to personality disintegration, as well as to deprive the person of sleep. It is often combined with other tactics. The UN Committee against Torture has determined that “sounding of loud music for prolonged periods” constitutes torture and cruel, inhuman or degrading treatment or punishment both when it is used in combination with other methods of interrogation and when it is used by itself. The UN Special Rapporteur on Torture has similarly determined that depriving a detainee of, or exposing him to, light for a prolonged period constitutes torture and ill-treatment.

2.17 Threats of Harm

Threats to an individual’s life or physical well-being or to the well-being of his family or friends can have a long-lasting psychological impact. Such threats are known to induce extreme fear and are associated with PTSD and major depression among trauma survivors. Individuals who have been threatened with death often relive their near-death encounters in nightmares, flashbacks, and intrusive memories. These experiences can provoke feelings of intense anxiety that cause dysfunction at work and in family settings. Mock executions and other situations where death is threatened often cause victims to repeatedly experience their last moments before anticipated death and induce chronic fear and hopelessness. Those who experience mock executions and death threats often suffer from PTSD

89 Broken Laws, Broken Lives pp. 102.
symptoms, anxiety and depressive symptoms and increased frequency of suicidal behaviour.

The UN Human Rights Committee has found that conducting a mock execution within a prison environment constitutes cruel and inhuman treatment and breaches a State’s obligation to respect human dignity. The UN Committee against Torture determined that threats, including but not limited to death threats, constitute both torture and cruel, inhuman or degrading treatment.

A photograph illustrating the use of military dogs used to induce fear among detainees in US custody.

3. Psychological Consequences of Torture

3.1 Introduction

Psychological reactions to torture present physicians, clinicians and social scientists with the challenge of evaluating and assisting individuals who have survived crises of life-threatening proportions. For many that have survived torture, the experience can cause profound effects at a deeply personal level that may persist and fluctuate for many years. Psychological consequences develop in the context of personal meaning and personality development. They will vary over time and are shaped by cultural, social, political, interpersonal, biological and intrapsychic factors that are unique to each individual. One should not assume that all forms of torture have the same outcome. However, over the past two decades much has been learned about psychological, biological and neuropsychiatric responses to extreme stress, including torture, and clusters of typical symptoms have emerged that are recognised across cultures.

3.2 The Paradox of Psychological Consequences of Torture

The psychological consequences of torture present two paradoxes. First, psychological wounds are the most personal, intimate, and enduring consequences of torture and can affect not only the victim but also his/her family and community. Yet these scars are invisible; there are no objective signs, measurable parameters, lab tests or x-rays that are able to document psychological wounds. The goal of torture is not to simply physically

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incapacitate the victim, but to reduce the individual to a position of extreme helplessness and distress and break his/her will. At the same time, torture sets horrific examples to those that come in contact with the victim and can profoundly damage intimate relationships between spouses, parents and children, and other family members, as well as relationships between the victims and their communities. In this way, torture can break or damage the will and coherence of entire communities.

The second paradox is that despite the fact that torture is an extraordinary life experience capable of causing a wide range of psychological suffering, extreme trauma such as torture does not always produce psychological problems. Therefore, if an individual does not have mental problems, it does not mean that he/she was not tortured. When there are no physical or psychological findings, this does not refute or support whether torture had actually occurred.

3.3 The Psychological Consequences of Torture

The potential effects of torture include cumulative traumatic experiences on individual, family and community levels.

On the individual level

Torture is a dynamic process that begins at the moment of losing liberty, and involves a sequence of traumatic events that may take place at different times and places, ending with the release or demise of the victim. Sometimes this cascade of events may start again within a short time-frame, without leaving any time for the individual to recover. The person experiences complete lack of control, inability to escape, and is also challenged by the unpredictability of the torturer.

Generally torture has an extremely threatening and painful character, and can induce immediate reactions of panic and fear, including significant fear of death, with a very high level of tension and, sometimes subsequently, of emotional numbness. These feelings may be accompanied by a sense of complete confusion, powerlessness, and loss of control which can bring about a shattered understanding of one’s self, of any meaningful existential system and of the predictability of the world. Torture can damage individuals on a number of levels:

- physical and psychological integrity and entity,
- cognitive, emotional, behavioural, social well-being,
- personality,
- identity,
- autonomy,
- self-actualisation,
- self-respect or self-esteem,
- sense of safety and survival,
- dreams, hopes, aspirations for the future,
- belief system,
- system of meaning about him/herself and the world,
- attachment,
- connectedness, and
- trust.
The aim of torture is often not only the intentional destruction of the victim, but of his or her economic, social, and cultural worlds of the victims. Torture also may profoundly affect an individual’s sense of being grounded in a family and in society. It may also cause secondary problems which compromise social, educational and occupational functioning.

On the family level

Torture can profoundly damage intimate relationships between spouses, parents, children and other family members, and relationships between the victims and their communities. Such trauma can lead to various forms of family dysfunction and disruptions including:

- Other members of the family may also be detained, tortured and ill treated.
- Other members of the family may suffer from the secondary traumatisation.
- The repercussions of the physical and psychological suffering of the tortured person within the family can cause an increased level of stress as well as fear, worry, feelings of being terrorised and threatened, and loss of sense of safety and security, affecting the family system and the other members of the family.
- Torture may change the roles and relationship patterns in the family; it may result in deterioration in the ability to care for children and loved ones, and in parenting capacity.
- Torture experiences may also cause substantial disruption of the quality of life in the family due to health problems, forced change of living place, loss of work and diminished social support.

3.4 Social, Political and Cultural Context

There are three complimentary approaches for understanding the psychological impact of torture. The personal approach is the individual’s story as told through testimony, oral history, literature, and art. The clinical approach utilizes a medical and psychological paradigm and relies on clinical history, physical exam, and mental status exam. The community approach involves epidemiological studies of traumatised groups and populations. In combination these approaches provide a broad and deep understanding of the impact of torture on human beings. Each approach requires consideration of the context of torture. Torture has unique cultural, social and political meanings for each individual. These meanings will influence an individual’s ability to describe and speak about their experiences. Similarly, these factors contribute to the impact that the torture inflicts psychologically and socially. Descriptive methods, therefore, are the best approaches when attempting to evaluate psychological or psychiatric reactions and disorders because what is considered disordered behaviour or a disease in one culture may not be viewed as pathological in another. While some psychological symptoms may be present across differing cultures, they may not be the symptoms that concern the individual the most. Therefore, the clinician’s inquiry has to include the individual’s beliefs about their experiences and meanings of their symptoms, as well as an evaluating the presence or absence of symptoms of trauma-related mental disorders. For example, intrusive memories may be interpreted as a supernatural experience. Therefore the health professional’s inquiry has to include the individual’s beliefs about their experiences and meanings of their symptoms.

Torture is powerful enough on its own to produce mental and emotional consequences, regardless of the individual’s pre-torture psychological status. Nevertheless, torture has variable effects on people because the social, cultural and political contexts vary widely.
Outcomes can be influenced by many interrelated factors that include but are not limited to the following:

- Circumstances, severity and duration of the torture
- Cultural meaning of torture/trauma and cultural meaning of symptoms
- Age and developmental phase of the victim
- Genetic and biological vulnerabilities of the victim
- Perception and interpretation of torture by the victim
- The social context before, during and after the torture
- Community values and attitudes
- Political factors
- Prior history of trauma
- Pre-existing personality

The psychological impact of ill-treatment clearly depends on the individual (see risk factors listed below). For example, someone who is politically active might be able to undergo substantial torture without necessarily developing persistent psychological symptoms because he or she could have anticipated the experience, and put the episode into a personal and political context. However, someone who was arrested simply as a result of being in the wrong place at the wrong time might not suffer much ill-treatment, but could still be devastated by the experience, because the incident was not anticipated and the person was not sustained by a political ideology or religious faith.

Similarly, the consequences are different for a young woman who is raped during torture and is from a culture that attaches a severe negative stigma of impurity to a woman who has been raped, compared with a former military officer who is captured and suffers long-term solitary confinement and multiple beatings. It goes without saying that both types of torture are extremely severe, yet the impact on the individual’s life is vastly different. The young woman might be socially ostracized and condemned even by her own family and community. The former military officer may have brain damage from beatings to the head with resultant long-term disability.

3.5 Risk factors for Trauma and Torture-Related Disorders

In considering who may be at heightened risk for developing psychological problems, one must evaluate both general/overall risk factors as well as those risk factors specific to traumatised populations including how trauma affects family and social relationships and other natural supports. The general risk factors for developing mental illness are based on age, sex, education, social class, divorced/widowed status, history of mental illness, and family history of mental illness. Additional risk factors for torture survivors include torture, war, political oppression, imprisonment, witnessing or experiencing atrocities, loss of family and/or separation from family, and distortion of social relationships. If the torture survivor is also a refugee or asylum seeker, he/she has the further risk factors of migration (loss of home, loved ones, possessions, etc), acculturation, poverty, prejudice, cultural beliefs and traditional roles, cultural and linguistic isolation, absence of adequate support systems, and unemployment or underemployment. The multiple layers of increasing risk present a clinical picture that has been described by as one of “cumulative synergistic adversity.”

3.6 Psychological Symptoms

For a detailed discussion of psychological symptoms and assessment of psychological evidence, see Module 6. Despite the variability due to personal, cultural, social and political
factors, certain psychological symptoms and clusters of symptoms have been observed among survivors of torture and other types of violence. The diagnosis of Posttraumatic Stress Disorder (PTSD) has been applied to an increasingly broad array of individuals suffering from the impact of widely varying types of violence. Although the utility of this diagnosis in non-western cultural groups has not been clearly established, evidence suggests that there are high rates of PTSD and depression symptoms among traumatised refugee populations from multiple different ethnic and cultural backgrounds.

The core symptoms and signs of severe trauma and torture across cultures have become increasingly clear. Many are physiological reactions that can persist for years. The main psychiatric disorders associated with torture are PTSD and Major Depression. One does not have to be tortured to develop PTSD and/or Major Depression because these disorders appear in the general population. Similarly, everyone who has been tortured does not develop PTSD and Major Depression.

The course of Major Depression and PTSD varies over time. There can be asymptomatic intervals, recurrent episodes, and episodes during which an individual is extremely symptomatic. Therefore, when conducting an evaluation of a torture survivor, one must consider the following questions:

- What is the timeframe of onset of symptoms; did symptoms occur immediately following the traumatic events or were they delayed for weeks, months or even years?
- Is there a history of recurring episodes of symptomatology?
- How do problems and symptoms emerge over time?
- Where is the survivor in the recovery process at the time of the assessment?
## MODULE 5

Physical Evidence of Torture and Ill-treatment

### OBJECTIVES

- To provide in-depth information on physical examination methods, factors to consider during examinations, and the interpretation of findings.
- To be able to conduct a physical examination of each organ system and assess possible acute and chronic signs and symptoms of torture and ill-treatment
- To understand basic mechanisms of injury
- To be familiar with specific examination considerations for victims of sexual assault
- To understand the effective use of medical photography and the appropriate use of diagnostic tests
- Discuss the circumstances for the appropriate use of directed vs. comprehensive physical examinations
- To be familiar with the differentiation of self-inflicted injuries and those caused by torture and ill-treatment

### CONTENT

- Physical evidence of torture
- Medical history
  - Acute symptoms
  - Chronic symptoms
- The physical examination
  - Acute symptoms
  - Chronic symptoms
  - Dermatologic Evaluation
    - Abrasions
    - Contusions
    - Lacerations
    - Incisions
    - Burns and scalds
    - Complex Lesions
    - Scarring
  - Head and neck
  - Eyes
  - Ears
  - Nose
  - Jaw, Oropharynx and Teeth
  - Chest and Abdomen
  - Musculoskeletal System
    - Fractures
  - Neurological Examination
    - Head Trauma and Post-traumatic Epilepsy
    - Nerve damage
  - Examination of Women
    - Examination Following a Recent Assault
    - Examination After the Immediate Phase
    - Follow-up
- Genital Examination of Women
  o Genital Examination of Men
  o Perianal Examination
  o Medical Photography
  o Assessment for Referral
  o Diagnostic Tests
    - Radiologic Imaging
    - X-Rays
    - Scintigraphy
    - Ultrasound
    - CT scans
    - MRI
    - Biopsy of Electric Shock Injury

**DISCUSSION TOPICS**

- Students should work in groups or individually to answer questions contained in Self-Assessment 5

Additional Discussion Topics:
- Discuss relevant considerations to distinguish physical findings caused by torture and ill-treatment and those that may be self-inflicted or the result of other causes
- Discuss the relative value of diagnostic tests and their limitations and develop a series of country-specific recommendations for indications of using diagnostic tests in various documentation settings
- Discuss appropriate indications for a genital examination (women and men), how the examinations should, and should not, be performed, and any relevant country-specific considerations for the evaluation of allegations of sexual assault

**TEACHING FORMATS**

- **Group Activity:**
  - Divide the class into several groups and have each group work on answering questions contained in Self-Assessment 5
  - A facilitator should be identified to moderate the discussion and rapporteur should be identified to record the group’s findings and report them when the class reconvenes.
  - After 20-30 minutes of group discussion, the entire class should reconvene
  - Rapporteurs should briefly report on their group’s findings
  - Open class discussion

  Alternative Option:
  - Divide the class into several groups and assign each group with one or more (or all) of the Discussion Topics
  - Follow the usual sequence for conducting group activities as outlined above

- **Individual Research/Assignment:**
  - Individual students should answer all questions contained in Self-Assessment 5
  - **Journal Entry:** (Instructor to assign Write a few paragraphs -- no more than a page)
  - Respond to one or more of the Discussion Topics

**PRIMARY RESOURCES**

- *The Istanbul Protocol, Chapter V*
- *The Medical Documentation of Torture*
- *Medical Investigation and Documentation of Torture: A Handbook for Health Professionals*
- *Medical Physical Examination of Alleged Torture Victims: A Practical Guide to the Istanbul Protocol for Medical Doctors*
- *Examining Asylum Seekers*
1. Physical Evidence of Torture

Witness and survivor testimony are necessary components in the documentation of torture. To the extent that physical evidence of torture exists, it may provide important confirmatory evidence that a person was tortured. Torture victims may have injuries that are substantially different from other forms of trauma. Although acute lesions may be characteristic of the alleged injuries, most lesions heal within about six weeks of torture, leaving no scars or, at the most, non-specific scars. This is often the case when torturers use techniques that prevent or limit detectable signs of injury. Under such circumstances, the physical examination may be within normal limits, but this in no way negates allegations of torture. As the Istanbul Protocol makes clearly, the absence of such physical evidence should not be construed to suggest that torture did not occur, since such acts of violence against persons frequently leave no marks or permanent scars. A detailed account of the patient’s observations of acute lesions and the subsequent healing process often represent an important source of evidence in corroborating specific allegations of torture or ill-treatment.

A medical evaluation for legal purposes should be conducted with objectivity and impartiality. The evaluation should be based on the physician’s clinical expertise and professional experience. The ethical obligation of beneficence demands uncompromising accuracy and impartiality in order to establish and maintain professional credibility. When possible, clinicians who conduct evaluations of detainees should have specific essential training in forensic documentation of torture and other forms of physical and psychological abuse. They should have knowledge of prison conditions and torture methods used in the particular region where the patient was imprisoned and the common after-effects of torture. The medical report should be factual and carefully worded. Jargon should be avoided. All medical terminology should be defined so that it is understandable to lay persons.

In addition, the physician should not assume that the official requesting a medico-legal evaluation has related all the material facts. It is the physician’s responsibility to discover and report upon any material findings that he or she considers relevant, even if they may be considered irrelevant or adverse to the case of the party requesting the medical examination. Findings that are consistent with torture or other forms of ill-treatment must not be excluded from a medico-legal report under any circumstance.

1.1 Medical history

As stated in Module 3, the physician should obtain a complete medical history, including information about prior medical, surgical or psychiatric problems. S/he should:

- Be sure to document any history of injuries, medical conditions and surgery before the period of detention and any possible after-effects;
- Avoid leading questions;
• Structure inquiries to elicit an open-ended, chronological account of the events experienced during detention.

Specific historical information may be useful in correlating regional practices of torture with individual allegations of abuse. Examples of useful information include descriptions of torture devices, body positions, methods of restraint, descriptions of acute or chronic wounds and disabilities and identifying information about perpetrators and places of detention. While it is essential to obtain accurate information regarding a torture survivor’s experiences, open-ended interviewing methods require that a patient disclose these experiences in their own words using free recall. An individual who has survived torture may have trouble expressing in words his or her experiences and symptoms. In some cases, it may be helpful to use trauma event and symptom checklists or questionnaires. If the interviewer believes it may be helpful to use trauma event and symptom checklists, there are numerous questionnaires available; however, none are specific to torture victims. All complaints of a torture survivor are significant. Although there may be no correlation with the physical findings, they should be reported. Acute and chronic symptoms and disabilities associated with specific forms of abuse and the subsequent healing processes should be documented.

**Acute Symptoms**

The individual should be asked to describe any injuries that may have resulted from the specific methods of alleged abuse. For example, bleeding, bruising, swelling, open wounds, lacerations, fractures, dislocations, joint stress, haemoptysis (coughing up blood), pneumothorax (lung puncture), tympanic membrane perforation, genitourinary system injuries, burns (including colour, bulla or necrosis according to the degree of burn), electrical injuries (size and number of lesions, their colour and surface characteristics), chemical injuries (colour, signs of necrosis), pain, numbness, constipation and vomiting. The intensity, frequency and duration of each symptom should be noted. The development of any subsequent skin lesions should be described and whether or not they left scars. Ask about health on release; was he or she able to walk, confined to bed? If confined, for how long? How long did wounds take to heal? Were they infected? What treatment was received? Was it a physician or a traditional healer? Be aware that the detainee’s ability to make such observations may have been compromised by the torture itself or its after-effects and should be documented. It is important to note that acute lesions are often characteristic since they may show a pattern of inflicted injury that differs from non-inflicted injuries, for example by their shape, repetitiveness, and distribution on the body.

**Chronic Symptoms**

Elicit information of physical ailments that the individual believes were associated with torture or ill-treatment. Note the severity, frequency and duration of each symptom and any associated disability or need for medical or psychological care. Even if the after-effects of acute lesions are not observed months or years later, some physical findings may still remain, such as electrical current or thermal burn scars, skeletal deformities, incorrect healing of fractures, dental injuries, loss of hair and myofibrosis. Common somatic complaints include headache, back pain, gastrointestinal symptoms, sexual dysfunction and muscle pain. Common psychological symptoms include depressive affect, anxiety, insomnia, nightmares, flashbacks and memory difficulties (see Module 6).

2. The Physical Examination
The physical examination is usually the last component of a medical evaluation of an alleged torture victim, after the acquisition of all background information, allegations of abuse, acute and chronic symptoms and disabilities, and after the psychological evaluation, if, in fact, the psychological evaluation is performed by the same clinician who is assessing physical evidence and conducting the physical examination.

As mentioned in Module 2, it is essential to obtain the individual’s informed consent prior to the physical examination. The physical examination must be conducted by a qualified physician. Whenever possible, the patient should be able to choose the gender of the physician and, where used, interpreter. If the doctor is not the same gender as the patient, a chaperone who is of the same gender as the patient should be used unless the patient objects. The patient must understand that he or she is in control and has the right to limit the examination or to stop at any time (see Module 3). A complete physical examination is recommended unless the allegations of torture are limited and there is no history of loss of consciousness or neurological or psychological symptoms that may affect recall of torture allegations. Under such circumstances, a directed examination may be appropriate in which only pertinent positive and negative evidence are pursued on examination.

In this Module, there are many references to specialist referral and further investigations. Unless the patient is in detention, it is important that physicians have access to physical and psychological treatment facilities, so that any identified need can be followed up. In many situations, certain diagnostic test techniques will not be available, and their absence must not invalidate the report.

In cases of alleged recent torture and when the clothes worn during torture are still being worn by the torture survivor, they should be taken for examination without washing, and a fresh set of clothes should be provided. Wherever possible, the examination room should be equipped with sufficient illumination and medical equipment for the examination. Any deficiencies should be noted in the report. The examiner should note all pertinent positive and negative findings, using body diagrams to record the location and nature of all injuries (see anatomical drawings in Appendix 3 of the Istanbul Protocol to record the location and nature of all injuries). Some forms of torture such as electrical shock or blunt trauma may be initially undetectable, but may be detected during a follow-up examination. Although it will rarely be possible to record photographically lesions of prisoners in custody of their torturers, photography should be a routine part of examinations. If a camera is available, it is always better to take poor quality photographs than to have none. They should be followed up with professional photographs as soon as possible.

### 2.1 Dermatologic Evaluation

Physical evidence of torture is often revealed in a comprehensive examination of the skin. Description of skin lesions should include the following:

- Localisation (use body diagram): symmetrical, asymmetrical
- Shape: round, oval, linear, circumferential, etc
- Size: (use ruler)
- Colour
- Surface: scaly, crusty, ulcerative, bullous, necrotic
- Periphery: regular or irregular, zone in the periphery
- Demarcation: sharply, poorly demarcated
- Level in relation to surrounding skin: atrophic, hypertrophic, macular
Common injuries to the skin can be classified as:

- Abrasions (or grazes)
- Contusions (commonly known as bruises)
- Lacerations (also, commonly but confusingly, known as cuts)
- Incisions (including stab wounds)
- Burns and scalds.

**Abrasions**

An abrasion is a scraping away of the superficial portions of the epidermis or destruction of the superficial layers by tangential application of force against the rough surface of the blunt object. Abrasions are more commonly observed over bony prominences or where a thin layer of skin overlies bone. When the blunt instrument scrapes off the superficial layers of the skin the surface is striped. If abrasions are deep and extend down to the dermis, capillaries may bleed, and serosanguineous fluid deposits on the surface of the skin that forms a brownish scab when it dries out. The abrasion remains moist until it forms a scab which consists of a hardened exudate. During the two or three days following the injury, abrasions produce fluid that crusts over. This makes them very susceptible to infection, which delays and distorts the healing process. The scab organizes in a few days and covers the lesions for up to a few weeks, and then it usually leaves a pink intact surface after detaching. The pink colour gradually fades, within a few months. Unless the abrasions are of full-thickness, they will heal with few remaining signs, although they can leave hyperpigmentation or hypopigmentation.

Linear abrasions are referred to as scratches. These are caused by pointed objects such as wire-ends and pins. Sometimes victims of torture may be thrown from moving vehicles so that they slide on the road, or they may be dragged out on the ground during arrest or capture. In these cases extensive abrasions may be seen, and particles of dirt, sand, etc. will predispose the abrasion to infection. The same particles may become embedded in the skin and leave a sort of ‘tattoo’ effect that can persist for years.

Abrasions may show a pattern that reflects the contours of the instrument or surface that inflicted the injury. Identifiable patterns of scratches can be seen, for example, from fingernails. Elongated broad abrasions can be caused by the friction on the skin from objects such as ropes and cords. When the blunt force is directed perpendicular to the skin over the bony prominences, it will generally crush the skin at that point. Sometimes if there is anything between the object and the skin, its imprint may be observed on the skin, such as a shoe print. In hanging and other asphyxiations by ligature, patterned abrasions can often be found on the neck.
Circumferential loss of hair (cicatricial alopecia) following prolonged application of a tight cord around the leg six years prior to examination. [Danielsen and Berger, 1981, Acta Dermatovener (Stockh) 61: 43-46. Reprinted with permission from Taylor & Francis.]

**Contusions**

A contusion or bruise is caused when blunt trauma occurs to the subcutaneous tissue resulting in rupture of blood vessels with extravasation into the neighbouring soft tissue. The continuity of the skin surface is unbroken. Contusions may be present not only in skin but also in muscles and internal organs. A haematoma is a focal collection of blood in the area of the bruise.

Contusions cause blood to leak from small blood vessels, making the area tender and sometimes boggy. If the skin and subcutaneous tissues are thin, the bruise becomes apparent relatively quickly and may take the shape of the weapon used, although this might not be obvious in darker skins. The extent and severity of a contusion are related to the amount of force applied, but more importantly vascular structure of the traumatised area affects them. Elderly people and children who have loosely supported vascular structure will bruise more easily than young adults. Many medical conditions are associated with easy bruising or purpura, including blood disorders, vascular disorders, and vitamin and other nutritional deficiencies. Certain types of medication can also impair clotting and result in more extensive bruising.

Sometimes the shape of the bruise helps to identify shape of the blunt instrument that caused the injury. For example, a blow from a baton or heavy stick often leaves two parallel lines of bruising (tramline bruising) caused by the blood being pushed sideways by the contact. Ideally bruises should be photographed as soon as possible (see Medical Photography section below), before they spread or fade.
The formation of “tramline” bruising from the application of a rectangular or cylindrical object. [Knight, 1991, Forensic Pathology, pp 123-156.]

Contusions with a typical “tramline” appearance after alleged torture involving beating with a broom handle. [Knight, 1991, Forensic Pathology, pp 123-156.]

When the bruise is deep, the blood tracks slowly to the surface, and it may be several hours or even days before anything is visible. It is often helpful in such cases to re-examine the patient a day or two later. In such cases the extravasated blood (blood that has been lost from the vessels) follows tissue planes and may emerge some distance from the original injury, and is unlikely to be tender. For example, bruising of any part of the face may appear below the eye. Thus the site of the bruise is not the site of the injury, but the size of the bruise could be evidence of the force of the blow. This should be made clear in any report. 

Bruises change colour and fade over a period of hours and days as the blood pigments are metabolised and absorbed, but this takes a variable period of time in different parts of the body following a single incident. However, if there are bruises at different stages of resolution in the same place, this could support allegations of repeated assaults over several days.
Alleged torture involving beating with a stick on several areas of the skin, including the back of the thighs and the buttocks, five days previously, associated with massive haematomas in the gluteal regions and on the upper part of the posterior thighs, containing areas with parallel, linear, a few cm broad, haemorrhagic lesions circulating obliquely around the gluteal region and the upper part of the thigh.[Rasmussen, 1990, Dissertation, Lægeforeningens Forlag.]

Speculative judgments should be avoided in the evaluation of the nature and age of blunt traumatic lesions since a lesion may vary according to the age, sex, condition, and health of the patient, the tissue characteristics, and the severity of the trauma. Fresh and old injuries can be seen together on people who have a long history of torture.

Irradiation, corticosteroids, scurvy, diabetes, hepatic cirrhosis, uraemia, denervation of the wounded area, blood loss, cold, concussion, and shock all inhibit wound healing. Wounds heal faster in young people. Bruises resolve over a variable period, ranging from days to weeks. Reddish-blue, blue or purplish-black bruises are almost certainly recent. As the extravasated red cells are destroyed, the aging bruise goes through variable colour changes of bluish-green, greenish-yellow and brown. Estimating the age of non-recent bruises is one of the most contentious areas of forensic medicine.

**Lacerations**

Lacerations are caused by a tangential force such as a blow or a fall and produce tears of the skin. The wound edges tend to be irregular, and often any may be bruised or/and abraded. There might be tissue bridges (where the skin has not separated along the entire length of the wound). Lacerations develop easily on the protruding parts of the body since the skin is compressed between the blunt object and the bone surface under the subdermal tissues. With sufficient force, however, the skin can be torn on any portion of the body.

**Incisions**

Incisions are caused by sharp objects like a knife, bayonet, or broken glass that produce a more or less deep, sharp and well-demarcated skin wound. The acute appearance is usually easy to distinguish from the irregular and torn appearance of lacerations. The term ‘cut’ should never be used in a report, as colloquially the term usually means a laceration.
Incisional wounds have clearly defined edges and, on close inspection, it may be possible to see that hairs have been cut. There are no tissue bridges. Sometimes the wound can be jagged, suggesting that it was not caused by a single stroke. However, because the skin stretches as it is cut, the size of the wound is not necessarily related to the size of the implement used.

Small wounds and those that are supported by surrounding tissues heal at the surface, and they may be difficult to see after only a few days. If the wound is in a part of the skin that is not supported, it will gape. Unless it is sutured or otherwise closed, it will heal from inside.

Alleged torture two years previously in Africa involving the use of razor blades and the application of pepper to the open incised wounds. [Danielsen, 1992, Torture (Suppl 1): 27-32.]

Stab wounds are incisions that are deeper than they are wide. They should be examined carefully because of the risk of damage to deeper structures.

**Burns and scalds**

Burns are usually caused by dry heat, but the skin can also be scalded with very hot liquids or burnt with chemicals. Burning is a form of torture that frequently leaves permanent changes in the skin. The shape of the lesion can sometimes, but not always, reveal the shape of the object that caused the burn. The damage caused by heat is proportional to the temperature and the duration of exposure. Burns are classified into three degrees, according to severity.

- In superficial (first degree) burns, there is no permanent damage to the epidermis. They present as a reddening of the skin.
- In partial thickness (second degree) burns, some of the epidermis is destroyed and there may also be damage to deeper tissues. They present as moist, red, blistered lesions and are normally very painful.
- In full thickness (third degree) burns, there is complete destruction of the epidermis and significant damage to deeper tissues. Sometimes third-degree burns are seen with complete destruction of all layers of the skin. The shape of the lesions may or may not reflect the shape of object that caused the thermal injury. They may not be as painful as partial thickness burns. If the burns are widespread, there is usually death from shock and fluid loss.

Cigarettes are commonly used by torturers to inflict pain. Most cigarette burns are superficial and fade over a few hours to a few days. They tend to be circular, have a diameter of up to 1 cm. They cause an erythematous (reddening of the skin) and an oedematous circle that can blister. Deeper burns are caused when the lit cigarette is
pressed against the skin for a longer time. When this happens the lesion is deeper and there might be a full thickness burn in the centre surrounded by blisters. If the cigarette is rubbed in it leaves a larger and more irregular lesion. The cigarette fire has a conical structure and its intensity may vary on different parts of the surface. Sometimes there is indistinct blister formation and the lesion is deeper in one part, with blisters partially or totally surrounding it. There may be complete disruption of the epidermis and most of the basal layer.

Alleged torture involving burning with a cigarette four weeks previously. There are 5 to 10 mm, circular, macular scars with a depigmented centre and a hyperpigmented, relatively indistinct periphery noted on the back of the hand. [Kjærgaard and Genefke, 1977, Ugeskr Læger 139: 1057-1059.]

Electric burns usually consist of a red brown circular lesion, 1 - 3 mm in diameter, usually without inflammation, and may result in a hyperpigmented scar. The skin surfaces involved must be examined carefully because the lesions are often not easily discernible.
Alleged torture involving "Picana", i.e. electrical torture via electrodes shaped like a knitting needle, 72 hours previously. The skin of the frontal area of the trunk shows many erythematous lines, some 2-5 mm wide, mostly vertically arranged. Scattered among them are dark red, crusty spots. The linear shape of the lesions indicates external infliction corresponding to a pointed electrode moved across the skin, the red crusty spots correspond to the entrance of the electrical current. The crusts probably correspond to an electrical injury. The concomitant heat development has not been sufficient enough to induce a regular inflammation in the periphery. An important differential diagnosis is scratching. [Rasmussen, 1990, Dissertation, Lægeforeningens Forlag.]

Electrical burns may produce specific histologic changes, but these are not always present, and the absence of such changes in no way mitigates against the lesion being an electrical burn. The decision must be made on a case by case basis as to whether or not the pain and discomfort associated with a skin biopsy can be justified by the potential results of the procedure.

Burns from hot objects tend to take the shape of the surface that caused the burn. The wound contracts as it heals, so the lesion may be smaller than the object.

Alleged torture involving burning on several areas of the skin with a heated, circular metal rod, the size of a cigarette, one year previously. Circular scars with an atrophic centre and a regular, narrow, hyperpigmented zone in the periphery are seen. (The patient had 35, mostly circular, scars distributed on several areas of the skin, some of them with a hypertrophic zone in the periphery. Their diameter varied from below 1 cm to around 2 cm). [Danielsen and Berger, 1981, Acta Dermatovener (Stockh) 61: 43-46. Reprinted with permission from Taylor & Francis.]

Alleged torture involving burning with a glowing metal rod placed across the broad area of the calf four years previously. A scar shaped like a boatis noted on the calf, with an atrophic centre and a narrow zone of hyperpigmentation in the periphery. The scar has a shape corresponding to a lesion.
induced by a rod pressed against the soft calf. The scar is typical for a third degree burn because of the regular, narrow zone in the periphery. [Danielsen, 1995, Sår 3: 80-83. Reprinted with permission from Sår.]

Liquids flow on contact with the skin, and this can leave a distinctive pattern reflecting the survivor's posture at the time of the incident. Scalds lose heat rapidly so the resulting lesion diminishes away from the point of first contact, whereas chemical burns are often more extensive. A number of lesions from scalding in different parts of the body are suggestive of torture. A single burn might be caused by torture but could also be due to an accident either at work or otherwise. A good occupational history is paramount.

Alleged torture involving acid thrown against the victim. Linear scars, a few cm wide, with a depigmented centre and a regular, narrow, hyperpigmented zone in the periphery are seen on the thighs and buttocks. The scars appear in an asymmetric pattern, mostly obliquely directed down the legs. The scars show signs of external infliction in agreement with a liquid running down the legs. They show sequels to necrotic areas with a narrow hyperpigmented zone in the periphery. [Gordon and Mant, 1984, Lancet 1: 213-214. Reprinted with permission from Elsevier.]

**Complex Lesions**

Many lesions comprise areas of different types of wounds. For example, as noted above, many lacerations are bruised and abraded at their edges. Wounds caused by broken glass may be a mixture of incision and laceration.

Bites tend to be a mixture of laceration and crush injury. Human bites, especially those that are sexual in nature, can show petechiae from sucking. Petechiae are obvious in the twenty-four hours following the assault. The marks from human bites have a semicircular shape and appear blunt. Animal bites cause deeper and sharper wounds. It is important to look for lacerations caused by the claws.

**Scarring**

It is often the case that a health professional will see a survivor of torture months or years after the incidents. In such cases the wounds are likely to have healed to a greater or lesser extent. Healing is influenced and often impaired by many factors that can be present in places of detention including persistent, untreated infection; repeated trauma to the same
area; and malnutrition. When faced with the examination of old injuries, it is thus important to obtain a detailed history from the individual of the acute appearance of the injury, any treatment received (such as sutures, antibiotics) and a description of how the wound healed and in what time frame. Such descriptions from a lay person may in themselves assist in corroborating allegations since they may indicate medical phenomena that a lay person would not usually be aware of. Such a description of wound healing may also reveal elements of the detention which are also deliberately neglected, such as:

- Inadequate healthcare provision
- Poor toilet and washing facilities
- Insufficient or nutritionally incomplete diet.

The commonest physical finding following the late examination of survivors of torture is scarring. Most scars are nonspecific, but some individual scars can be helpful in supporting a history of torture, as can the pattern of scarring. Occasionally the individual will have photographs of the acute lesions, and these can be very helpful in giving an opinion on the cause of the late signs. However, before citing such photographs in an expert report, it is essential to be certain of the date of the photographs, and that they really are of that individual.

Full thickness wounds (those that go through the epidermis) heal in one of two ways. When the wound is small and the edges are opposed, it heals from the top down (by primary intention). This tends to leave a small, tidy scar. Pockets of infection inside can become abscesses.

If this process cannot occur, especially if the wound gapes, it heals from below (by secondary intention). This is a slow process and prone to infection, and will leave a wide scar. When the original wound was straight, and especially if it was an incision, the scar tends to be symmetrical, with curved edges, and is widest at the middle (a biconvex scar).

The number, position and size of lesions may indicate other aspects of the conditions in which the individual was detained. For example, if the floor of a cell is flooded for any reason, and there is no access to a toilet so that the person has to urinate and defecate in the cell, the detainees will have to sit or stand in dilute sewage. In these circumstances, minor wounds, whether caused by assault or accident, may well become infected and can leave many small scars around the lower legs or buttocks. These must be differentiated from lesions left by childhood skin infections and other causes. All scars should be documented, including those that the individual feels were caused in incidents other than torture.

If a scar has suture marks around it, this should be documented, as this demonstrates that medical care was given. Equally it should also be noted if there are scars from wounds that have clearly not received medical attention, or have been seriously infected. Scars from surgery should also be noted, especially if it is alleged to be associated with torture, for example the removal of a ruptured spleen.

Sometimes scars are self-inflicted in order to support a weak medico-legal case, but these are often apparent. Generally they are superficial and within easy reach of the dominant hand.

Small regular patterns of scarring, particularly but not exclusively in Africans, could either be tribal marking or caused by traditional healers. The former are generally on the face. The
latter tend to be multiple, symmetrical, and around painful parts of the body. However, some torturers may also produce small symmetrical patterns of scarring.

Bullet wounds are rarely caused during torture but may be caused prior to arrest or during escape (sometimes security forces stage escapes before shooting detainees). Generally, as a bullet enters the body it leaves a small, regular wound, but as it leaves the wound is much larger and more ragged. The appearance depends on the distance from the weapon and its type. If there is an entry wound but no exit wound, it may be appropriate to arrange an X-ray to find out if the bullet is still in the body. A photograph or, if a camera is not available, a drawing of the wounds might be helpful if an expert opinion needs to be sought.

**Upper limbs**

Small wounds to the backs of the hands can be caused by punching or being hit. Wounds on the backs of the forearm could be defence injuries. The inside of the non-dominant forearm is the usual location of self-inflicted wounds. Superficial abrasions or reddening around the wrists could have been caused by tight handcuffs or cords. At a later stage there is often hair loss and there may be hyperpigmentation.

Finger and toe nails can be extracted or crushed during torture, but the late appearance is normally indistinguishable from infection or innocent trauma. Vaccination scars should be noted to ensure they are not attributed to ill-treatment.

**Lower limbs**

Scars on the knees and shins are common in many people, especially those who have played contact sports. Thus lesions in this part of the body can rarely be significant, though they might be consistent with allegations of torture. Additionally, tropical ulcers in childhood can leave large, irregular scars primarily around the lower legs. Lesions on the upper thighs and particularly those inside the thighs are much more important, as they are less likely to be the result of disease or accidental causes.

**Keloid scarring**

Keloids are scars that exceed the boundaries of the original wound. They are much more common in some skin types than others. The exact pathogenesis is unclear, but the tendency to them is probably inherited. Those who have a tendency to keloid will probably have several thickened scars on their bodies. Thus such scars are more difficult to attribute to specific allegations of torture.

**Post-inflammtory hyperpigmentation**

Hyperpigmentation can follow inflammation in darker skins, irrespective of the cause. It is not seen in pale skins, nor in very dark skins. The hyperpigmentation retains the shape of the original inflammation, which can be important forensically. For example, classic tramline bruising (e.g. parallel lines of bruising) following a blow from a baton or similar object or inflammation from burns can leave distinctive patterns of hyperpigmentation. The increased pigmentation can last for between five and ten years.

Whipping can sometimes leave lines of hyperpigmentation, especially in darker skin. These lesions are rarely confused with striae distensae (see below) commonly referred to as “stretch marks.”
Less regular patterns of hyperpigmentation are seen following abrasions, again particularly in darker skins. Tight ropes or handcuffs may leave marks around the wrists, and marks following rope burns can be seen elsewhere on the body where the individual has been tied up or suspended. These are rarely pathognomonic individually, but the locations and distribution of the marks can support the history of torture.

As hyperpigmentation can follow any inflammation, any other cause of inflammation can cause a similar pattern. For example, lines of increased pigmentation that follow an irritant dermatitis from contact with plant stems can be mistaken for similar lines following whipping (although it is not unknown for victims to be whipped with irritant plant stems as a form of ill-treatment).

**Striae Distensae**

*Striae distensae* (stretch marks) are most common on the abdomen (especially after pregnancy), the lower back, the upper thighs, and around the axillae. They are hypopigmented lines in which the skin might be folded. They must not be confused with scars from whipping. In striae, the skin is intact. They can be evidence of significant weight loss, for example in detention.

![Alleged torture involving beating and scalding on the back two years previously. Symmetrical, atrophic, finely wrinkled, depigmented, irregularly linear changes on the back are noted. The skin changes are typical for striae distensae, a skin condition primarily induced by hormonal changes. They do not support the alleged history of torture. The patient may, however, have been unaware of the changes on the back before the torture. [Danielsen, 1992, Torture (Suppl 1): 27-32.]](image)

### 2.2 Head and neck

Lesions on the face are particularly distressing for survivors of torture because they are a frequent reminder of the episode. Most traumatic scars on the face tend to be relatively small, and scars from acne and chickenpox, and tribal markings, must not be mistaken for them.

Lesions are common over bony points, especially the eyebrows and the cheekbones. These may be associated with a fracture of the malar bone (cheekbone). Bruises and scars in the
scalp can be difficult to find, especially if the hair is thick. Bruises will normally be tender to touch. Broken or missing teeth are often shown by individuals as evidence of assault, but where the general oral hygiene is poor this usually makes this sign unhelpful. Petechiae of the palate may be evidence of forced oral intercourse. Slaps to the ear can sometimes damage the eardrum. However, the finding of scars of the tympanic membrane (eardrum) does not exclude childhood infections.

Eyes

Conjunctival hemorrhage, lens dislocation, subhyeloid hemorrhage, retrobulbar hemorrhage, retinal hemorrhage, and visual field loss may all be observed following torture. Referral to an ophthalmologist is recommended whenever there is a suspicion of ocular trauma or disease.

Ears

Blunt trauma to the external ear may result in haematoma. Cartilage necrosis and infection are likely sequelae if the ear is left untreated. Lacerations of the pinna vary from those of minor significance to complete amputation. Rupture of the tympanic membrane is a frequent consequence of harsh beatings. Prompt examination is necessary to detect tympanic membrane ruptures less than 2 mm in diameter, as they can heal within 10 days. About 80% of traumatic tympanic membrane perforations diagnosed within 14 days of injury will have healed spontaneously.

The short and long term sequelae of significant injury to the middle and inner ear are hearing loss, vertigo, tinnitus, unsteadiness and, less commonly, facial nerve paralysis. An audiogram should be performed to assess injury to the ossicles and inner ear. A conductive hearing loss is usually due to a tear in the tympanic membrane and blood in the middle ear. A hearing loss of less than 40 dB suggests an ossicular chain dislocation. Sensorineural loss indicates cochlear or retrocochlear damage.

Fluid may be observed in the middle and/or external ear. If otorrhea is confirmed by laboratory analysis to be CSF (cerebrospinal fluid), then MRI or CT should be performed, if possible, to determine the fracture site. The radiographic examination of fractures of the temporal bone or disruption of the ossicular chain is best determined by CT, then hypocycloidal tomography, and lastly linear tomography.

Nose

The nose should be evaluated for alignment, crepitation, and deviation of the nasal septum. Initially soft tissue swelling may make interpretation difficult and it may be necessary to re-examine nose after 48 hours when this has subsided. Frequently there is an associated deviation of nasal septum which may result in nasal obstruction. For simple nasal fractures, standard nasal radiographs should be sufficient. Sometimes the fracture of the nasal bone includes the frontal process of the maxilla, and sometimes it extends to include ethmoid labyrinth. For complex nasal fractures and when the cartilaginous septum is displaced, and when rhinorrhea is present, CT and/or MRI are recommended.

Jaw, Oropharynx and Teeth

The oral cavity must be carefully examined. During the application of electric current to the mouth, the tongue, gingiva or lips may be bitten. Lesions might also be produced by forcing objects or materials into the mouth. Temporomandibular joint syndrome can be caused by
electric current and blows to the face. It will produce pain in the temporomandibular joint, limitation of jaw movement, and in some cases subluxation of this joint.

A careful dental history should be taken and, if dental records exist, these should be requested. The patient should be referred to a dentist if there is any damage to the teeth. Mandibular fractures, avulsions or fractures of the teeth, broken prostheses, swelling of the gums, bleeding, pain, or loss of fillings from teeth can all result from direct trauma or electric shock torture. Dental caries and gingivitis should also be noted. Poor quality dentition may be due to conditions in detention, or may have preceded it. X-rays and MRI are suggested for determining the extent of soft tissue, mandibular and dental trauma.

2.3 Chest and Abdomen

Examination of the trunk, in addition to noting lesions of the skin, should be directed toward detecting regions of pain, tenderness or discomfort that would reflect underlying injuries of the musculature, ribs or abdominal organs. The examiner must consider the possibility of intramuscular, retroperitoneal and intra-abdominal hematomas, as well as laceration or rupture of an internal organ. Ultrasonography, CT scans and bone scintigraphy should be used, when realistically available, to confirm such injuries. Routine examination of the cardiovascular system, lungs and abdomen should be performed in the usual manner. Pre-existing respiratory disorders are likely to be aggravated in custody, and new ones may develop. Near asphyxiation often leaves no marks and may cause acute and chronic respiratory problems as well as other complications.

Victims can be exposed in a confined space to smoke or tear gas. Many survivors will give an account of a persistent dry cough for a few days or weeks afterwards, probably as a result of inhalation pneumonitis (inflammation of the lungs). Some survivors say that they have been asthmatic since such an incident, but it would be very difficult to demonstrate causation. Examination of the lungs, and respiratory function tests are usually normal.

Rib fractures are a frequent consequence of beatings to the chest. If displaced, they may be associated with lacerations of the lung and possible pneumothorax. Fractures of the vertebral pedicles may result from direct blunt force. Fractures of the lower right ribs carry approximately a 10% risk of hepatic injury.

Following acute abdominal trauma, the physical examination must seek evidence of damage to abdominal organs or the urinary tract, but this examination is often negative. Gross haematuria is the most significant indication of kidney contusion. Organ injury may present on investigation as free air, extraluminal fluid, and areas of low attenuation, which may represent oedema, contusion, haemorrhage or a laceration. Peripancreatic edema is one of the signs of acute traumatic and non-traumatic pancreatitis. Ultrasound is particularly useful in detecting subcapsular hematomas of the spleen. Peritoneal lavage may detect occult abdominal haemorrhage, but free abdominal fluid detected subsequently on CT scan might be from the lavage or haemorrhage; thus invalidating the finding. Acute renal failure due to crush syndrome may be seen acutely following severe beatings.

2.4 Musculoskeletal System

Complaints of musculoskeletal aches and pains are very common in survivors of torture. They may be the result of repeated beatings, of suspension, or of other positional torture. They may also be somatic. They are non-specific, but should be documented. In accordance with the characteristics of torture, complaints are characterized as pain in the respective
region of the body, limitation of joint movement, swelling, parasthesiae, numbness, loss of sensation to touch, and tendon reflex loss.

Physical examination of the skeleton should include testing for mobility of joints, the spine and the extremities. Pain with motion, contractures, strength, evidence of compartment syndrome, fractures with or without deformity, and dislocations should all be noted after documenting visible signs such as contusions, abrasions, and lacerations as described above. Trauma to muscle should be checked for, such as muscle rupture and muscle tearing. Specific clinical signs of ligament tear include swelling, bruising, muscle spasm, and painful stress test, often with joint laxity. There may be a palpable gap in the ligament. If it is completely torn, then considerable swelling and bruising occurs. Tendon ruptures, avulsions from the insertion of the bone, and dislocation of a tendon from its groove may all be observed.

Back pain is also common in survivors of torture, and there may be some local tenderness in the lumbar spine. However, these findings are non-specific and common in the general population. Fractures of the vertebral pedicles (the parts of the vertebra going away from the main body) may result from direct blunt force and, in some instances, radiography of the vertebrae may indicate recent or healed fractures.

**Fractures**

Fractures are caused by a loss of bone integrity due to the effect of a blunt mechanical force on various vector planes. Fractures can be caused by a direct blow, in which case the fracture is at the site of the impact, or by twisting or crushing, in which case the fracture tends to be at the weakest part of the bone. In the acute phase, local swelling, bony deformity, tenderness and loss of function will be typical findings on clinical examination. In the chronic phase, various degrees of bony deformity, pain with activity and loss of function may be found. A direct fracture occurs at the site of impact or at the site where the force was applied. In an indirect fracture, the location, contours, and other characteristics of a fracture reflect the nature and direction of the applied force. The most frequent fractures seen in survivors of torture are of the nasal bones, the ribs, the radius, ulna and small bones of the hand, the transverse process of vertebrae, and those of the coccyx. The hyoid bone and laryngeal cartilage may be fractured in partial strangulation or from blows to the neck.

If a person alleges that a bone was fractured during torture and a callus is palpable, that should normally be sufficient to document. X-rays are unlikely to add anything. Generally, even with an X-ray, it is only possible to say that a bone was fractured within a wide time-frame, but very rarely that the fracture was caused by torture. Mal-united fractures are highly supportive of a history of torture with no immediate medical treatment.

Routine radiographs are recommended at the initial examination, if facilities are available. Injuries to tendons, ligaments, and muscles are best evaluated with MRI, but arthrography (arthroscopy) can also be performed. In the acute stage, MRI can detect hemorrhage and possible muscle tears. Muscles usually heal completely without scarring, so later imaging studies will be negative. MRI or scintigraphy may detect bone injury such as a subperiosteal haematoma, which may not be detected on routine radiographs or CT. Radiographic aging of relatively recent fractures should be performed by an experienced trauma radiologist.

3. Neurological Examination
The neurological examination should include both the central and peripheral nervous systems. Particular attention should be paid to assessment of both motor and sensory neuropathies and cranial nerves. Performing examination of reflexes is important. Radiculopathies, other neuropathies, cranial nerve deficits, hyperalgesia, paraesthesias, hyperaesthesia, change in position and temperature sensation, motor function, gait and coordination may all result from trauma associated with torture. In patients with a history of dizziness and vomiting, vestibular examination should be conducted, and evidence of nystagmus noted.

3.1 Head Trauma and Post-traumatic Epilepsy

Head trauma is among the most common forms of torture. Even repeated minor head trauma can cause permanent damage to brain tissues. This can in turn cause permanent physical handicap. Lacerations and abrasions of the head and their late consequences should be documented as above. Scalp bruises are frequently not visible externally acutely unless there is swelling. Bruises also may be difficult to see in dark skinned individuals, but will be tender to palpation.

Survivors of torture often report that they were unconscious at times, but it is impossible for them to know what happened unless they were with a reliable witness. It is necessary to try to differentiate between loss of consciousness following blows to the head, post-traumatic epilepsy (see below), asphyxiation, pain and exhaustion, or any combination of these.

Many victims of torture have suffered blows to the head, and many complain of persistent or recurrent headaches, whether or not they have sustained any head injury. Generally the headaches are psychosomatic or due to tension headache. In some cases with a history of repeated blows to the head, it is possible to feel areas of hyperaesthesia (extreme sensitivity of neurological sensation) and some thickening of the scalp from scar tissue.

Headache may also be the initial symptom of an expanding subdural haematoma. There may be associated psychological changes of acute onset, and a CT scan or MRI must be arranged urgently, if one is available. It may also be appropriate to arrange psychological or neuropsychological assessment. Soft tissue swelling and/or haemorrhage will usually be detected with CT or MRI. In cases of trauma caused by falls, contracoup lesions (on the opposite side to the point of impact) of the brain may be observed on investigation, whereas following direct trauma, the main damage to the brain may be seen directly under the point of impact.

Violent shaking of the upper body has been reported as a form of torture (as it has as a form of child abuse). Survivors complain of severe headaches and persistent changes in cognitive function. In these cases no injuries are visible. Shaking can lead to death due to cerebral oedema and subdural bleeding. Retinal haemorrhages have been noted on post-mortem examination and, when seen in children, are very suggestive of shaking injuries.

Immediately after severe head injury there may be concussive convulsions, but these do not necessarily lead to epilepsy. Convulsions (or seizures) in the first week or so after a severe head injury tend to be tonic-clonic. They may recur for a year or more, but are not generally lifelong. Severe head injuries leading to brain lesions, specifically in the temporal lobe, can cause convulsions that start months or years after the incident. The latter are complex partial seizures.

Typically (>90% of cases), complex partial seizures start with an aura (a strange feeling that precedes the convulsion). This is followed by an absence that can last up to two
minutes. Concurrent automatic movements, particularly lip smacking have been reported. After these episodes there is usually a period of a few minutes of disorientation. Often the aura is described as a strange feeling in the stomach, but it may involve bizarre smells or tastes. These must be differentiated from the re-experiencing phenomena of PTSD where the person is always capable of being roused and never completely loses consciousness.

In most countries the prevalence of epilepsy in the population is 2%. About 65% of epilepsy is due to complex partial seizures. The cause of complex partial seizures is unknown in 45% of cases. Traumatic events including birth events account for 3% of it. The likelihood of acquiring epilepsy after a head injury depends on the severity of the injury (see table).

<table>
<thead>
<tr>
<th>Degree of head injury</th>
<th>Loss of consciousness</th>
<th>Relative risk of epilepsy</th>
<th>Duration of increased risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td>&lt; 30 minutes</td>
<td>1.5</td>
<td>5 years</td>
</tr>
<tr>
<td>Moderate</td>
<td>&lt; 24 hours</td>
<td>2.9 (three times)</td>
<td>--</td>
</tr>
<tr>
<td>Severe</td>
<td>&gt; 24 hours</td>
<td>17.2 (17 times)</td>
<td>20 years</td>
</tr>
</tbody>
</table>

Survivors of torture rarely have an accurate account of their head injuries, and unless they have an external reference, they cannot know for certain how long they were unconscious. One problem with attributing epilepsy to head trauma is that there is rarely any information about the individual’s neurological state prior to the incident.

### 3.2 Nerve damage

Many forms of torture can cause nerve damage, including stretching injuries associated with joint damage and physical damage from fractures and incisions. The speed of resolution of nerve damage is relatively predictable, so it may be possible for an expert to determine the approximate time of the original injury from a series of examinations over several months.

‘Palestinian suspension’ can lead to neuropathy of the brachial plexus, especially if it has been prolonged (see Module 4). Sometimes there will be residual signs of this, and if they are still present after two years, they will probably be permanent. ‘Winging’ of the scapula must be looked for (by asking the person to push against a wall and observing the shoulders from behind). Survivors will sometimes describe having suffered weakness of the muscles around the shoulder associated with the loss of certain movements which have recovered progressively over a period of months. If he or she did not have access to information about the clinical processes involved, this description can be very supportive of allegations of torture. Often there is residual pain around the chest and shoulder joint, which may be partially or completely physical or may be psychosomatic.

Peripheral nerve lesions of the hands and feet may also be detected following the prolonged application of restraints (wires, ropes, handcuffs, etc.) to the wrists or ankles. Motor and sensory changes may be transient or, in cases of excessive and prolonged tightening, may be permanent. These lesions are sometimes known as handcuff ‘neuropathies’.

### 4. Examination of Women

Genital examination is generally the last part of the physical examination. The doctor must seek specific consent prior to a genital examination, even if consent for the physical examination has already been given. Prior notice of an intention to conduct a detailed physical examination that may include a genital examination could be reassuring to the person and help her to give informed consent. A clear, unambiguous explanation of the
reason for the genital examination should be given while the alleged victim is fully clothed. Rape victims in particular may feel disempowered, and may feel that they cannot refuse a request from the doctor, who should make every effort to ensure that any consent given is real and informed.

If the alleged victim refuses consent, the doctor should record any relevant observations on the alleged victim’s demeanour, such as embarrassment or fear. It is unwise to draw conclusions about a refusal to consent to genital examination. Lying prone on an examination table, exposed and with legs apart in front of a relative stranger, can trigger powerful recall of the rape. The individual may be anxious, and shame can be profound, making genital examination unacceptable to her.

If informed consent is obtained, the woman should be made at ease, reassured and explained the procedures that are going to be performed. The genitals should be inspected for the presence of a hymen, the likelihood of having been pregnant, and evidence of genital mutilation. Is there vaginal discharge or tenderness, or spasm of the vaginal muscles?

4.1 Examination Following a Recent Assault

While it is rare that a victim of rape during torture is released, it is still possible to identify acute signs of the assault. In these cases, there are many issues to be aware of that may impede the medical evaluation. Recently assaulted victims may be troubled and confused about seeking medical or legal help due to their fears, sociocultural concerns or the destructive nature of the abuse. In such cases, a doctor should explain to the individual all possible medical and judicial options and should act in accordance with the individual’s wishes. The duties of the physician include obtention of voluntary informed consent for the examination, recording of all medical findings of abuse and obtention of samples for forensic examination. Whenever possible, the examination should be performed by an expert in documenting sexual assault. Otherwise, the examining physician should speak to an expert or consult a standard text on clinical forensic medicine. When the physician is of a different gender from the victim, he or she should be offered the opportunity of having a chaperone of the same gender in the room. If an interpreter is used, then the interpreter may also fulfil the role of the chaperone. Given the sensitive nature of investigation into sexual assaults, a relative of the alleged victim is not normally an ideal person to use in this role. The individual should be comfortable and relaxed before the examination.

A thorough physical examination should be performed, including meticulous documentation of all physical findings, including size, location and colour, and, whenever possible, these findings should be photographed and evidence collected of specimens from the examination. The physical examination should not initially be directed to the genital area. Particular attention must be given to ensure a thorough examination of the skin, looking for cutaneous lesions that could have resulted from an assault. These include bruises, lacerations, ecchymoses and petechiae from sucking or biting. Lesions on the breasts, particularly from bites, should be enquired about in women who have been sexually assaulted. When the legs are examined, the inner thighs should be inspected thoroughly. Where women have had their legs forced apart, there may be finger bruising, scratches, cigarette burns, incisions and other wounds, or their late consequences.

When genital lesions are minimal, lesions located on other parts of the body may be the most significant evidence of an assault. Even during examination of the female genitalia immediately after rape, there is identifiable damage in less than 50 per cent of the cases.
Anal examination of men and women after anal rape shows lesions in less than 30 per cent of cases. Clearly, where relatively large objects have been used to penetrate the vagina or anus, the probability of identifiable damage is much greater.

Where a forensic laboratory is available, the facility should be contacted before the examination to discuss which types of specimen can be tested, and, therefore, which samples should be taken and how. Many laboratories provide kits to permit physicians to take all the necessary samples from individuals alleging sexual assault. If there is no laboratory available, it may still be worthwhile to obtain wet swabs and dry them later in the air. These samples can be used later for DNA testing. Sperm can be identified for up to five days from samples taken with a deep vaginal swab and after up to three days using a rectal sample. Strict precautions must be taken to prevent allegations of cross-contamination when samples have been taken from several different victims, particularly if they are taken from alleged perpetrators. There must be complete protection and documentation of the chain of custody for all forensic samples.

If the woman is being examined shortly after the rape, it is important to discuss issues of pregnancy and emergency contraception, and however long has passed since the assault, sexually transmitted diseases (especially gonorrhoea, chlamydia, syphilis and trichomoniasis) and other infectious diseases such as Hepatitis B (HBV) and HIV must be considered (see below), and treated where present if the necessary facilities are available. If rape occurred within the previous seventy-two hours, consideration must be given to the administration of post-exposure prophylaxis (PEP) of anti-retrovirals (ARVs) for preventing infection by HIV and this depends on a detailed assessment of the nature of the sexual assault. The risk of infection with HBV should be assessed and the need for immunisation determined.

Some women are raped persistently over a long period which increases the likelihood that they will become pregnant; in some cases they are then detained until it is too late to consider termination of pregnancy (if that would otherwise be an option). In such cases routine ante-natal examinations should be performed including, if possible, ultrasounds. This will enable the time of conception to be estimated.

4.2 Examination After the Immediate Phase

Where the alleged assault occurred more than a week earlier and there are no signs of bruises or lacerations, there is less immediacy in conducting a pelvic examination. Time can be taken to try to find the most qualified person to document findings and the best environment in which to interview the individual. However, it may still be beneficial to photograph residual lesions properly, if this is possible.

The background should be recorded as described above, then examination and documentation of the general physical findings. In women who have delivered babies before the rape, and particularly in those who have delivered them afterwards, pathognomonic findings are not likely, although an experienced female physician can tell a considerable amount from the demeanour of a woman when she is describing her history. It may take some time before the individual is willing to discuss those aspects of the torture that he or she finds most embarrassing. Similarly, patients may wish to postpone the more intimate parts of the examination to a subsequent consultation, if time and circumstances permit.

4.3 Follow-up
Many infectious diseases can be transmitted by sexual assault, including sexually transmitted diseases such as gonorrhoea, chlamydia, syphilis, HIV, hepatitis B and C, herpes simplex and Condyloma acuminatum (venereal warts), vulvovaginitis associated with sexual abuse, such as trichomoniasis, Moniliasis vaginitis, Gardnerella vaginitis and Enterobius vermicularis (pinworms), as well as urinary tract infections.

Appropriate laboratory tests and treatment should be prescribed in all cases of sexual abuse. In the case of gonorrhoea and chlamydia, concomitant infection of the anus or oropharynx should be considered at least for examination purposes. Initial cultures and serologic tests should be obtained in cases of sexual assault, and appropriate therapy initiated. Sexual dysfunction is common among survivors of torture, particularly among victims who have suffered sexual torture or rape, but not exclusively. Symptoms may be physical or psychological in origin or a combination of both and include:

- Aversion to members of the opposite sex or decreased interest in sexual activity;
- Fear of sexual activity because a sexual partner will know that the victim has been sexually abused or fear of having been damaged sexually. Torturers may have threatened this and instilled fear of homosexuality in men who have been anally abused. Some heterosexual men have had an erection and, on occasion, have ejaculated during non-consensual anal intercourse. They should be reassured that this is a physiological response;
- Inability to trust a sexual partner;
- Disturbance in sexual arousal and erectile dysfunction;
- Dyspareunia (painful sexual intercourse in women) or infertility due to acquired sexually transmitted disease, direct trauma to reproductive organs or poorly performed abortions of pregnancies following rape.

4.4 Genital Examination of Women

In many cultures, it is completely unacceptable to penetrate the vagina of a woman who is a virgin with anything, including a speculum, finger or swab. If the woman demonstrates clear evidence of rape on external inspection, it may be unnecessary to conduct an internal pelvic examination. Genital examination findings may include:

- Small lacerations or tears of the vulva. These may be acute and are caused by excessive stretching. They normally heal completely, but, if repeatedly traumatised, there may be scarring;
- Abrasions of the female genitalia. Abrasions can be caused by contact with rough objects such as fingernails or rings;
- Vaginal lacerations. These are rare, but, if present, may be associated with atrophy of the tissues or previous surgery. They cannot be differentiated from incisions caused by inserted sharp objects.

It is rare to find any physical evidence when examining female genitalia more than one week after an assault. Later on, when the woman may have had subsequent sexual activity, whether consensual or not, or given birth, it may be almost impossible to attribute any findings to a specific incident of alleged abuse. Therefore, the most significant component of a medical evaluation may be the examiner’s assessment of background information (for example, correlation between allegations of abuse and acute injuries observed by the individual) and demeanour of the individual, bearing in mind the cultural context of the woman’s experience.
5. Genital Examination of Men

Men who have been subjected to torture of the genital region, including the crushing, wringing or pulling of the scrotum or direct trauma to that region, usually complain of pain and sensitivity in the acute period. Hyperaemia, marked swelling and ecchymosis can be observed. The urine may contain a large number of erythrocytes and leucocytes. If a mass is detected, it should be determined whether it is a hydrocele, haematocele or inguinal hernia. In the case of an inguinal hernia, the examiner cannot palpate the spermatic cord above the mass. With a hydrocele or a haematocele, normal spermatic cord structures are usually palpable above the mass. A hydrocele results from excessive accumulation of fluid within the tunica vaginalis due to inflammation of the testis and its appendages or to diminished drainage secondary to lymphatic or venous obstruction in the cord or retroperitoneal space. A haematocele is an accumulation of blood within the tunica vaginalis, secondary to trauma. Unlike the hydrocele, it does not transilluminate.

Testicular torsion may also result from trauma to the scrotum. With this injury, the testis becomes twisted at its base, obstructing blood flow to the testis. This causes severe pain and swelling and constitutes a surgical emergency. Failure to reduce the torsion immediately will lead to infarction of the testis. Under conditions of detention, where medical care may be denied, late sequelae of this lesion may be observed.

Individuals who were subject to scrotal torture may suffer from chronic urinary tract infection, erectile dysfunction or atrophy of the testes. Symptoms of PTSD are not uncommon. In the chronic phase, it may be impossible to distinguish between scrotal pathology caused by torture and that caused by other disease processes. Failure to discover any physical abnormalities on full urological examination suggests that urinary symptoms, impotence or other sexual problems may be explained on psychological grounds. Scars on the skin of the scrotum and penis may be very difficult to visualize. For this reason, the absence of scarring at these specific locations does not demonstrate the absence of torture. On the other hand, the presence of scarring usually indicates that substantial trauma was sustained.

As with sexual assault of women described above, male victims of sexual violence also need to be assessed for prophylaxis of sexually transmitted diseases, Hepatitis B and HIV.

6. Perianal Examination

After anal rape or insertion of objects into the anus of either gender, pain and bleeding can occur for days or weeks. This often leads to constipation, which can be exacerbated by the poor diet in many places of detention. Gastrointestinal and urinary symptoms may also occur. Generally, visual inspection of the anogenital region is sufficient to find scarring and other lesions of the skin. The focus of the examination will depend on the history. In the acute phase, any examination beyond visual inspection may require local or general anaesthesia and should be performed by a specialist. For example, if an individual has persistent bleeding after an object was pushed through the anus, there may be scarring of the rectal mucosa and this can be looked for by proctoscopy. In the chronic phase, several symptoms may persist, and they should be investigated. There may be anal scars of unusual size or position, and these should be documented. Anal fissures may persist for many years, but it is normally impossible to differentiate between those caused by torture and those caused by other mechanisms. On examination of the anus, the following findings should be looked for and documented:
- Fissures tend to be non-specific findings as they can occur in a number of “normal” situations (constipation, poor hygiene). However, when seen in an acute situation (i.e. within 72 hours) fissures are more specific findings and can be considered evidence of penetration;
- Rectal tears with or without bleeding may be noted;
- Disruption of the rugal pattern may manifest as smooth fan-shaped scarring. When these scars are seen out of midline (i.e. not at 12 or 6 o’clock), they can be an indication of penetrating trauma;
- Skin tags, which can be the result of healing trauma;
- Purulent discharge from the anus. Cultures should be taken for gonorrhoea and chlamydia in all cases of alleged rectal penetration, regardless of whether a discharge is noted.

Following rape, the possibility of sexually transmitted diseases should be considered and local protocols followed. If there is any possibility of the perpetrator being prosecuted, air dried internal and external anal swabs can be taken up to five days after the rape, even if the survivor has defecated, and stored for DNA testing.

7. Medical Photography

One helpful tool in the documentation of physical evidence of torture is photography. It may be possible to ask experts elsewhere to comment on photographs if there is no local expertise available to interpret them. Those interviewing in custodial settings may not be permitted to use such equipment, but it can sometimes be negotiated with the detaining authorities. If photography is not possible, drawings and diagrams can be useful.

When working with a person who is alleging recent torture, it is very helpful to be able to document the injuries as quickly as possible, before any change occurs. Any photographic equipment can be used to capture a wound in the first instance and more photographs can be taken later, with a better camera if possible.

The subject of clinical photography must consent to having the pictures taken and agree about how the photographs will be stored and used.

The first photograph should show the individual clearly with, if possible, the lesions visible to allow identification in court if necessary. The front page of a recent newspaper (or other object of verifiable age) can demonstrate that the photograph was not taken prior to that date. If there are date and time settings on the camera, these should be used correctly. There should always be an indicator of scale for close-up images. A tape measure is best but, if necessary, any well-known object of standard size can be used, such as a 35mm film canister or a coin. In photographs taken using the camera’s built-in flash, wounds tend to be obscured. It is better to work in daylight or to use background lighting.

Digital cameras allow many photographs to be taken using different angles and lighting conditions and the best produced as evidence, although every image taken should be stored securely (for example, on a secure computer, with password protection). Films can also be useful as courts have not generally agreed how digital images should be treated as evidence. Digital images and scanned prints can be useful as they can be e-mailed to experts for an opinion. If necessary they can be cropped and enlarged, but the original version must always be retained. Further interference must be avoided as allegations of manipulation are difficult to refute.
Once the photographs have been taken, the chain of custody of the images must be ensured. A ‘chain of custody’ is a detailed record showing the exact date, time and location in which a piece of evidence entered the possession of different individuals. A chain of custody aims to prevent outside interference with evidence. It may be valuable to add to a witness statement a phrase such as: ‘I took photographs of [name] on [date] using my [type] digital camera. I kept it in my possession until I transferred the images to [X] directory on [X] computer. To the best of my knowledge it has not been tampered with, and the photographs in this report were made from that file.’

7.1 Assessment for Referral

The clinician should not hesitate to seek any further consultation and examination that he or she considers necessary for the evaluation. Those who need further medical and/or psychological care should be referred to appropriate services as discussed in Module 3. During ongoing care, further evidence may be detected that may not have been foreseen. If there is a rehabilitation centre for torture survivors in the region, the clinician may contact them for further support and advice.

In countries with a tradition of systematic torture, and pressure on health care professionals, the examining clinician may also prefer to refer patients to specialists to increase the number of medical witnesses to the torture (e.g. consulting with a dermatologist for a simple contusion).

8. Diagnostic Tests

In some cases, the use of diagnostic tests may aid in corroborating allegations of torture. Before obtaining such tests, however, clinicians should carefully consider the potential value of such tests and their inherent limitations in light of the level of “proof” needed in a particular case, the potential adverse consequences for the individual, and any resource limitations. Generally, diagnostic tests are not warranted unless they are likely to make a significant difference to a medico-legal case.

Radiologic Imaging

In the acute phase of injury, various imaging modalities may be quite useful in providing additional documentation of both skeletal and soft tissue injuries. Once the physical injuries of torture have healed, however, the residual sequelae generally are no longer detectable by these same imaging methods. This is often true even when the survivor continues to suffer significant pain or disability from his/her injuries.

References have already been made to various radiologic studies in the discussions of the examination of the patient and in the context of various forms of torture. What follows is a summary of the application of these methods, recognizing that the more sophisticated (and expensive) technology is not universally available.

Radiologic and imaging diagnostic examinations include routine radiographs (x-rays), radiotoposic scintigraphy, computerized tomography (CT), nuclear magnetic resonance imaging (MRI), and ultrasonography (USG). Each has its advantages and disadvantages. X-rays, scintigraphy, and CT scanning use ionizing radiation, which may be a concern for pregnant women and children. MRI uses a magnetic field; potential biologic effects on fetuses and children are theoretical, but thought to be minimal. Ultrasound uses sound waves; no biologic risk is known.
**X-Rays**

X-rays are readily available. They can be very useful when searching for fractures, fissures, deformity and foreign bodies in osseous structures. Excluding the skull, all injured areas should have routine radiographs as the initial examination. While routine radiographs will demonstrate facial fractures, CT is a superior examination as it demonstrates more fractures, fragment displacement and associated soft tissue injury and complications. When periosteal damage or minimal fractures are suspected, bone scintigraphy should be used in addition to x-rays.

The type of fracture can reveal important information on the force and its form of application. In this respect, soft tissue changes adjacent to the fracture or deformity as well as foreign bodies in the vicinity can also contribute information. The awareness of the forms of torture used can specify the cause of a lesion otherwise considered to be non-specific. Extension deformities can be followed up with these approaches during chronic stages.

A percentage of x-rays will be negative even when there is an acute fracture or early osteomyelitis. It is possible for a fracture to heal leaving no radiographic evidence of previous injury; this is especially true in children. Routine radiographs are not the ideal examination for evaluation of soft tissues.

**Scintigraphy**

Scintigraphy is an examination of high sensitivity but low specificity. Scintigraphy is an economic and effective examination to screen the entire skeleton for disease processes such as osteomyelitis or trauma. Testicular torsion can also be evaluated, but ultrasound is better suited to this task. Scintigraphy is not the appropriate examination to identify soft tissue trauma.

Scintigraphy can detect an acute fracture within twenty-four hours, but generally it takes two to three days and may occasionally take a week or more, particularly in the elderly. Generally the scan returns to normal after two years. However, it may remain positive in both fractures and cured osteomyelitis for years. The use of bone scintigraphy to detect fractures at the epiphysis or metadiaphysis (ends of long bones) in children is very difficult because of the normal uptake of the radiopharmaceutical at the epiphysis. Scintigraphy is often able to detect rib fractures that are not apparent on routine x-ray films.

Scintigraphy is more sensitive in the demonstration of bone tissue lesions than classical radiological techniques. It allows observation of the effects years later. It is more cost effective than MRI which can verify lesions in early stages. Fundamental events in revealing the pathology are osteoblastic activity and increased blood flow in tissues. In trauma not leading to fractures, bone metabolism and thus turnover is increased, and as trauma continues microfractures develop. The contribution of scintigraphy significantly increases in areas such as ribs, spinous processes and the scaphoid bone which are hard to evaluate by direct X-rays. Thus scintigraphy yields better results in trauma directed to thorax. Lesions such as epiphyseal separation or metaphyseal edge fractures which are easily missed can well be differentiated by the shape of epiphyseal plate and its visualisation. Scintigraphy also provides advantages as a screening procedure in multiple traumatic injuries.

Another contribution of scintigraphy is that activity of radioactive material changes in time. In acute stages, positive results are obtained in 80 % of the lesions within the first 24 hours.
and 95% in 72 hours. Increased activity may be observed 1-2 years after the alleged injuries and may sometimes persist for 10-15 years.

Application of Bone Scintigraphy to the Diagnosis of Falanga: Bone scans may be performed either with delayed images at about three hours or as a three-phase examination. The three phases are: 1) radionucleide angiogram (arterial phase); 2) blood pool images (venous phase, which is soft tissue); and 3) delayed phase (bone phase). Patients examined soon after falanga should have two bone scans performed at one-week intervals. A negative first delayed scan and positive second scan indicates exposure to falanga within days before the first scan. In acute cases, two negative bone scans at an interval of one week do not necessarily mean that falanga did not occur, but that the severity of the falanga applied was under the sensitivity level of the scintigraphy. Initially, if three-phase scanning is done, increased uptake in the radionucleide angiogram phase and in blood pool images and no increased uptake in the bone phase indicate hyperemia compatible with soft tissue injury. Trauma in the foot bones and soft tissue can also be detected with MRI.

Ultrasound

Ultrasound is inexpensive and without biologic hazard. The quality of the examination depends on the skill of the operator. In parts of the world where CT is not available, USG is used to evaluate acute abdominal trauma. Tendonopathy can also be evaluated by USG, and it is a method of choice for testicular abnormalities.

Shoulder USG is carried out in acute and chronic periods following suspension torture. In the acute period, edema, fluid collection on and around the shoulder joint, lacerations and hematomas of the rotator cuffs can be observed by USG. The reapplication of USG and subsequent observation that findings from the acute period disappear in time strengthens the diagnosis. In such cases, EMG, scintigraphy and other radiological examinations should be carried out together and their correlation examined. Even lacking positive results from other examinations, USG findings alone are adequate to prove suspension torture.

Although ultrasound is primarily used for evaluation of muscles and joints, especially the shoulder joint, its contributions can be much wider depending on the skill of the applicator administering it. Insufficient documentation increases the possibility of mis-diagnosis as results may appear conclusive. However, results by less experienced operators can well serve as a document for more experienced specialists who evaluate the event later.

Contribution of conventional ultrasound varies according to its capacity for morphological evaluation. At present, high channel probes with multifrequencies between 8 and 15 MHz can be more sensitive than CT and MRI in showing changes in cutaneous, subcutaneous, osseous and soft tissues as well as in muscles and joints. Ultrasound sensitivity to pathology related to shoulder, knee and ankle joints and related lesions of joints, tendons and adjacent soft tissues is usually is higher than MRI. It is possible to demonstrate correctly muscle contusion and haematomas, subcutaneous contusion and haemorrhages, loss of uniformity of subcutaneous fat tissue, soft tissue micro and macro-calcifications and foreign bodies with ultrasound. Traumatic changes and contusions of soft tissue in genitals, breast and perineum can be identified in detail with high resolution probes.

A second contribution is information on the perfusion of tissues identified by Doppler studies. Focal deficits of tissue perfusion and areas of reactive hyperaemia can be identified in injuries especially caused by cold (cold water, cold air). Findings of testicular torsion or of early detorsion can also be successfully demonstrated. It is also possible to demonstrate fracture, fissure, small osseous cortical discontinuities, neovascularisation due to wound
healing, or reactive periosteal callus formation in osteochondral injuries earlier and more precisely in comparison to direct X-rays or CT and MRI. However, in cases when there are no cortical injuries, verification of medullary and trabecular osseous changes is possible neither by classic nor by Doppler sonographic studies.

**CT scans**

CT is excellent for imaging both soft tissue and bone. MRI is better for soft tissue than bone. However, MRI may detect an occult fracture before it can be imaged by either routine radiographs or scintigraphy. Use of open scanners and/or sedation may alleviate anxiety and claustrophobia that are especially prevalent among torture survivors.

CT is also excellent for diagnosing and evaluating fractures, especially temporal bone and facial bones. Other advantages include determining alignment and displacement of fragments, especially spinal, pelvic, shoulder and acetabular fractures. CT cannot identify bone bruising.

CT with and without intravenous infusion of a contrast agent should be the initial examination for acute, subacute and chronic central nervous system (CNS) lesions. If the CT examination is negative, equivocal or does not explain the survivor’s CNS complaints or symptoms, proceed to an MRI.

CT with bone windows and a pre- and post-contrast examination should be the initial examination for temporal bone fractures. Bone windows may demonstrate fractures and ossicular disruption. The pre-contrast examination may demonstrate fluid and cholesteatoma. Contrast is recommended because of the common vascular anomalies that occur in this area. For rhinorrhea, injection of contrast into the spinal canal should follow a temporal bone. MRI may also demonstrate the tear responsible for the leakage of fluid.

When rhinorrhea is suspected, a CT of the face with soft tissue and bone windows should be performed. Then, a CT should be obtained after contrast is injected into the spinal canal.

**MRI**

MRI is more sensitive than CT in detecting central nervous system (CNS) abnormalities. The time course of CNS hemorrhage is divided into immediate, hyperacute, acute, subacute and chronic phases. The time course of CNS hemorrhage has ranges that correlate with imaging characteristics of the hemorrhage. Thus, the imaging findings may allow estimation of the timing of head injury and correlation to alleged incidents. CNS hemorrhage may completely resolve or produce sufficient hemosiderin deposits that the CT scan will be positive even years later. Hemorrhage in soft tissue, especially in muscle, usually completely resolves leaving no trace, but rarely can ossify. This is called heterotrophic bone formation or myositis ossificans and is detectable on CT scan.

Recently there have been significant advances in demonstration of acute and chronic lesions using MRI. MRI with Turbo STIR sequences, directed to the whole body can demonstrate general body trauma and identify lesions and areas needing detailed evaluation. Unidentified lesions and those not causing any clinical complaints can also be visualized. Early stage cortical and medullary oedema and trabecular destructions can be much more readily demonstrated than CT. Minimal changes identified as bone bruise in pre-oedema stages can also be identified in osseous tissues. New special sequences which can verify these changes within hours are being developed and administered. Small millimetric cortical
destructions, minimal oedematous changes of soft tissue, especially in series with fat suppression, and muscle contusion or strain injuries can also be identified.

**Biopsy of Electric Shock Injury**

Electric shock injuries may, but do not necessarily, exhibit microscopic changes that are highly diagnostic and specific for electric current trauma. The absence of these specific changes in a biopsy specimen does not mitigate against a diagnosis of electric shock torture, and judicial authorities must not be permitted to make such an assumption. Unfortunately, if a court requests that a petitioner alleging electric shock torture submit to a biopsy for confirmation of the allegations, refusal to consent to the procedure or a “negative” result is bound to have a prejudicial impact upon the court. Furthermore, clinical experience with biopsy diagnosis of torture-related electrical injury is limited, and the diagnosis can usually be made with confidence from the history and physical examination alone.

This procedure is therefore one that should currently be done in a clinical research setting, and not promoted as a diagnostic standard. In giving informed consent for biopsy, the individual must be informed of the uncertainty of the results and permitted to weigh the potential benefit against the impact upon an already traumatised psyche.

*Rationale for biopsy:*

There has been extensive laboratory research measuring the effects of electric shocks on the skin of anaesthetized pigs. This work has shown that there are histologic findings specific for electrical injury that can be established by microscopic examination of punch biopsies of the lesions. However, further discussion of this research, which may have significant clinical application, is beyond the scope of this publication. The reader is referred to the above cited references for further information.

Few cases of electric shock torture of humans have been studied histologically. Only in one case, where lesions were excised probably 7 days after the injury, were alterations in the skin believed to be diagnostic of electrical injuries observed (deposition of calcium salts on dermal fibers in viable tissue located around necrotic tissue). Lesions excised a few days after alleged electrical torture in other cases have shown segmental changes and deposits of calcium salts on cellular structures highly consistent with influence of an electrical current, but not diagnostic since deposits of calcium salts on dermal fibers were not observed. A biopsy taken one month after alleged electrical torture showed a conical scar, 1-2 mm broad, with increased number of fibroblasts and tightly packed, thin collagen fibers, arranged parallel to the surface, consistent with, but not diagnostic of, electrical injury.

*Method:*

After receiving informed consent from the patient, and before biopsy, the lesion must be photographed according to accepted forensic methods. Under local anesthesia, a 3-4 mm punch biopsy is obtained, and placed in buffered formalin or similar fixative. Skin biopsy should be performed as soon as possible after injury. Since electrical trauma is usually confined to the epidermis and superficial dermis, the lesions may quickly disappear. Biopsies can be taken from more than one lesion, but the potential distress to the patient must be considered.

Biopsy material should be examined by a pathologist experienced in dermatopathology.
Diagnostic findings for electrical injury:

1. Vesicular nuclei in epidermis, sweat glands and vessel walls (only one differential diagnosis: injuries via basic solutions)
2. Deposits of calcium salts distinctly located on collagen and elastic fibers (the differential diagnosis, calcinosis cutis, is a rare disorder only found in 75 of 220,000 consecutive human skin biopsies, and the calcium deposits are usually massive without distinct location on collagen and elastic fibers.

*Calcified collagen fibres are seen in an area deep in the dermis. Danielsen et al., 1991, Am J Forensic Med and Path 12: 222-226. [Reprinted with permission from Lippincott, Williams and Wilkins.]*

Typical, but not diagnostic, findings for electrical injury:

1. Lesions appearing in conical segments, often 1-2 mm large
2. Deposits of iron or copper on epidermis (from the electrode)
3. Homogenous cytoplasm in epidermis, sweat glands and vessel walls
4. Deposits of calcium salts on cellular structures in segmental lesions
5. No abnormal histologic observations
# MODULE 6

Psychological Evidence of Torture and Ill-treatment

## OBJECTIVES

- To appreciate the central role of psychological evaluation in medical evaluations of torture and ill-treatment
- To understand how to conduct a psychological evaluation, document psychological findings, and formulate clinical impressions and conclusions regarding torture and ill-treatment
- To review transference, counter-transference, re-traumatisation issues
- Using the Psychological Evaluations #1 and #2, students will be asked to develop interpretations of the psychological findings and conclusions and recommendations using Istanbul Protocol standards
- To understand the value and limitations of diagnostic classifications (ICD-10 and DSM) in the evaluation of psychological evidence of torture and ill-treatment
- To understand the value and limitations of psychometric instruments (questionnaires, scales, etc) during the psychological evaluation
- To be familiar with psychological evaluations of torture and ill-treatment in children

## CONTENT

- The central role of the psychological evaluation
- Conducting the psychological evaluation
- Psychological findings and diagnostic considerations
- Components of the psychological/psychiatric evaluation
  - Identifying Data
  - History of Torture and Ill-treatment
  - Current Psychological Complaints
  - Post-torture History
  - Pre-torture History
  - Medical History
  - Past Psychiatric History
  - Neuro-psychological Assessment
  - Mental Status Examination
  - Assessment of Social Function
  - Psychological Testing and the Use of Checklists and Questionnaires
  - Clinical Impression
  - Recommendations
  - Treatment Considerations
- Children and Torture
  - Developmental Considerations
  - Clinical Considerations
  - Role of the Family
- International statistical classification of diseases and related health problems, Annex

## DISCUSSION TOPICS

- Students should work in groups or individually on one or both of the Psychological Evaluations (#1 and #2, see Appendix I at the end of this Module). Each group should
write up their interpretation of findings and conclusions and recommendations.

Additional Discussion Topics:
- Discuss the reasons why some survivors of torture have difficulties recalling and recounting their experiences
- Discuss possible reasons for inconsistencies in the evaluation and strategies to explain inconsistencies in medico-legal reports
- Discuss how to assess the possibility of simulation of psychological symptoms
- Discuss who can/should conduct the psychological evaluations in your country (consider: qualifications, authority, official vs. non-official, etc)
- Discuss current, country-specific challenges in conducting psychological evaluations of torture and ill-treatment and their validity, or lack thereof, in medico-legal contexts

TEACHING FORMATS

- **Group Activity:**
  - Students should work in groups or individually on one or both of the Psychological Evaluations (#1 and #2, see Appendix I at the end of this Module). Each group should write up their interpretation of findings and conclusions and recommendations based on Istanbul Protocol standards.
  - A facilitator should be identified to moderate the discussion and rapporteur should be identified to record the group’s findings and report them when the class reconvenes.
  - After 20-30 minutes of group discussion, the entire class should reconvene
  - Rapporteurs should briefly report on their group’s findings
  - Open class discussion

Alternative Option:
- Divide the class into several groups and assign each group with one or more (or all) of the Discussion Topics
- Follow the usual sequence for conducting group activities as outlined above

- **Individual Research/Assignment:**
  - Individual students should assigned to read one or both of the Psychological Evaluations and write up their interpretation of findings and conclusions and recommendations based on Istanbul Protocol
  - **Journal Entry:** (Instructor to assign; Write a few paragraphs -- no more than a page)
  - Respond to one or more of the Discussion Topics

- In your opinion, what are the most significant challenges in conducting a psychological evaluation of torture and ill treatment? Explain.

PRIMARY RESOURCES

- *The Istanbul Protocol, Chapter VI*
- *Psychological Evaluation of Torture Allegations: An International Training Manual*
- *The Medical Documentation of Torture*
- *Medical Investigation and Documentation of Torture: A Handbook for Health Professionals*
- *Trainers’ Guidelines for Health Professionals: Training of Users*

1. The Central Role of the Psychological Evaluation

Psychological evaluations can provide critical evidence of abuse among torture victims. It has a central role in the medical investigation and documentation of torture allegations. All
medical investigations and documentation of torture should include a detailed psychological evaluation because:

- One of the main aims of torture is to destroy the psychological, social integrity and functioning of the victim.

  *Perpetrators often attempt to justify their acts of torture and ill-treatment by the need to gather information. Such conceptualisations obscure the purpose of torture and its intended consequences. One of the central aims of torture is to reduce an individual to a position of extreme helplessness and distress that can lead to a deterioration of cognitive, emotional and behavioural functions. Torture is a means of attacking the individual’s fundamental modes of psychological and social functioning. The torturer strives not only to incapacitate a victim physically, but also to disintegrate the individual’s personality: The torturer attempts to destroy a victim’s sense of being grounded in a family and society as a human being with dreams, hopes and aspirations for the future.* (IP, §235)

Internationally accepted definitions of torture acknowledge that provoking mental suffering is often the intention of the torturer.

- All kinds of torture inevitably comprise psychological processes.
- Torture often causes psychological/psychiatric symptoms at various levels.
- Torture methods are often designed not to leave physical lesions, and physical methods of torture may result in physical findings that either disappear quickly or lack specificity.

The improvement in the methods of detecting and providing evidence of physical torture has paradoxically led to more sophisticated methods of torture that do not leave visible evidence on the victim’s body. Most physical symptoms and signs of torture, if there are any, rapidly disappear.

It is important to realise that torturers may attempt to conceal their acts. To avoid physical evidence of torture, precautions are taken with the intention of producing maximal pain and suffering with minimal evidence. Especially under conditions of raised awareness in society, torture applied with these precautions and sophisticated methods may leave almost no physical signs.

Torturers know that by not leaving permanent physical scars, they help their cause and make the work of their counterparts in the human rights arena more difficult. For this reason, in the Istanbul Protocol it is underscored that, “the absence of such physical evidence should not be construed to suggest that torture did not occur.”

- Psychological symptoms are often more prevalent and long-lasting than physical symptoms.

Contrary to the physical effects of torture, the psychological consequences of torture are often more persistent and troublesome than physical disability. Several aspects of psychological functioning may continue to be impaired long-term. If not treated, victims may still suffer from the psychological consequences of torture even months or years following the event, sometimes for life, with varying degrees of severity.
1.1 Conducting the Psychological Evaluation

Psychological evaluations may take place in a variety of settings and contexts; as a result, there are important differences in the manner in which evaluations should be conducted and how symptoms will be interpreted. For example, whether or not certain sensitive questions can be asked safely will depend on the degree to which confidentiality and security can be assured. An evaluation by a clinician visiting a prison or detention centre may be very brief and not allow for as detailed an evaluation as one performed in a clinic or private office that may take place over several sessions and last for several hours. At times some symptoms and behaviours typically viewed as pathological may be viewed as adaptive or predictable, depending on the context. For example, diminished interest in activities, feelings of detachment and estrangement would be understandable findings in a person in solitary confinement. Likewise, hypervigilance and avoidance behaviours may be necessary for those living under threat in repressive societies.

The clinician should attempt to understand mental suffering in the context of the survivor’s circumstances, beliefs, and cultural norms rather than rush to diagnose and classify. Awareness of culture specific syndromes and native language-bound idioms of distress is of paramount importance for conducting the interview and formulating the clinical impression and conclusion. When the interviewer has little or no knowledge about the alleged victim’s language and culture, the assistance of an interpreter is essential. An interpreter from the alleged victim’s country of origin will facilitate an understanding of the language, customs, religious traditions, and other beliefs that will need to be considered during the evaluation.

Clinicians should be aware of the potential emotional reactions that evaluations may elicit in survivors (see Transference and Counter-transference in Module 3). Fear, shame, rage and guilt are typical reactions. A clinical interview may induce mistrust on the part of the torture survivor and possibly remind him or her of previous interrogations thereby “re-traumatizing” him or her. To reduce the effects of re-traumatisation, the clinician should communicate a sense of empathy and understanding. A torture survivor may suspect the clinician of having voyeuristic and sadistic motivations or may have prejudices towards the clinician because he/she hasn't been tortured. The clinician is a person in a position of authority and, for that reason, may not be trusted with certain aspects of the trauma history. Alternatively, individuals still in custody may be too trusting in situations where the clinician cannot guarantee that there will be no reprisals for speaking about torture. Torture victims may fear that information that is revealed in the context of an evaluation cannot be safely kept from being accessed by persecuting governments. Fear and mistrust may be particularly strong in cases where physicians or other health workers were participants in the torture. In the context of evaluations conducted for legal purposes, the necessary attention to details and the precise questioning about history is easily perceived as a sign of doubt on the part of the examiner. Under these pressures, survivors may feel overwhelmed with memories and affect or mobilize strong defences such as withdrawal, affective flattening or numbing during evaluations.

As mentioned in Module 3, if the gender of the clinician and the torturer is the same, the interview situation may be perceived as resembling the torture more than if the genders were different. For example, a woman who was raped and tortured in prison by a male guard is likely to experience more distress, mistrust, and fear when facing a male clinician than she might experience with a female. On the other hand, it may be much more important to the survivor that the interviewer is a physician regardless of gender so as to
ask specific medical questions about possible pregnancy, ability to conceive later, and future of sexual relations between spouses.

When listening to individuals speak of their torture, clinicians should expect to have personal reactions and emotional responses themselves (see Transference and Counter-transference in Module 3). Understanding these personal reactions is crucial because they can have an impact on one’s ability to evaluate and address the physical and psychological consequences of torture. Reactions may include avoidance and defensive indifference in reaction to being exposed to disturbing material, disillusionment, helplessness, hopelessness that may lead to symptoms of depression or “vicarious traumatisation,” grandiosity or feeling that one is the last hope for the survivor’s recovery and well-being, feelings of insecurity in one’s professional skills in the face of extreme suffering, guilt over not sharing the torture survivor's experience, or even anger when the clinician experiences doubt about the truth of the alleged torture history and the individual stands to benefit from an evaluation.

1.2 Psychological Findings and Diagnostic Considerations

It is prudent for clinicians to become familiar with the most commonly diagnosed disorders among trauma and torture survivors and to understand that it is not uncommon for more than one mental disorder to be present as there is considerable co-morbidity among trauma-related mental disorders. The two most common classification systems are the International Statistical Classification of Diseases and Health Related Problems (ICD-10)\(^92\) Classification of Mental and Behavioural Disorders and the Diagnostic and Statistical Manual of the American Psychiatric Association-Edition IV (DSM-IV).\(^93\) Non-mental health clinicians such as internists and general practitioners who perform evaluations of torture survivors should be familiar with the common psychological responses to torture and be able to describe their clinical findings. They should be prepared to offer a psychiatric diagnosis if the case is not complicated. A psychiatrist or psychologist skilled in the differential diagnosis of mental disorders related to severe trauma will be needed for particularly emotional individuals, cases involving multiple symptoms or atypical symptom complexes, psychosis, or in cases presenting confusing clinical pictures.

It is important to note that the association between torture and both PTSD and depression has become very strong in the minds of health providers, immigration courts and the informed lay public. This has created the mistaken and simplistic impression that PTSD and depression are the main psychological consequences of torture. Torture-related mental disorders are not limited to depression and PTSD and evaluators must have comprehensive knowledge of the most frequent diagnostic classifications among trauma and torture survivors. In this sense, a detailed evaluation is always very important. Overemphasising PTSD and depression criteria might result in missing other possible diagnoses and reinforcing the simplistic notion that the psychological evidence of torture can be reduced to the presence or absence of PTSD and depression. A wide range of diagnostic considerations are provided below and ICD-10 diagnostic criteria are included in the Appendix II at the end of this Module.

The diagnosis most commonly associated with torture is Post-traumatic stress disorder (PTSD). Typical symptoms of PTSD include re-experiencing the trauma, avoidance and


emotional numbing, and hyperarousal. Re-experiencing can take several forms: intrusive memories, flashbacks (the subjective sense that the traumatic event is happening all over again), recurrent nightmares, and distress at exposure to cues that symbolize or resemble the trauma. Avoidance and emotional numbing include avoidance of thoughts, conversations, activities, places or people that arouse recollection of the trauma, feelings of detachment and estrangement from others, inability to recall an important aspect of the trauma, and a foreshortened sense of the future. Symptoms of hyperarousal include difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, and exaggerated startle response.

Depressive states are very common among survivors of torture. Depressive disorders may occur as a single episode or be recurrent. They can present with or without psychotic features. Symptoms of Major Depression include depressed mood, anhedonia (markedly diminished interest or pleasure in activities), appetite disturbance, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue and loss of energy, feelings of worthlessness and excessive guilt, difficulty concentrating, and thoughts of death, suicidal ideation, or suicide attempts.

A survivor of severe trauma such as torture may experience dissociation or depersonalisation. Dissociation is a disruption in the integration of consciousness, self-perception, memory and actions. A person may be cut off or unaware of certain actions or may feel split in two and feel as if observing him or herself from a distance. Depersonalisation is feeling detached from oneself or one's body.

Somatic symptoms such as pain and headache and other physical complaints, with or without objective findings, are common problems among torture victims. Pain may shift in location and vary in intensity. Somatic symptoms can be directly due to physical consequences of torture, be of psychological origin, or both. Also, various types of sexual dysfunction are not uncommon among survivors of torture particularly, but not exclusively, among those who have suffered sexual torture or rape.

Psychotic symptoms may be present such as delusions, paranoia, hallucinations (auditory, visual, olfactory or tactile), bizarre ideation, illusions or perceptual distortions. Cultural and linguistic differences may be confused with psychotic symptoms. Before labelling someone as psychotic, one must evaluate the symptoms within the individual’s cultural context. Psychotic reactions may be brief or prolonged. It is not uncommon for torture victims to report occasionally hearing screams, his or her name being called, or seeing shadows, but not have florid signs or symptoms of psychosis. Individuals with a past history of mental illness such as bipolar disorder, recurrent major depression with psychotic features, schizophrenia and schizoaffective disorder may experience an episode of that disorder.

The ICD-10 includes the diagnosis "Enduring Personality Change." PTSD may precede this type of personality change. To make the ICD-10 diagnosis of enduring personality change, the following criteria must have been present for at least two years and must not have existed prior to the traumatic event or events. These criteria are: hostile or distrustful attitude towards the world, social withdrawal, feelings of emptiness or hopelessness, chronic feelings of "being on edge" as if constantly threatened, and estrangement.

Alcohol and drug abuse may develop secondarily in torture survivors as a way of blocking out traumatic memories, regulating affect and managing anxiety. Other possible diagnoses include: generalized anxiety disorder, panic disorder, acute stress disorder, somatoform disorders, bipolar disorder, delusional disorder, disorders due to a general medical condition, (possibly in the form of brain impairment with resultant fluctuations or deficits in
level of consciousness, orientation, attention, concentration, memory and executive functioning), and phobias such as social phobia and agoraphobia.

1.3 Components of the Psychological/Psychiatric Evaluation

The psychological evaluation starts at the beginning of the interview, with the very first contact. The individual’s overall appearance and manner of dress, posture, the manner of recalling and recounting the trauma, signs of anxiety or emotional distress, numbness or over-excitement, moments of emotional intensity, startled responses, posture and bodily expression while relating the events of torture, avoidance of eye contact, and emotional fluctuations in his/her voice can give important clues about the personal history and psychological functioning of an individual. Not only the verbal content of the examinee (what he/she says), but also his/her manner of speaking (how he/she says it) are important for the psychological evaluation. The individual may have difficulties in recollecting and recounting what s/he experienced or in talking about his/her complaints. Therefore, non-verbal communication may provide important information about his/her symptoms, as well as some clues for establishing and maintaining an effective relationship that allows the interviewer to elicit relevant information.

The psychological evaluation should provide a detailed description of the individual’s history, a mental status examination, an assessment of social functioning, and a formulation of clinical impressions/opinions. The impact of the symptoms on daily life can be highly relevant for forensic procedures or questions of compensation in torture cases. If appropriate, a psychiatric diagnosis should be given.

The components of psychological/psychiatric evaluation are as follows:

Identifying Data

- Individual’s name, age, ethnicity, country of origin, marital status, number of children
- Referral source
- Summary of collateral sources (such as medical, legal, psychiatric records)
- Methods of assessment utilized (interviews, symptom inventories and checklists, neuropsychological testing, etc.)

History of Torture and Ill-treatment

Every effort should be made to document the full history of torture, persecution and other relevant traumatic experiences (see Module 3). This part of the evaluation is often exhausting for the person being evaluated. Therefore, it may be necessary to proceed in several sessions (if it is possible). The interview should start with a general summary of events before eliciting the details of the torture experiences and include.

- **Summary of detention and abuse**: Before obtaining a detailed account of events, elicit summary information, including dates, places, duration of detention, frequency and duration of torture sessions
- **Circumstances of apprehension**: What time, from where, by whom (with details, if possible); other persons around, witnesses/bystanders; interaction with family members; violence/threats used during the apprehension; use of restraints or blindfold
- **Place and conditions of detention**: What happened first, where, any identification process, transportation, distinctive features; other procedures; condition of the
cell/room; size/dimensions, ventilation, lighting, temperature, toilet facilities, food; contact with third persons (family members, lawyer, health professionals); conditions of overcrowding or solitary confinement, etc.

- **Methods of torture and ill-treatment:**
  - Assessment of background: Where, when, how long, by whom; special features of the environment, perpetrators, devices/instruments; usual “routine”, sequences and other information
  - For each form of abuse: body position, restraint, nature of contact, duration, frequency, anatomical location, the area of the body affected and how and other information
  - Sexual assaults
  - Deprivations (sleep, food, toilet facilities, sensory stimulation, human contact, motor activities); threats, humiliations, violations of taboos, behavioural coercions and other methods
  - Previous medico-legal reporting process (if any)

As mentioned in Module 3, a method-listing approach may be counter-productive, as the entire clinical picture produced by torture is much more than the simple sum of lesions produced by methods on a list.

**Current Psychological Complaints**

Assessment of current psychological functioning constitutes the core of the evaluation:

- All affective, cognitive, and behavioural symptoms that appeared since the torture should be described. For each symptom: first emergence, duration, intensity, frequency, content, fluctuation of each symptom should be asked and recorded with examples and all details.
- Adaptive and maladaptive strategies and triggers such as anniversary reactions, specific stimuli or places, situations and topics causing avoidance should be noted.
- Specific questions about the most common symptoms and diagnostic criteria for most common diagnosis need to be asked.

**Post-torture History**

The clinician should inquire about current life circumstances including:

- Sources of additional stress, traumas, losses, difficulties (i.e. other traumatic experiences or ongoing persecution to the individual or his/her family, refugee displacement, etc.)
- Formal and/or informal social support resources.
- Marital and family situation.
- Employment status, livelihood.
- Vocational, social status and conditions.
- Life conditions and quality of life of the interviewee and his/her family.

**Pre-torture History**

This component of the psychological evaluation obtains information about current life circumstances and stresses. The summary of pre-trauma history is important to assess mental health status and level of psychosocial functioning of the alleged torture victim prior to the traumatic events. In this way, the interviewer can compare the current mental health status with that of the individual before he or she was tortured. In evaluating background information the interviewer should keep in mind that the duration and severity of responses
to trauma is affected by the severity and duration of the trauma events, the meaning assigned to the individual’s experiences, genetic and biological predisposition, developmental phase, age, prior trauma, pre-existing personality, and social support system. A Pre-torture History should include:

- Developmental history
- Family history: family background, family illnesses, family composition
- Educational history
- Occupational history
- Social history: activities, including political activities, interests, group interactions
- History of past trauma: childhood abuse, war trauma, domestic violence, etc
- Cultural and religious background

**Medical History**

The medical history summarises pre-trauma and current health conditions and should include:

- Pre-trauma health conditions.
- Current health conditions.
- Body pain, somatic complaints.
- Physical injuries and findings: physical findings that might be related to trauma should be noted. It is important that the health professional that is making the psychological evaluation should also look for and document the physical findings of trauma. In some instances, the clinician who conducts the psychological evaluation may be the first or the only health professional with whom the alleged victim comes in contact with.
- Use of medications, including possible side effects and obstacles in using medications.
- Relevant sexual history.
- Past surgical procedures and other medical data.

**Past Psychiatric History**

One should inquire whether the individual has a past history of mental or psychological disturbances, the nature of the problems, and whether they received treatment or required psychiatric hospitalisation. Inquire which, if any, psychotropic medications were used in treatment.

**Substance Use and Abuse History**

The clinician should inquire about substance use before and after the torture, changes in the pattern of use and abuse, and whether substances are being used to cope with insomnia or psychological/psychiatric problems.

**Neuro-psychological Assessment**

Torture can involve physical trauma that leads to various levels of brain impairment. Blows to the head, suffocation and prolonged malnutrition may have long-term neurological and neuro-psychological consequences that may not be readily assessed during the course of a medical examination. Frequently, the symptoms for such assessments have significant overlap with the symptomatology arising from PTSD and major depressive disorders. Fluctuations or deficits in level of consciousness, orientation, attention, concentration, memory and executive functioning may result from functional disturbances as well as organic causes.
Clinical neuropsychology is an applied science concerned with the behavioural expression of brain dysfunction. Neuropsychological assessment, in particular, is concerned with the measurement and classification of behavioural disturbances associated with organic brain impairment. The discipline has long been recognised as useful in discriminating between neurological and psychological conditions and in guiding treatment and rehabilitation of patients suffering from the consequences of various levels of brain damage. Neuropsychological evaluations of torture survivors are performed infrequently and to date neuropsychological studies of torture survivors is limited in the literature. 94

Despite significant limitations, neuropsychological assessment may be useful in evaluating individuals suspected of having brain injury and in distinguishing brain injury from PTSD. Neuropsychological assessment may also be used to evaluate specific symptoms, such as problems with memory that occur in PTSD and related disorders.

**Mental Status Examination**

The mental status exam begins the moment the clinician meets the subject. The interviewer should make note of the person’s appearance (such as signs of malnutrition, lack of cleanliness, etc.), changes in motor activity during the interview, use of language, presence of eye contact, and the ability to relate to the interviewer. The following list summarises the components of the exam: general appearance, motor activity, speech, mood and affect, thought content, thought process, suicidal and homicidal ideation, cognitive status (alertness, orientation, concentration and calculation, long term memory, intermediate recall, and immediate recall), and insight.

The individual’s responses to specific mental status items are affected by their culture of origin, educational level, literacy, language proficiency, and level of acculturation. The mental status examination of torture survivors requires flexibility on the part of the examiner, who must have a good understanding of the individual’s cultural, linguistic, and educational background before attempting any formal assessment. The level of education is an important factor in determining the appropriate questions and tasks.

**Assessment of Social Function**

Trauma and torture can affect a person’s ability to function. The psychological consequences of the experience may impair the individual’s ability to care for him/herself, earn a living, support a family, or pursue education. The clinician should assess the individual’s current level of functioning by inquiring about daily activities, social role function (as housewife, student, worker, etc), social and recreational activities, and perceptions of health status. For obvious reasons, one cannot accurately assess the social functioning of an individual held in detention.

**Psychological Testing and the Use of Checklists and Questionnaires**

If an individual has trouble expressing in words his or her experiences and symptoms, it may be useful to use a trauma event questionnaire or symptom checklist. These tools may facilitate disclosure of severely traumatic memories and reduce the anxiety often experienced in an unstructured interview. There are numerous questionnaires available;

However, none is specific to torture victims. Caution must be exercised in the interpretation of responses and scores because established norms do not exist for most refugee populations. Similarly, there is little published information about the use of standard psychological and neuropsychological tests among torture survivors. Due to the fact that there is such wide cultural and linguistic diversity among survivors, one should exercise extreme caution when requesting or employing psychological and psychometric tests of any kind, most of which have not been cross-culturally validated.

In some countries and/or situations, courts and/or other authorities tend to give more weight to the results of psychometric tests and consider them more “objective” than the clinical impressions that clinicians obtain as a result of several interviews. However, for the psychological evaluation of trauma, the clinical interview, evaluation and the subsequent clinical formulation the clinician reaches are fundamental, whereas psychological tests have only complementary value. It is the clinician himself/herself who decides whether there is any need to use psychological testing in the evaluation process. Furthermore, the clinician must make his/her own decision without any interference in his/her clinical independence.

**Clinical Impression**

An essential aspect of the psychiatric evaluation is the formulation of a concise statement of the interviewer’s analysis of the case. Interpretation of the findings and formulation of a clinical impression are the last stages where the entire interview is discussed and evaluated; therefore care must be taken while formulating a clinical decision.

Interpretation of the clinical findings is a complex task. The following questions from the Istanbul Protocol will help guide the formulation of the clinical impression and diagnostic conclusions.

1. Are the psychological findings consistent with the alleged report of torture?
2. Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?
3. Given the fluctuating course of trauma-related mental disorders over time, what is the timeframe in relation to the torture events? Where in the course of recovery is the individual?
4. What are the coexisting stresses impinging on the individual? (e.g. ongoing persecution, forced migration, exile, loss of family and social role, etc) What impact do these issues have on the victim?
5. What physical conditions contribute to the clinical picture? Pay special attention to head injury sustained during torture and/or detention.
6. Does the clinical picture suggest a false allegation of torture?

When writing reports, clinicians should comment on the emotional state of the person during the interview, symptoms, history of detention and torture, and personal history prior to torture. Factors such as the onset of specific symptoms in relation to the trauma, the specificity of any particular psychological findings, as well as patterns of psychological functioning should be noted. If the survivor has symptom levels consistent with one or more DSM IV or ICD 10 psychiatric diagnosis, the diagnosis should be stated. If not, the consistency between the psychological findings and the history of the individual should be evaluated as a whole and stated in the report. Additional factors such as forced migration, resettlement, difficulties of acculturation, language problems, loss of home, family, social status, as well as unemployment should be discussed. The relationship and consistency between events and symptoms should be evaluated and described. Physical conditions such as head trauma or brain injury may require further evaluation. Behavioural, cognitive and
emotional aspects of the individual observed during verbal and non-verbal communication should be noted as well.

It is common in medico-legal contexts for the clinician to be asked whether psychological symptoms were caused by that alleged torture and ill-treatment or other traumatic experiences that may have occurred before or after the alleged events. Clinician should note temporal relationships between the onset of symptoms and the alleged torture and ill-treatment. They should also consider content-specific symptoms that may relate to the alleged torture and ill-treatment such as: the content of nightmares, triggers for intrusive recollection, reliving experiences, avoidance reactions, etc.

It is important for clinicians to make clear to any court or judicial authority that not everyone who has been tortured develops a diagnosable mental illness. It must be stressed that even though a diagnosis of trauma-related mental disorder supports the claim of torture, not meeting criteria for a psychiatric diagnosis does not mean the person was not tortured. The absence of conclusive physical and/or psychological signs and symptoms does not invalidate an allegation of torture. The clinician should also take into consideration the possibility that an absence of psychological symptoms can be due to the episodic or often delayed nature of PTSD or to denial of symptoms because of shame or other difficulties.

It is possible that some people may falsely allege torture or exaggerate a relatively minor experience or symptoms for personal or political reasons. The clinician should keep in mind, however, that such fabrication requires a detailed knowledge about trauma related symptoms that individuals rarely possess. Also, inconsistencies can occur for a number of valid reasons such as memory impairment due to brain injury, confusion, dissociation, cultural differences in perception of time, or fragmentation and repression of traumatic memories (see Module 3). Additional sessions should be scheduled to help clarify inconsistencies and when possible, family or friends may be able to corroborate detail. Inconsistencies that are attributable to the psychological effects of an individual’s torture experiences may, in fact, support his or her allegations of abuse.

**Recommendations**

The recommendations following the psychological evaluation depend on the questions posed at the time the evaluation was requested. The issues under consideration may concern legal and judicial matters, asylum, resettlement, and a need for treatment. Recommendations can be for further assessments, such as neuro-psychological testing, medical or psychiatric treatment or a need for security or asylum. The clinician should not hesitate to insist on any consultation and examination that s/he considers necessary.

In the course of documenting psychological evaluation of torture allegations the clinicians are not absolved of their ethical obligations. Evaluation for documentation of torture for medico-legal reasons should be combined with an assessment for other needs of the individual. Those who appear to be in need of further medical or psychological care should be referred to the appropriate services. Clinicians should be aware of the local rehabilitation and support services.

**Treatment Considerations**

A full discussion of treatment is beyond the scope of this Module. To briefly summarise, intervention necessarily begins with establishing safety, protection, and basic human necessities for survival (food, shelter, income, etc.). Without these basic elements, no meaningful “treatment” can be effective. Any meaningful clinical treatment and
rehabilitation program should include social services and if possible, legal services. Treatment can begin once basic necessities are secured, or perhaps even while they are being secured. Because torture affects an individual on so many levels, an integrated, coordinated multidisciplinary approach to treatment is essential. Mental health treatment modalities include individual, group, and family psychotherapy, psychopharmacology, psychoeducation, and somatic therapies. Traditional medicine practices should be respected and included in the treatment if the individual wishes, provided they are safe and that one avoids deleterious interactions between medications and herbal preparations.

NOTE: An online course, “Caring for Torture Survivors,” offered by the Boston Center for Refugee Health and Human Rights, is available at: http://www.bcrhhr.org/pro/course/course_index.html#

2. Children and Torture

2.1 Introduction

Torture can affect a child directly or indirectly. The impact can be due to the child having been tortured or detained, the torture of his/her parents or close family member or the witnessing of torture and violence. When individuals in a child’s environment are tortured, the torture will inevitably have an impact on the child, albeit indirectly, because torture affects the entire family and community of torture victims. A thorough discussion of the psychological impact of torture on children and complete guidelines for conducting an evaluation of a child who has been tortured is beyond the scope of this Manual. Nevertheless, several important points can be summarised.

First, when evaluating a child who is suspected of having undergone or witnessed torture, the clinician must make sure that the child receives support from caring individuals and that he/she feels secure during the evaluation. This may require a parent or trusted care provider to be present during the evaluation. Second, the clinician must keep in mind that children often do not express their thoughts and emotions regarding trauma verbally, but rather behaviourally. The degree to which a child is able to verbalize thought and affect depends on his/her age and developmental level as well as on other factors, such as family dynamics, personality characteristics and cultural norms.

If a child has been physically or sexually assaulted, it is important, if at all possible, for the child to be seen by an expert in child abuse. Genital examination of children, likely to be experienced as traumatic, should be performed by clinicians experienced in interpreting the findings. Sometimes it is appropriate to videotape the examination so that other experts can give opinions on the physical findings without the child having to be examined again. It may not be appropriate to perform a full genital or anal examination without a general anaesthetic. Furthermore, the examiner should be aware that the examination itself may be reminiscent of the assault, and it is possible that the child may make a spontaneous outcry or psychologically decompensate during the examination.

2.2 Developmental Considerations

A child’s reactions to torture depend on age, developmental stage and cognitive skills. The younger the child, the more his/her experience and understanding of the traumatic event is influenced by the immediate reactions and attitudes of caregivers following the event. For children under the age of three who have experienced or witnessed torture, the protective and reassuring role of their caregivers is crucial. Very young children’s reactions to
traumatic experiences typically involve hyperarousal, such as restlessness, sleep disturbance, irritability, heightened startle reactions and avoidance. Children over three often tend to withdraw and refuse to speak directly about traumatic experiences. The ability for verbal expression increases during development. A marked increase occurs around the concrete operational stage (8-9 years old), when children develop the ability to provide a reliable chronology of events. During this stage, concrete operations and temporal and spatial capacities develop. These new skills are still fragile and it is usually not until the beginning of the formal operational stage (12 years old) that children are consistently able to construct a coherent narrative. Adolescence is a turbulent developmental period. The effects of torture can vary widely. Torture experiences may cause profound personality changes in adolescents, resulting in antisocial behaviour. Alternatively, the effects of torture on adolescents may be similar to those seen in younger children.

2.3 Clinical Considerations

Symptoms of PTSD may appear in children. The symptoms can be similar to those observed in adults but the clinician must rely more heavily on observations of the child’s behaviour than on verbal expression. For example, the child may demonstrate symptoms of re-experiencing as manifested by monotonous, repetitive play representing aspects of the traumatic event, visual memories of the events in and out of play, repeated questions or declarations about the traumatic event and nightmares. The child may develop bedwetting, loss of control of bowel movements, social withdrawal, restricted affect, attitude changes toward self and others and feelings that there is no future. S/he may experience hyperarousal and have night terrors, problems going to bed, sleep disturbance, heightened startle response, irritability and significant disturbances in attention and concentration. Fears and aggressive behaviour that were non-existent before the traumatic event may appear, such as aggressiveness toward peers, adults or animals, fear of the dark, fear of going to the toilet alone and phobias. The child may demonstrate sexual behaviour that is inappropriate for his/her age and may experience somatic reactions. Anxiety symptoms may appear, such as exaggerated fear of strangers, separation anxiety, panic, agitation, temper tantrums and uncontrolled crying. The child also may develop eating problems.

2.4 Role of the Family

The family plays an important dynamic role in persisting symptomatology among children. In order to preserve cohesion in the family, dysfunctional behaviours and delegation of roles may occur. Family members, often children, can be assigned the role of patient and develop severe disorders. A child may be overly protected or important facts about the trauma may be hidden. Alternatively, the child can be “parentified” and expected to care for the parents.

When the child is not the direct victim of torture but only affected indirectly, adults often tend to underestimate the impact on the child’s psyche and development. When loved ones around a child have been persecuted, raped and tortured or the child has witnessed severe trauma or torture, s/he may develop dysfunctional beliefs, such as that he/she is responsible for the bad events or that s/he has to bear the parent’s burdens. These types of beliefs can lead to long-term problems with loyalty conflicts, guilt, personal development and maturing into an independent adult.
Appendix I

Psychological Evaluation #1
(based on an asylum evaluation conducted by Dr. Kathleen Allden, M.D. in November 2000, Boston, MA, USA)

I. Case Information

Name: Mr. __
Birth Date: x/xx/68
Birth Place: __
Gender: male
Clinician’s Name: Kathleen Allden, MD
Dates of Evaluation: August 23, 2000 (2 hours), September 6, 2000 (1 hour), September 13, 2000 (2 hours)
Interpreter: Not needed as client speaks English
Exam Requested by: Attorney Jane Doe
Subject Accompanied by: Attorney Jane Doe (first appointment only)

II. Clinician’s Qualifications [deleted]

Attached is my curriculum vitae

I have personally examined this individual and have examined the facts recited in this written report. I believe all statements to be true. I would be prepared to testify to these statements based on my personal knowledge and belief.

III. Psychological / Psychiatric Evaluation

Background Information

Mr. __ is a 35 year old married man from [country A]. He came to the United States seeking asylum in February 2000. His wife and three children, ages 14, 10 and 5 years, are in a refugee camp in [country B], along with his mother and sister.

Summary of Collateral Sources
Draft Application for Asylum and Withholding of Removal supplied by his attorneys

Methods of Assessment Utilized
Clinical interviews

History of Torture and Ill-treatment

Mr. __ reports that he came to the United States in February 2000. He is seeking asylum because he feels it is not safe for him to return to [country A]. He says that in 1990 he was at his parents’ home when __ rebel forces attacked the house. He believes that his family was targeted because of his father’s job in the government, and because they are of the __ ethnic group. He was at home with his father, mother and sister when the house was
attacked. Mr. __ and his family were taken to a rebel camp. He reports that the rebels forced him to hold his sister down while they gang raped her. Also, he was forced to watch as rebels tortured his father and cut off his limbs one at a time. He reports he was forced at gunpoint to hold his father down while they did this. He believes the rebels killed his father because at the time he was an officer in the government.

After a period of time, his mother and sister were able to leave the camp but Mr. __ says he was taken to another camp where he was burned and cut on the right arm and put in a pit. While in pit, the rebels urinated on him, threw dirty water on him and beat him. He remained in the pit for a long period of time. Conditions were filthy in the pit and his right arm became very infected. Mr. __ recalls becoming ill and coughing up brown sputum. While he was still in the pit, [country A] soldiers overtook the camp and freed him. He said that they could tell that he was not one of the __ rebel forces soldiers because it was obvious that he had been severely mistreated by them. For this reason, his life was spared at that time. He reports then being taken to the border where he escaped to [country B] and was able to reunite with his mother and sister.

During the years 1990-96, Mr. __ reports that there were many factions fighting in [country A]. He did not go back to [country A] until 1996 when there was a cease-fire. He went to check on the family’s property but found that the family’s house had been burned. He remained in [country A] where he participated in the presidential campaign of __, and was physically beaten by opposing political forces that were on the same side that had originally attacked his home and killed his father. The soldiers took him to a prison. Mr. __ and his family are members of the __ tribe. He reports that he and other __ tribe prisoners were taken away to the forest to be killed. The soldiers shot at the group of prisoners as the prisoners ran away. An unknown number were killed but Mr. __ escaped.

He went to live in barracks in an area where other __ tribe people were staying because they felt they might be safe there. In 1998, when __ rebel forces attacked this area, many people were killed. Soldiers attempted to arrest Mr. __. He believed they would take him away and kill him. He managed to escape and ran to __ peacekeeping base where other __ tribe people as well as other civilians had fled. __ peacekeeping base personnel helped Mr. __ and others flee the country by arranging for flights from an airbase. Mr. __ was flown to [country B] where he joined his mother and sister in a refugee camp.

In describing these events, Mr. __ reports that he witnessed many horrible atrocities. He said he saw soldiers ask people if they wanted a "long sleeve" or a "short sleeve" and then would chop off the arm accordingly. He also saw soldiers kill infants by bashing their heads until the brains came out. He reports seeing a group of children thrown in a well to die. While describing these experiences he said he felt ashamed to be telling me about these events. He said he felt ashamed of what had happened in his country and in other nearby countries such as [country C]. He said of the war and violence that he has experienced and witnessed, "It’s part of me now.” He describes feeling permanently changed, altered by these terrible things.

Current Psychological Complaints

Mr. __ reports that when he first arrived in the United States he was afraid to go out of the house. He lives with friends who reassured him that the United States is not like [country A] and that people are safe when they go out of their houses. He felt he might be attacked if he went out. With his friends’ encouragement, he gradually tried going out of the house and
now is able to travel without significant difficulty. He has learned how to use public transportation and feels comfortable enough to use the bus.

He describes other symptoms and fears that were particularly bothersome when he first arrived in the United States but that have gradually diminished. For example, he would sleep in his clothes. He did this because in the past he felt he always had to be ready to run, ready to escape. When he came here he continued this habit until, gradually with friends’ encouragement, he was able to undress for sleep. He reports previously having difficulty falling asleep and staying asleep. He says that now he is able to sleep several hours per night but that he has nightmares of terrible past experiences during the war. His sleep disturbance and the frequency of his nightmares have improved slowly over the months since his arrival in the United States. He describes experiencing intrusive memories of the past and finds that he constantly worries about what would happen if he were sent back to [country A]. He describes being very sensitive to loud sounds and easily startled. During July 4 celebrations this summer, neighbor children were lighting firecrackers. This caused him to be very fearful and anxious as it reminded him of being in the war. His nightmares also worsened during that time period.

Mr. ___ reports avoiding being reminded of the war and violence that he has experienced. For example, he avoids speaking about it. He also avoids television programmes that have violent scenes, or reports and news clips about war in [country C]. He says he avoids becoming angry or annoyed. He says he knows what people can do when they lose control and act on their anger. He says he tries to keep himself numb. He offers the example that if someone slapped him on the face, he would not feel it because he would be numb. He describes trying to push bad memories out of his mind and trying to distance himself from the past. He avoids going out on the street or in public and tries to stay indoors away from people he does not know. He says it is hard for him to see injustice or someone being mistreated. Because he becomes very angry when he witnesses injustices, he keeps himself isolated in order not to be exposed to situations that would anger him. He also feels that the cultural differences between the United States and his home are many and it is hard for him to cope with the differences. He says he only wants to be around people who encourage him and reassure him that things will turn out all right in the long run.

He worries about his family living as refugees in [country B]. His main goals are to bring his wife and children here and to work to send money to his mother and sister. (He has been told he will not be able to bring his mother and sister to the United States.) He says that having these goals helps him survive. He says that now that his father is dead it is his responsibility to look after the needs of his mother and the rest of the family. If it were not for these responsibilities, Mr. ___ says he would prefer to be dead. He says he has seen too much suffering and cruelty. The past seems like a dream, the happy times in the past seem unreal. Although he contemplates suicide, he says all is not lost because if he is granted asylum, he may be able to bring his wife children to the United States so they can have a better future. He does not have confidence that there will be peace in his country for a long time.

Mr. ___ says that his religious beliefs help him cope with his life. He reads the Bible every day. He speaks of his devotion to Jesus Christ and his faith in God.

Post-Torture History

Mr. ___ was a refugee in [country B] before coming to the United States. He said that life in [country B] is very harsh. Food is scare, infectious diseases are common, and it is very hard
to make a living. Also, people in the region do not trust people from [country A], according to Mr. __, fearing they are members of rebel groups. His family encouraged him to leave __ and go to the United States. He traveled to the United States via [country A] with the assistance of a close friend of the family. His mother, sister, wife and children are living in [country B] in a refugee camp. Currently, Mr. __ lives with friends in Massachusetts. He feels welcomed and supported by them. He has been staying with these friends since his arrival in the United States. His hosts are friends of his late father. Mr. __ does not work because he is not legally permitted to work. He feels he is able to work and he would like to work in order to earn money for his family.

Pre-Torture History

Family history: Mr. __ is one of two siblings; he has one sister. He grew up in the home of his mother and father, who were Baptists. His father was a government official in the former government. According to Mr. __, his father was able to earn a good living and the family was well provided for. Mr. __ met his wife when they were both in school; they were married around 1985. After they were married they lived with Mr. __’s parents. They have three children ages 14, 10, and 5. He describes a happy childhood and family life until the time that war broke out in his country in 1990.

Educational history: Mr. __ reports he has a high school education and completed a junior college programme in computer science.

Occupational history: Mr. __ is trained in computer science. He has not practiced that profession. While a refugee in [country A], he supported his family as a vendor.

Cultural and religious background: Mr. __ was raised as a Baptist and continues to practice his religion in the United States. He is from the __ tribe.

Medical History

Prior to the war, Mr. __’s had several episodes of malaria. Otherwise his health was good. During the time he was kept in the pit he developed a severe respiratory illness which he describes as bronchitis with a productive cough and vomiting that required long-term treatment with antibiotics after he was finally released. He says he still has right-sided chest pain and that when he takes a deep breath, he hears wheezes in his chest. He still coughs up phlegm. His chest pain is worse during rainy weather. Also, he complains of right arm pain where his arm was cut by his torturers. He has not had a physical exam since coming to the United States.

Past Psychiatric History

There is no past history of mental illness.

Substance Use and Abuse History

Prior to coming to the United States, Mr. __ reports that he had great difficulty falling asleep. He would drink alcohol to help fall asleep. He does not do this now. He denies using illicit drugs.

Mental Status Examination
1) General appearance – Mr. ___ is a neatly dressed man who was very polite and cooperative during the interviews. He was clearly distressed by having to retell his history of trauma. He was tearful and moderately agitated especially during our first meeting.

2) Motor activity – No obvious psychomotor retardation. He was somewhat agitated and frustrated at times but able to tolerate the long interviews.

3) Speech – His English is fluent but his accent is very heavy and I had difficulty understanding him at times. His speech was logical and goal directed. He was able to express his emotions and ideas very well.

4) Mood and affect – Frequently during the interviews, he was clearly overwhelmed with feelings of loss and sadness. He also expressed horror at witnessing extreme cruelty and violence. He appeared frustrated at not being able to communicate to me how extremely awful the atrocities that he witnessed were. His affect was labile. He was often tearful. He was able to smile on occasion.

5) Thought content – His thoughts centered on two main themes, his worries for his family and the horrors he has witnessed and experienced. These worries and memories seem to occupy his thought much of the time.

6) Thought process – There is no evidence of paranoia, delusions, referential ideation or other disturbance of thought. There is no evidence of hallucinations.

7) Suicidal and homicidal ideation – There is no evidence of homicidal ideation but he has thoughts of suicide. He says that he would prefer to be dead and that the only reason that he stays alive is that his family is his responsibility and he hopes to be able to help them have a better life.

8) Cognitive exam – He is oriented and alert. He gives the proper date and place. He does not seem to have difficulty with long term recall but admits that giving precise dates of events is very hard for him. His immediate recall is impaired as evidenced by is ability to recall only 4 of 6 digits when asked to do so. His intermediate recall is similarly impaired as evidenced by his ability to recall only 2 of 3 objects that he is asked to recall after a 3-minute time lapse. His overall global cognitive function may also be impaired as evidenced by is inability to spell a five-letter word backwards.

Clinical Impression (Interpretation of Findings)
Conclusion and Recommendations
Psychological Evaluation #2
(based on an asylum evaluation conducted by Dr. Uwe Jacobs, Ph.D. on May 8 2001, San Francisco, CA, USA)

Conditions of Interview

Prior to this psychological evaluation, Mr. Doe and his client agreed to the condition that I approach the assessment with no particular result in mind and that I would exercise independent professional judgment on all aspects of this evaluation. Further, the payment of fees would not be connected to the contents of any report or consultation or any particular finding or recommendation on the matter in question.

Prior to commencing the interview, I informed Mr. ___ that confidentiality is limited in a forensic psychological examination. I further informed him that I would discuss my findings with his attorney and write a report that his attorney could submit as evidence to the court if deemed helpful. He indicated that he understood my role to be that of an objective evaluator and that a forensic evaluation was not psychological treatment. I further informed Mr. ___ that I had reviewed the asylum declaration prepared by his attorney and that I would be reviewing the entire history with him once more.

I interviewed Mr. ___ on 4/27/01 for a total of about 5 hours face-to-face at the offices of Survivors International, San Francisco. In addition, I administered the Hopkins Checklist-25 (HCL-25), the Trauma Symptom Inventory (TSI), and the Harvard Trauma Questionnaire (HTQ). Present for the evaluation were Mr. ___, myself, Ms. Erika Falk (Survivors International Intake Coordinator and Psy.D. candidate), and Mr. ___, who functioned as interpreter and provided limited collateral information where indicated. Prior to the interview, I reviewed the following history and background information which was provided by Mr. ___ during the face-to-face interview.

Relevant History

Mr. ___ was born and raised in ___, a little village near ___ in Region ___ of ___. His date of birth on all records has been 5/6/71. However, he states that this date of birth was registered falsely and that he is approximately three years younger. He cannot state his exact and true date of birth and has always used the one given to him. His father registered his sons as older so that they would be done with the compulsory military service sooner and “begin life earlier”. He adds that this was common practice in his geographical area. Mr. ___ is the youngest of six children and spent the later part of his childhood alone with his parents after his siblings had all moved away to ___. He completed five years of compulsory formal education and was working on his father’s farm from a young age. He briefly stayed with a relative to start a secondary education about 100 km away from his village, but soon returned home to work on the farm.

Mr. ___ describes his early family life as harmonious and states that his father was generally more lenient and loving than most fathers. His mother was a homemaker and took care of the household and family. He states that he does not have a very clear memory of his childhood overall, except that he was always working and that his only pastime was riding horses. When he was about 15, the family moved to ___, near ___. His father had a job as a night watchman and he worked as an apprentice in welding. The interpreter adds here that child labor is illegal in ___ but rather commonly practiced.
When asked about the reason for the family’s move, __ states that most of the other 300 families of the village had already left because of the increased clashes between the army and the guerilla army __. He also states that he does not remember seeing any of this activity himself, and that the older people in the village discussed it. Mr. __ does not describe a strong identification with his ethnic __ background and states that he gradually lost a lot of the __ language he spoke as a young child. In addition, he says that he did not grow up with a sense of tension between the ethnic __s and other groups in his village and that some families spoke __ language, others spoke the language of the majority, and yet others spoke dialects he could not understand.

Mr. __ was drafted into the army approximately three years following the family’s move to __. He was sent for basic training to __, which lasted 3 months. Subsequently, he was sent to become a member of a commando unit that fought the guerilla army __ in the __ region. He states that this was the worst experience he had ever had. He was involved in an estimated 10-15 battles, at times being forced to shoot at targets he could not even see. He had to spend long periods of time in the mountains, in both summer and winter, and suffered from constant sleep deprivation and poor nutrition. He saw comrades wounded and killed. One friend who was from a village near his own was mortally wounded in one of the clashes. He helped dispose of his body when the fighting had ceased. When asked about having suffered any differential treatment because of his ethnic __ identity, he states that he often heard rumors about ill-treatment but did not experience it directly, except for the constant derogatory remarks that were made about the “illiterate” ethnic __s. He says that he felt hurt inside by this, but that in the army one has to do what one is told. When asked about his feelings regarding fighting people of his own ethnic group, he became very gloomy and refused to discuss this further. When asked why, he simply stated that there are things in life that are better not discussed.

Due to his active combat duty, Mr. __ was released after 15 months of service instead of the usual 18 months. After returning to __, he stayed at home for the first two months and felt like he literally could not move. He had difficulty breathing, experienced chest pains, thought he was dying, and never went out for fear of falling down and passing out and being publicly embarrassed. He went to see a physician, who gave him a prescription and advised him to go out and try to do things he finds enjoyable. He states that the pills did not make him feel any better, but rather made him feel even emptier inside, so he discontinued taking them. However, he did follow the doctor’s advice, started going out, began to feel better, and eventually met the woman who later became his wife.

Mr. __ explained that he was discovered as a musical talent by his teacher in elementary school and has always been a singer. He met his wife while singing at a wedding in 1994-1995. He began his singing career mostly by singing at weddings but increasingly got more work, gave some concerts, and made a couple of recordings as well. He states that he was doing well financially because he kept his welding job and made as much money from singing as he made at welding. During this time, he increased his repertoire of ethnic __ folksongs, which he learned from colleagues who were more familiar with the language and culture than he was.

On May 21, 1995, Mr. __ had been invited by a production company to perform in a concert for the traditional ethnic __ coming of spring celebration. This was an important event for him, as he expected more and better work as a result of this appearance. He was performing together with a female ethnic __ musician by the name of Ms. __. While performing ethnic __ songs they were interrupted by two policemen who jumped onto the stage, separated them, and pushed them into the background, saying things like “Don’t you know you’re not supposed to sing in ethnic __ language?” and “Why are you provoking this
audience?” The crowd booed the officers. Mr. __ and Ms. __ were arrested and taken to the police station separately and kept separated upon arrival at the police station. Mr. __ was detained for about 12 hours. His possessions were taken from him and returned upon release. During this explanation, Mr. __ looked around the interview room and stated that his holding cell had been similar in size but the windows were smaller, the walls were white, and there was no clock that he could see.

Mr. __ was forced to sit in the same chair for 12 hours and was not allowed to use the restroom when he requested to use it. The officer let him use the restroom about 1-2 hours after he had asked. Mr. __ asked to make a phone call and was denied. He was denied water and cigarettes. He was constantly talked at for the entire time he was there, being told over and over that he was not supposed to sing in ethnic __ language. He was interrogated about who had organized the event. When asked about his feelings, he stated that he was feeling very irritated in recounting this event, that his visual recollection was vague but felt very real at the same time. When asked, Mr. __ stated that he still has a newspaper clipping in his possession from this event, the headline of which reads something like “Local Artist Arrested”.

Regarding his later arrests, Mr. __ states that he does not remember precise dates but only the seasons and years. It was difficult to ascertain these dates during the rest of the interview, as Mr. __ was not telling the story chronologically as he described events and there were a few misunderstandings. There might therefore be some discrepancies between the dates identified in this report and those specified other documentation.

In 1996 there was at least one incident of police harassment in connection with Mr. __’s involvement with a musician’s association that helped artists get engagements and allowed them to learn from each other. The organisation’s founder is named __. Policemen visited Mr. __ at home on one occasion while he was playing with his child. The doorbell rang and he asked his wife to open the door. Two policemen charged in, insulted him in front of his wife, a fact about which he is particularly bitter, and threatened to beat him up. He was interrogated about the purpose of the musicians’ organisation and a large record collection and scores of regional folk music were confiscated.

Another incident occurred in 1997 while Mr. __ was singing for a group of striking workers at the factory where he had once worked. The strike and the performance had been organized by a labor union. He was accompanied by drums and reed instruments. When he and his friend Mr. __, with whom he had worked at the factory for some time, left the factory, the police stopped them within a block, checked their ID’s, and took them to the police station. They were separated from each other and Mr. __ was interrogated. The police accused them of being members of the __ party, which is an underground organisation and apparently stands for __ __ __, an organisation Mr. __ had never heard of. The police told him they knew who they were and threatened that if he did not tell them about his friend Mr. __, they would electrocute his genitals and he would be impotent for the rest of his life. They also threatened that he might not ever see his wife and children again.

At this point in the interview, the interpreter adds that Mr. __ had instructed him not to translate the part about the electrocution of his genitals. I asked him to inform Mr. __ that he had done so, which resulted in an angry face and disgusted gesture on Mr. __’s part. I then reminded him that this was also detailed in his declaration and the interpreter stated that when he had helped prepare the declaration Mr. __ had also requested that it not be translated. However, the interpreter was advised by the attorney that these details were important.
Mr. __ went on to say he was not, in fact, electrocuted but that the officer repeatedly twisted his arm and frequently hit him on his chin with the palm of his hand, which may not seem very bad now but was very uncomfortable at the time (he gestured to demonstrate the way he was hit). He was so uncomfortable that he considered making up a story about his friend Mr. __ in order to get away but did not. He was also pushed around and detained for close to 24 hours. After his release, he never saw his friend Mr. __ again. Mr. __ says that he feels ashamed of this now, but he never inquired about his friend because he was scared by the threat of electrocution and feared for the future of his child and his wife, who was pregnant with their second child at the time.

In 1998 a similar incident occurred in which two officers reportedly came to his apartment and took him to the police station. On this occasion, Mr. __ was interrogated about an artist named __ and other members of the musician’s association. The officers harassed him by saying things like, "Don’t you know that the __ flag is only __ and __ colors?” Officers twisted his arm, pushed him around and told him to shut up. Mr. __ describes this as “sort of harmless”, i.e., it did not result in injury, but says that he felt very afraid at the time. Mr. __’s colleagues later told him that they were detained and interrogated about him in similar fashion.

The latest event that prompted Mr. __’s decision to leave the country is one that was not listed in the declaration that was made available to me and seemed to arise almost by accident. Mr. __ did not seem to want to discuss this event, even though it is a crucial piece of his persecution history. He added that he still sees this event vividly and that he felt very uncomfortable discussing it. One night after walking home from one of his wedding engagements, he was suddenly attacked, had a sack put over his head and upper body, and was beaten up and repeatedly kicked. He was carrying money but nothing was stolen from him. After he was left in the street, he found that his nose was bleeding. He sustained no lasting injuries but had aches and pains that lasted for days. He did not want to face his wife in this condition so he went to a public restroom in a religious compound and cleaned himself. He decided to return home much later, around 3-4 a.m., and he did not tell his wife the details of this event. He did tell his brother-in-law, however, who advised him to “leave now”, and suggested fleeing to either Germany or the United States. Mr. __ added that even Romania seemed an alternative, but the brother-in-law opined that the United States was good and that the people there appreciated music. Earlier, Mr. __ had stated that he never wanted to come to the United States in the first place but that his brother (by whom he meant his brother-in-law) had made him come.

Mr. __ states that he had no idea what political asylum meant when he arrived and that he learned of this only through his conversations with his translator, a man whom he had met at a local restaurant and to whom he had opened up about his experiences over time.

Medical History

Mr. __ denied any significant medical history apart from the psychiatric history following his combat experiences as described above and the presence of headaches in conjunction with his current psychological state. He uses over the counter medication for these headaches in low-moderate dosage and frequency. He described himself as generally healthy and denied any history of surgeries and accidents.

Psychological Assessment
The following conclusions are drawn from the individual interview of Mr. __ and psychological testing (HCL-25, TSI, HTQ).

**Behavioural Observations/Mental Status Exam:**

Mr. __ appeared on time for the interview and was appropriately dressed and groomed, looking his stated age. He was alert, fully oriented, pleasant and cooperative throughout the evaluation. There were no gross abnormalities in movement or posture on observation. Sensory functions and motor functions appeared to be intact. He appeared to possess high average intellectual ability, with good insight and judgment, although he was not well educated by Western standards. He became distressed when discussing particular events and admitted to feeling irritable while discussing sensitive details. Speech appeared clear and fluent, and there was no evidence of delusions, hallucinations or psychotic thought processes. Remote memory was intact. Attention appeared intact. Concentration and working memory could not be formally assessed but Mr. __ reported that they were impaired. Mood was depressed and affect was constricted. There was no evidence of suicidal or homicidal ideation.

**Psychological Findings:**

Mr. __ obtained a psychological profile on the TSI and HTQ that is highly suggestive of Posttraumatic Stress Disorder. Validity indicators suggest that he answered test items in a straightforward and internally consistent manner. There was no sign of dissimulation and results were valid for interpretation. Mr. __ reports the following psychiatric symptomatology:

1) Persistent Reexperiencing of Traumatic Events and Avoidance Behaviour: Mr. __ evinced intermittent distress while recounting traumatic events as well as profound discomfort while discussing relevant details, particularly in relation to experiences he considered embarrassing according to his cultural norms. His discomfort was also a reaction to the fact that he was experiencing an active, intrusive recall of events, especially in relation to the last assault he suffered before leaving the country. He reported nightmares from which he awakens in a sweat. The content of his dreams includes trauma-related material to varying degrees, but usually not precise repetitions of actual events.

2) Persistent Symptoms of Increased Arousal: Mr. __ suffers from poor sleep throughout the night and wakes up frequently. He states that this continues to be quite a problem, even though it has improved since he first arrived in the United States. He also startles easily, jumping in response to any kind of sudden noise. He feels that his concentration is impaired. He describes wandering through the city and not being able to find a major street, even though he has been there many times. He cannot concentrate on reading, even on familiar subjects in his national language. He has wanted to learn English but has had great trouble studying. Rather than studying from books, he has now begun to use tapes.

3) Dissociative Symptoms: Mr. __’s most frequently cited complaint is that his mind “goes blank” for minutes at a time. He finds it rather distressing to have this symptom; he feels that at times his mind is so empty that he feels he is going crazy. He then also has faint auditory illusions, for example the repeated experience of hearing a whistle when no one is whistling. He states that he hates that experience.
4) Somatic Complaints and Anxiety Symptoms: Mr. ___ has a history of panic and anxiety symptoms dating back to his discharge from the military. The symptomatology described in terms of chest pains, shortness of breath, thoughts of death and dying and not leaving home for fear of fainting and embarrassing himself in public, constituted a diagnosis of Panic Disorder with Agoraphobia. This condition remitted without major treatment and on the advice of his physician to overcome his avoidance behaviour. Subsequent to the later events of persecution, these elements of panic disorder have reoccurred. Mr. ___ frequently feels a lump in his throat, experiences shortness of breath and tingling and numbing sensations from his chest down through his extremities. He also suffers from frequent tension headaches that respond well to over-the-counter medicine.

Clinical Impression (Interpretation of Findings)

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Conclusion and Recommendations

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APPENDIX II

International Statistical Classification of Diseases and Related Health Problems
10th Revision
(ICD-10)
Version for 2007
http://www.who.int/classifications/apps/icd/icd10online

Mood [affective] disorders (F30-F39)

F32 DEPRESSIVE EPISODE

In typical mild, moderate, or severe depressive episodes, the patient suffers from lowering of mood, reduction of energy, and decrease in activity. Capacity for enjoyment, interest, and concentration is reduced, and marked tiredness after even minimum effort is common. Sleep is usually disturbed and appetite diminished. Self-esteem and self-confidence are almost always reduced and, even in the mild form, some ideas of guilt or worthlessness are often present. The lowered mood varies little from day to day, is unresponsive to circumstances and may be accompanied by so-called "somatic" symptoms, such as loss of interest and pleasurable feelings, waking in the morning several hours before the usual time, depression worst in the morning, marked psychomotor retardation, agitation, loss of appetite, weight loss, and loss of libido. Depending upon the number and severity of the symptoms, a depressive episode may be specified as mild, moderate or severe.

Includes: single episodes of:
   · depressive reaction
   · psychogenic depression
   · reactive depression

Excludes: adjustment disorder (F43.2)
   recurrent depressive disorder (F33.-)
   when associated with conduct disorders in F91.- (F92.0)

F32.0 Mild depressive episode
   Two or three of the above symptoms are usually present. The patient is usually distressed by these but will probably be able to continue with most activities.

F32.1 Moderate depressive episode
   Four or more of the above symptoms are usually present and the patient is likely to have great difficulty in continuing with ordinary activities.

F32.2 Severe depressive episode without psychotic symptoms
   An episode of depression in which several of the above symptoms are marked and distressing, typically with loss of self-esteem and ideas of worthlessness or guilt. Suicidal thoughts and acts are common and a number of "somatic" symptoms are usually present.
   Agitated depression }
   Major depression single episode without psychotic symptoms
   Vital depression }

F32.3 Severe depressive episode with psychotic symptoms
An episode of depression as described in F32.2, but with the presence of hallucinations, delusions, psychomotor retardation, or stupor so severe that ordinary social activities are impossible; there may be danger to life from suicide, dehydration, or starvation. The hallucinations and delusions may or may not be mood-congruent.

Single episodes of:
- major depression with psychotic symptoms
- psychogenic depressive psychosis
- psychotic depression
- reactive depressive psychosis

F32.8 Other depressive episodes
F32.9 Depressive episode, unspecified

Under “Mood [affective] disorders (F30-F39)” see also:
F30 Manic episode
F31 Bipolar affective disorder
F33 Recurrent depressive disorder
F34 Persistent mood [affective] disorders
F38 Other mood [affective] disorders

Neurotic, stress-related and somatoform disorders (F40-F48)

F43 REACTION TO SEVERE STRESS AND ADJUSTMENT DISORDERS

This category differs from others in that it includes disorders identifiable on the basis of not only symptoms and course but also the existence of one or other of two causative influences: an exceptionally stressful life event producing an acute stress reaction, or a significant life change leading to continued unpleasant circumstances that result in an adjustment disorder. Although less severe psychosocial stress ("life events") may precipitate the onset or contribute to the presentation of a very wide range of disorders classified elsewhere in this chapter, its etiological importance is not always clear and in each case will be found to depend on individual, often idiosyncratic, vulnerability, i.e. the life events are neither necessary nor sufficient to explain the occurrence and form of the disorder. In contrast, the disorders brought together here are thought to arise always as a direct consequence of acute severe stress or continued trauma. The stressful events or the continuing unpleasant circumstances are the primary and overriding causal factor and the disorder would not have occurred without their impact. The disorders in this section can thus be regarded as maladaptive responses to severe or continued stress, in that they interfere with successful coping mechanisms and therefore lead to problems of social functioning.

F43.0 ACUTE STRESS REACTION

A transient disorder that develops in an individual without any other apparent mental disorder in response to exceptional physical and mental stress and that usually subsides within hours or days. Individual vulnerability and coping capacity play a role in the occurrence and severity of acute stress reactions. The symptoms show a typically mixed and changing picture and include an initial state of "daze" with some constriction of the field of consciousness and narrowing of attention, inability to comprehend stimuli, and disorientation. This state may be followed either by further withdrawal from the surrounding situation (to the extent of a dissociative stupor - F44.2), or by agitation and over-activity.
(flight reaction or fugue). Autonomic signs of panic anxiety (tachycardia, sweating, flushing) are commonly present. The symptoms usually appear within minutes of the impact of the stressful stimulus or event, and disappear within two to three days (often within hours). Partial or complete amnesia (F44.0) for the episode may be present. If the symptoms persist, a change in diagnosis should be considered.

Acute: · crisis reaction
   · reaction to stress

Combat fatigue
Crisis state
Psychic shock

F43.1 POST-TRAUMATIC STRESS DISORDER
Arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. Predisposing factors, such as personality traits (e.g. compulsive, asthenic) or previous history of neurotic illness, may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence. Typical features include episodes of repeated reliving of the trauma in intrusive memories ("flashbacks"), dreams or nightmares, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. The onset follows the trauma with a latency period that may range from a few weeks to months. The course is fluctuating but recovery can be expected in the majority of cases. In a small proportion of cases the condition may follow a chronic course over many years, with eventual transition to an enduring personality change (F62.0)

- Traumatic neurosis

F43.2 ADJUSTMENT DISORDERS
States of subjective distress and emotional disturbance, usually interfering with social functioning and performance, arising in the period of adaptation to a significant life change or a stressful life event. The stressor may have affected the integrity of an individual's social network (bereavement, separation experiences) or the wider system of social supports and values (migration, refugee status), or represented a major developmental transition or crisis (going to school, becoming a parent, failure to attain a cherished personal goal, retirement). Individual predisposition or vulnerability plays an important role in the risk of occurrence and the shaping of the manifestations of adjustment disorders, but it is nevertheless assumed that the condition would not have arisen without the stressor. The manifestations vary and include depressed mood, anxiety or worry (or mixture of these), a feeling of inability to cope, plan ahead, or continue in the present situation, as well as some degree of disability in the performance of daily routine. Conduct disorders may be an associated feature, particularly in adolescents. The predominant feature may be a brief or prolonged depressive reaction, or a disturbance of other emotions and conduct.

Culture shock
Grief reaction
Hospitalism in children

F43.8 Other reactions to severe stress
F43.9 Reaction to severe stress, unspecified

F44 DISSOCIATIVE [CONVERSION] DISORDERS

The common themes that are shared by dissociative or conversion disorders are a partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements. All types of dissociative disorders tend to remit after a few weeks or months, particularly if their onset is associated with a traumatic life event. More chronic disorders, particularly paralyses and anaesthesias, may develop if the onset is associated with insoluble problems or interpersonal difficulties. These disorders have previously been classified as various types of "conversion hysteria". They are presumed to be psychogenic in origin, being associated closely in time with traumatic events, insoluble and intolerable problems, or disturbed relationships. The symptoms often represent the patient's concept of how a physical illness would be manifest. Medical examination and investigation do not reveal the presence of any known physical or neurological disorder. In addition, there is evidence that the loss of function is an expression of emotional conflicts or needs. The symptoms may develop in close relationship to psychological stress, and often appear suddenly. Only disorders of physical functions normally under voluntary control and loss of sensations are included here. Disorders involving pain and other complex physical sensations mediated by the autonomic nervous system are classified under somatization disorder (F45.0). The possibility of the later appearance of serious physical or psychiatric disorders should always be kept in mind.

Includes: conversion: hysteria
reaction
hysteria
hysterical psychosis

F44.0 DISSOCIATIVE AMNESIA

The main feature is loss of memory, usually of important recent events, that is not due to organic mental disorder, and is too great to be explained by ordinary forgetfulness or fatigue. The amnesia is usually centred on traumatic events, such as accidents or unexpected bereavements, and is usually partial and selective. Complete and generalized amnesia is rare, and is usually part of a fugue (F44.1). If this is the case, the disorder should be classified as such. The diagnosis should not be made in the presence of organic brain disorders, intoxication, or excessive fatigue.

Under dissociative [conversion] disorder see also:
F44.1 Dissociative fugue
F44.2 Dissociative stupor
F44.3 Trance and possession disorders
F44.4 Dissociative motor disorders
F44.5 Dissociative convulsions
F44.6 Dissociative anaesthesia and sensory loss
F44.7 Mixed dissociative [conversion] disorders
F44.8 Other dissociative [conversion] disorders

F45 SOMATOFORM DISORDERS
The main feature is repeated presentation of physical symptoms together with persistent requests for medical investigations, in spite of repeated negative findings and reassurances by doctors that the symptoms have no physical basis. If any physical disorders are present, they do not explain the nature and extent of the symptoms or the distress and preoccupation of the patient.

**F45.0 SOMATIZATION DISORDER**
The main features are multiple, recurrent and frequently changing physical symptoms of at least two years' duration. Most patients have a long and complicated history of contact with both primary and specialist medical care services, during which many negative investigations or fruitless exploratory operations may have been carried out. Symptoms may be referred to any part or system of the body. The course of the disorder is chronic and fluctuating, and is often associated with disruption of social, interpersonal, and family behaviour. Short-lived (less than two years) and less striking symptom patterns should be classified under undifferentiated somatoform disorder (F45.1).

Briquet's disorder
Multiple psychosomatic disorder

Excludes: malingering [conscious simulation] (Z76.5)

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**F45.4 PERSISTENT SOMATOFORM PAIN DISORDER**
The predominant complaint is of persistent, severe, and distressing pain, which cannot be explained fully by a physiological process or a physical disorder, and which occurs in association with emotional conflict or psychosocial problems that are sufficient to allow the conclusion that they are the main causative influences. The result is usually a marked increase in support and attention, either personal or medical. Pain presumed to be of psychogenic origin occurring during the course of depressive disorders or schizophrenia should not be included here.

Psychalgia
Psychogenic:
  · backache
  · headache

Somatoform pain disorder

Excludes: backache NOS (M54.9)

pain:
  · NOS (R52.9)
  · acute (R52.0)
  · chronic (R52.2)
  · intractable (R52.1)
  · tension headache (G44.2)

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**Under F45 Somatoform disorders, See also:**
F45.1 Undifferentiated somatoform disorder
F45.2 Hypochondriacal disorder
F45.3 Somatoform autonomic dysfunction
F45.8 Other somatoform disorders

Under “Neurotic, stress-related and somatoform disorders (F40-F48)” see also:
-F40 Phobic anxiety disorders
-F41 Other anxiety disorders
  F41.0 Panic disorder (episodic paroxysmal anxiety)
F41.1 Generalized anxiety disorder
F41.2 Mixed anxiety and depressive disorder
F41.3 Other mixed anxiety disorders
F41.8 Other specified anxiety disorders
F41.9 Anxiety disorder, unspecified
-F42 Obsessive-compulsive disorder

Disorders of adult personality and behaviour (F60-F69)

**F62 ENDURING PERSONALITY CHANGES, NOT ATTRIBUTABLE TO BRAIN DAMAGE AND DISEASE**

Disorders of adult personality and behaviour that have developed in persons with no previous personality disorder following exposure to catastrophic or excessive prolonged stress, or following a severe psychiatric illness. These diagnoses should be made only when there is evidence of a definite and enduring change in a person's pattern of perceiving, relating to, or thinking about the environment and himself or herself. The personality change should be significant and be associated with inflexible and maladaptive behaviour not present before the pathogenic experience. The change should not be a direct manifestation of another mental disorder or a residual symptom of any antecedent mental disorder.

Excludes: personality and behavioural disorder due to brain disease, damage and dysfunction (F07.-)

**F62.0 ENDURING PERSONALITY CHANGE AFTER CATASTROPHIC EXPERIENCE**

Enduring personality change, present for at least two years, following exposure to catastrophic stress. The stress must be so extreme that it is not necessary to consider personal vulnerability in order to explain its profound effect on the personality. The disorder is characterized by a hostile or distrustful attitude toward the world, social withdrawal, feelings of emptiness or hopelessness, a chronic feeling of "being on edge" as if constantly threatened, and estrangement. Post-traumatic stress disorder (F43.1) may precede this type of personality change.

Personality change after:
· concentration camp experiences
· disasters
· prolonged:
· captivity with an imminent possibility of being killed
· exposure to life-threatening situations such as being a victim of terrorism
· torture

Excludes: post-traumatic stress disorder (F43.1)

Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)
F52 SEXUAL DYSFUNCTION, NOT CAUSED BY ORGANIC DISORDER OR DISEASE

Sexual dysfunction covers the various ways in which an individual is unable to participate in a sexual relationship as he or she would wish. Sexual response is a psychosomatic process and both psychological and somatic processes are usually involved in the causation of sexual dysfunction.

Under “F52-Sexual dysfunction, not caused by organic disorder or disease” see:
F52.0 Lack of loss of sexual desire
F52.1 Sexual aversion and lack of sexual enjoyment
F52.2 Failure of genital response
F52.3 Organic dysfunction
F52.4 Premature ejaculation
F52.5 Nonorganic vaginismus
F52.6 Nonorganic dyspareunia

Under “Behavioural syndromes associated with physiological disturbances and physical factors (F50-59)”, see also:
F50 Eating disorders
F51 Non organic sleep disorders

Organic, including symptomatic, mental disorders (F00-F09)

F07 PERSONALITY AND BEHAVIOURAL DISORDERS DUE TO BRAIN DISEASE, DAMAGE AND DYSFUNCTION

Alteration of personality and behaviour can be a residual or concomitant disorder of brain disease, damage or dysfunction.

F07.2 POSTCONCUSSIONAL SYNDROME
A syndrome that occurs following head trauma (usually sufficiently severe to result in loss of consciousness) and includes a number of disparate symptoms such as headache, dizziness, fatigue, irritability, difficulty in concentration and performing mental tasks, impairment of memory, insomnia, and reduced tolerance to stress, emotional excitement, or alcohol.
Postcontusional syndrome (encephalopathy)
Post-traumatic brain syndrome, nonpsychotic

Schizophrenia, schizotypal and delusional disorders (F20-F29)

F23 ACUTE AND TRANSIENT PSYCHOTIC DISORDERS

A heterogeneous group of disorders characterized by the acute onset of psychotic symptoms such as delusions, hallucinations, and perceptual disturbances, and by the severe disruption of ordinary behaviour. Acute onset is defined as a crescendo development of a clearly abnormal clinical picture in about two weeks or less. For these disorders there is no evidence of organic causation. Perplexity and puzzlement are often present but disorientation for time, place and person is not persistent or severe enough to justify a diagnosis of organically caused delirium (F05.-). Complete recovery usually occurs within a few months, often within a few weeks or even days. If the disorder persists, a change in classification will be necessary. The disorder may or
may not be associated with acute stress, defined as usually stressful events preceding the onset by one to two weeks.

Under “F 23 Acute and Transient Psychotic Disorders”, see

F23.0 Acute polymorphic psychotic disorder without symptoms of schizophrenia
F23.1 Acute polymorphic psychotic disorder with symptoms of schizophrenia
F 23.2 Acute schizophrenia-like psychotic disorder
F 23.3 Other acute predominantly delusional psychotic disorders
F 23.8 Other acute and transient psychotic disorders

F 23.9 Acute and transient psychotic disorder, unspecified

Brief reactive psychosis NOS
Reactive psychosis
MODULE 7

CASE EXAMPLE #01

OBJECTIVES

• To conduct a complete medical evaluation of an alleged torture victim using Istanbul Protocol standards, including assessments of physical and psychological evidence of torture
• To develop essential interview skills including: effective communication, earning trust, balancing empathy and objectivity, applying appropriated questioning techniques, obtaining informed consent, ensuring procedural safeguards, providing an appropriate and comfortable setting, respecting gender considerations, taking steps to avoid re-traumatisation
• To understand the relevant transference and counter-transference issues that may arise in the course of conducting medical evaluations of alleged torture victims
• To identify possible reasons for difficulties recalling and recounting the story and/or inconsistencies in the story of the alleged victim
• To provide a well-reasoned interpretation of findings and conclusions regarding torture and ill-treatment.
• To appreciate the possible difficulties that may arise during an interview with an alleged torture victim
• To identify and address individual interviewing strengths and weaknesses in conducting an interview

CONTENT

• See Introduction and Preliminary Considerations and Materials below
• Review of Case Summary #01 by students
• Interview of individual role-player (alleged torture victim) by students or instructors (NOTE: role-players use Case Narrative #01 to act their parts)
• Instructor supervision/demonstration of interview(s) using Guidelines for Instructors Case #01 (see Guidelines for Instructors file)
• Debriefing between interviewers and role-players
• Class discussion
• Assignment: Ask students (individuals or groups) to write up a medical report of evaluation findings to be used in Module #9

DISCUSSION TOPICS

• Interviewing skills: How did the interviewers feel they performed? What observations/comments can the instructor and/other students share?
• Interview content: Was the interview complete? Was there any relevant components left out?
• Role-players should share their reactions to the interview, followed by the interviewers
• Discuss strategies to effectively address transference and counter-transference issues that arise in the course of interviewing survivors of torture
• Discuss your most significant concerns in conducting a psychological evaluation. Discuss how you can address them

TEACHING FORMATS
1. Introduction

The following modules (Module 7 and 8) each include a case example of alleged torture and ill-treatment. The Modules are designed for students to develop the clinical skills necessary for the effective documentation of medical evidence torture, including both physical and psychological evidence. These cases were used extensively in Istanbul Protocol trainings in Mexico and also, with some modifications, in Sudan. The content of each was specifically designed to represent common evaluation scenarios and to include a wide range of challenges related to the documentation of physical and psychological evidence of torture. The cases are complementary, i.e. one with “strong psychological and weak physical evidence” (Case #01) and the other with “strong physical and minimal psychological evidence” (Case #02) and reflect composite information of actual cases. Each case consists of 1) a brief Case Summary/Referral that the students read before the evaluation, 2) a Case Narrative to guide role-players in acting their part as an alleged torture victim, and 3) a detailed set of Guidelines for Instructors (and/or individual student users if that is the case) which outline learning objectives, relevant case information, and points for discussion for each of the 8 primary components of medical evaluation:

I. Introduction/Conditions of Interview & Identification Information
II. Past Medical and Surgical History & Psychosocial History – Pre-Arrest
III. Trauma History
IV. Review of Torture Methods
V. Physical Symptoms (acute and chronic) and Disabilities
VI. Psychological Assessment and Mental Status Examination
VII. Physical Examination
VIII. Interpretation of Findings & Conclusions

It is highly recommended for the instructors to contact local treatment centers for survivors of torture, and/or other experienced clinicians or providers who may be available to participate in the case examples.
2. Preliminary Considerations

1. There are a number of different formats to consider for the case examples contained in Module 7 and 8, depending on the time and resources available. Ideally, each student should have an opportunity to practice various components of the interview and engage in analysis of the information gathered. Options for teaching formats include but may not be limited to:
   - Student groups can be divided so that there are between 2 and 8 students per group. The instructor(s) should periodically check on each group to assess progress and address any questions or concerns that may arise. Student evaluation groups can work concurrently, with the 8 components of the interview divided up among the students. Each case example will require approximately 2 to 3 hours of time for the interview and feedback process.
   - If there is not adequate time in the course for the students to conduct Case #01 and #02 on separate days, it may be possible to have half of the students conduct Case 1 and the other half conduct Case #01 on the same day.
   - Alternatively, one demonstration evaluation may be conducted for the entire class and students asked to volunteer for various components of the interview. Several students may work together, or sequentially for each of the 8 primary components of medical evaluation so that each student has an opportunity to participate.
   - A single demonstration evaluation by one or more instructors may be another possibility, with student interaction at the end of each of the 8 components of the interviews.
   - Also, one or both Case Narratives may be assigned for students to read in advance (without role-play interviews) and followed by class discussion and/or a demonstration case.
   - Individual online users of the Model Curriculum may review all materials contained in Modules 7 and 8 and complete the related self-assessment quizzes.

2. Regarding Role-players: If interviews are conducted in class, instructors will need to use their best judgment in selecting role-players. Role-players may be individuals outside the class or the students themselves. In either case, the instructors should provide the role-players with adequate information to convey the information contained in Narratives for Case #01 and Case #02 and review a relevant process issues, for example:
   - Discuss the role-play for police coercion. Request permission to use paper handcuffs.
   - Provide role-players with Case Narratives
   - Instructor(s) and role-players will review the cases in detail and discuss content and process issues prior to class
   - Consider the following recommendations for role-players:
     - General affect or emotion conveyed in the interviews
     - Emotional responses to specific experiences related in the interviews
     - Importance of staying in the role of the detainee/alleged victim until the debriefing
     - Imagine having experienced what is alleged in the narratives or by a friend/spouse
     - Make effective use of silence or pauses when you respond to the interviewer
     - Make effective use of body language (eye contact, body position, tone and pattern of speech)
     - Discuss gender issues
     - Discuss how the detainee’s should appear and be dressed
   - Discuss the debriefing process
- At the end of each case interview, role-players should provide feedback on trainee performances and process issues.
- Consider relevant transference and counter-transference issues (see Module 3): Clinicians who conduct medical evaluations of detainees should be familiar with common transference reactions (i.e., potential reactions of the survivors toward the physician) that survivors experience and the potential impact of such reactions on the evaluation process. Counter-transference (i.e., the interviewer's emotional response to the torture survivor) reactions should also be discussed.

3. Instructors should note:
   • Students may feel uncomfortable role-playing as it is likely to cause emotional stress which may or may not be associated with past experiences. Do not require or make students feel obligated to "volunteer" as role-players.
   • Remind the students of the objectives of this module before it starts and that the point of the exercise is to practice and learn rather than conduct a "perfect" interview.
   • Encourage participants to convey their emotions during their feedback.
   • During the feedback:
     - Ensure that the language is non-judgmental, but constructive and respectful.
     - Take the group dynamics into consideration.
     - Take care that the ones in the role of interviewers do not get frustrated and do not feel judged.
     - Underline positive aspects.
     - Remind the participants that the task of interviewing somebody can create tension, is difficult and doesn't exactly reflect the real life interview experiences.
     - Show appreciation for the interviewee and interviewer.

4. Case Summaries/Referrals: A brief Case Summarie/Referral will be distributed to the trainees before each of the training sessions (Modules 7 and 8). The format is intended to approximate the information that may be contained in an official request for a forensic medical evaluation.

5. Case Narratives: The narratives provide considerable detail on the alleged trauma, subsequent symptoms and disabilities and physical and psychological assessments. The narratives will serve as background information and guidelines for the conduct of the interviews and will be used by the trainers and role-players in preparation for the training sessions. The students who conduct the interviews should not have prior access to the Case Narratives.

6. Time-outs: A break in the interview action used to make teaching points. Note: The instructor should indicate whether time-outs can be initiated only by the instructor or by the students as well. To conserve time, it may be advisable for time-outs to be reserved for instructors only. There should be time for discussion at the end of each of the 8 interview components so that all participants can ask questions and engage in relevant discussion.

7. Recommended Agenda: It is important to complete all components of the medical evaluation working sessions in the period allotted. This will help to ensure that each trainee has an opportunity to participate in the interview process and that the entire examination will be completed. The following recommended agenda is based on a 3 hour interview, but may be modified, proportionally, depending on the time available.

   Identify sequence of participation among students (5 min)
   1. Introduction/Conditions of Interview & Identification Information
   2. Past Medical and Surgical History & Psychosocial History – Pre-Arrest
   3. Trauma History
4. Review of Torture Methods
5. Symptoms (acute and chronic) and Disabilities
6. Psychological Assessment and Mental Status Examination
7. Physical Examination
8. Interpretation of Findings & Conclusions

NOTE: For the above 8 components, a total of 120 minutes: 15 min for each component (student = 10 min + discussion = 5 min)

Debriefing with Role-Player (15 min)
Summary Discussion (40 min)

9. Assessment of Student Performance: Instructors may assess each student’s performance for the two case interviews using periodic observation. It is recommended that students be required to take notes on all components of the case interviews in which they participate and to develop a written report that can be evaluated by the instructor. Any assignment for written reports should be due at the time of the final module, Module 9, which addresses Report Writing and Testifying in Court.

10. Terminology: Please keep in mind that the subject being evaluated should not be referred to as a “victim” or “survivor.” Please use the individual’s name or “detainee,” “alleged victim,” “subject,” “individual,” or some other neutral term.

11. Interview Setting: It is important that the students understand their role in providing a private and comfortable interview setting. Arrange the chairs so that the two interview chairs are next to one another and the other chairs in the room are some distance from those of the interviewer and the detainee.

12. Optional Simulation of Police Coercion: The “alleged victim” or “detainee” (role-player) will be brought to the “examination” room (conference or class room) when the instructor indicates that he/she is ready. The instructor should consider arranging for the detainee to enter the room in paper handcuffs (assuming this is acceptable to the role-player) and in the custody of a “police officer.” The reason for this is to simulate conditions that examiners are likely to experience in evaluating alleged victims. The “police officer” should be present for the first five minutes of the examination unless asked to leave by the trainee. This activity will help each group to discuss how to handle the issue of police coercion.

Materials

Case Summary/Referral #01 (distribute to students who conduct the interviews)

(Weak physical evidence, strong psychological evidence and strong historical evidence; medical evaluation 4 months after alleged torture)

Note: This case example is written specifically for a female role-player. All names included in the narrative are fictitious.

Name: Mrs. Asha Ali Yousif
Date Reporting to the Center: dd/mm/yyyy (today’s date)
Date of Birth: dd/mm/yyyy (age 35)
Age: 35 years-old
Marital Status/Children: Married, widow, 13 year-old daughter  
Religion: Muslim  
Ethnic Group: Fur  
Profession: Teacher  
Political/Social Affiliation: None  

Date and Place of Detention/Assault: dd/mm/yyyy (4 months prior to the exam date) in a field 2 Km east of Kalma Camp; dd/mm/yyyy (2 days following the alleged assault) at Nyala Wasat (Central) police station.  
Period of Detention: Less than 2 hours on both occasions  

Trauma History:  
On dd/mm/yyyy (4 months prior to the exam date), at approximately 2:00pm, Mrs. Yousif, her 13 year-old daughter, and two other women were attacked by armed men in military uniforms whilst fetching firewood several miles from Kalma camp. They were all beaten and raped. One of the women, Fatima Ibrahim (22 yrs), was shot and killed while attempting to escape. Several days later, Mrs. Yousif reported the incident to police at Nyala Wasat (Central) Police Station. Police refused to file a case. One of the police officers, Omer Mohamed Suliman, beat and sexually assaulted her. She then went to Nyala Hospital, but was refused a medico-legal evaluation since she did not have Police Form 8 (medico-legal form for treatment of injuries caused by a criminal act), formerly a requirement under Sudanese Law. A friend in Kalma was worried about her and insisted that she get help. The friend also suggested that Mrs. Yousif and her daughter take legal action against their perpetrators.  

Alleged Perpetrators:  
Men in military uniform, also, police officer Omer Mohamed Suliman from Nyala Wasat (Central) Police Station.  

Reasons for visit:  
Mrs. Yousif indicated that she would like to get help for her daughter and herself, but she was not sure about taking legal action against their perpetrators.  

Effects of Torture: Insomnia, nightmares, inability to concentrate, profound sadness, frequent headaches and decreased appetite. She is also very troubled about her daughter’s health and future.  

Case Narrative #01 (distribute to role-players only)  

Note: This case example is written specifically for a female role-player. All names included in the narrative are fictitious.  

Case Summary/Referral Information:  

Name: Mrs. Asha Ali Yousif  
Date Reporting to the Center: dd/mm/yyyy (today’s date)  
Date of Birth: dd/mm/yyyy (age 35)  
Age: 35 years-old  
Marital Status/Children: Married, widow, 13 year-old daughter
Religion: Muslim  
Ethnic Group: Fur  
Profession: Teacher  
Political/Social Affiliation: None  
Date and Place of Detention/Assault: dd/mm/yyyy (4 months prior to the exam date) in a field 2 Km east of Kalma Camp; dd/mm/yyyy (2 days following the alleged assault) at Nyala Wasat (Central) police station.  
Period of Detention: Less than 2 hours on both occasions  

Trauma History:
On dd/mm/yyyy (4 months prior to the exam date), at approximately 2:00pm, Mrs. Yousif, her 13 year-old daughter, and two other women were attacked by armed men in military uniforms whilst fetching firewood several miles from Kalma camp. They were all beaten and raped. One of the women, Fatima Ibrahim (22 yrs), was shot and killed while attempting to escape. Several days later, Mrs. Yousif reported the incident to police at Nyala Wasat (Central) Police Station. Police refused to file a case. One of the police officers, Omer Mohamed Suliman, beat and sexually assaulted her. She then went to Nyala Hospital, but was refused a medico-legal evaluation since she did not have Police Form 8 (medico-legal form for treatment of injuries caused by a criminal act), formerly a requirement under Sudanese Law. A friend in Kalma was worried about her and insisted that she get help. The friend also suggested that Mrs. Yousif and her daughter take legal action against their perpetrators.

Alleged Perpetrators:
Men in military uniform, also, police officer Omer Mohamed Suliman from Nyala Wasat (Central) Police Station.

Reasons for visit:
Mrs. Yousif indicated that she would like to get help for her daughter and herself, but she was not sure about taking legal action against their perpetrators.

Effects of Torture: Insomnia, nightmares, inability to concentrate, profound sadness, frequent headaches and decreased appetite. She is also very troubled about her daughter’s health and future.

1. **Identification Information:**  
My name is Asha Ali Yousif, and I am 35 years-old.

Additional Information:
- Date of Birth: dd/mm/yyyy (age 35)  
- Citizenship: Sudanese  
- Marital Status/Children: Married, widow, 13 year-old daughter  
- Place of Birth: A village east of Nyala  
- Place of Residence: Kalma IDP Camp, 17 Km. east of Nyala, southern Darfur state  
- Highest Level of Education: completed high school  
- Occupation: Former teacher, currently unemployed  
- Religion: Muslim  
- Identification Document Presented: None  
- Ethnic Group: Darfuri, Fur Tribe  
- Physician Examiner’s Name and License #: (To be fill out by the examining physician)  
- Individuals Present in the Examination Room and Reason for Presence: (To be fill
2. Past Medical/Surgical History and Psychosocial History

**Past Medical/Surgical History:**
Before my encounters with soldiers and police, I had no medical problems, no major illnesses or injury, no surgery, broken bones or head injury. I am not on any medications, except aspirin for headaches and pains in my body. I have never used any illegal drugs and I do not drink alcohol. I do not smoke either.

**Psychosocial History:**

I never had any mental problems, nor has anyone in my family. I am the oldest of four children. Although my family was very poor, we were able survive with the money that my parents made working odd jobs. I was able to go to school and become a teacher. My husband was also a teacher, but he and my father were killed about a year ago, when the Sudanese Army and Janjaweed militia burned my village to the ground. After that, my daughter and I went to Kalma camp.

**Prior Medical Evaluation:**
I went to Nyala Hospital after my daughter and I were attacked by soldiers, but the doctors refused to examine me because I did not have official papers from the police. On the same day, I visited a clinic in Kalma, and they gave me some aspirin for my headaches. I was planning to tell them about what happened to me, but I was too afraid after my experience with the police.

3. Trauma History

**NOTE:** Provide information in parentheses only if specifically asked by the interviewer.

About a year ago, the army and militia came to our village and burned it to the ground. They accused us of supporting the SLA and shot some of the men including my husband and father right in front of us. My daughter and I have been living in Kalma for about one year. Since I lost my husband, my home and my job, we don’t have enough to survive. Sometimes we cut grass in nearby fields to sell. We also have go outside the camp to wash our clothes and collect firewood. We know this is dangerous, but we do not have a choice. My daughter and I have been through a lot. When they burned our village to the ground, they threatened to rape the women. This happened to some of the women in our village, but we were lucky that day. Since then, I thought it was safer for my daughter and me to be together. Now I know this is not true.

On dd/mm/yyyy (4 months prior to the exam date), I went to fetch firewood with my daughter and two other women from Kalma. We had done this many times without any problems, but on that day, we were attacked by 10 men in military uniforms. They had guns and threatened to kill us if we tried to run away. They started insulting us, calling us slaves and saying that this land did not belong to us. I pleaded with them not to hurt my daughter, Salwa. One of them said: “Don’t worry she will soon be the mother of an Arab child.” Salwa was very frightened and began to cry. They slapped her and told her to take off her clothes, but she did not. I tried to wrap my arms around her to protect her, but they pulled her
away from me. I was stuck [above my left eye] with the butt of a gun and fell to the ground. They continued to punch and kick me. One of the other women, Fatima Ibrahim, who was also from our village, tried to run away, but they shot her in the back. She was not moving. One of the men walked over to her and shot her in the head. “This is what happens when you do not obey your masters,” he said. One of the men started raping me while several others threatened me with their guns. I could hear my daughter screaming, but could do nothing. After the third one had raped me, he spit on me and kicked me very hard on the right side of my face. Later I noticed it was very swollen [in front of my right ear] and I was unable to move the right side of my face [or close my right eye] for about 2 weeks. They said nothing else and left us there naked. My daughter was badly bruised on her face and there was blood running down her legs. I tried to reassure her, but we both just wept for a long time.

After 2 days, I decided to go to the police station in Nyala to make a complaint. I waited a long time and then was placed in a room with a police officer. His name was, Omer Mohamed Suliman. I told him what happened and he laughed. “I find this hard to believe,” he said. Who were the men that you say did this?” he asked. I told him that I did not know, but that they were in military uniforms. He refused to believe me and said: “You know nothing and have no witnesses. If you were raped, then show your injuries. His tone began to change and insisted I take off my clothes. He slapped my face and called me a liar. He grabbed me and started pulling off my clothes. He touched my breasts and between my legs. I yelled for help. He stopped when another police officer peered in through the door. After that, he began beating me with a hose on my back and arms. He said, “If you tell anyone, your daughter will find you dead.”

From the police station, I went to Nyala Hospital. I told the doctor what happened in the field. I was too afraid to tell him what happened at the police station. He said there was nothing he could do, since I did not have official papers from the police requesting an examination.

A few days later, I visited a clinic in Kalma and they gave me some aspirin for my headaches and a bandage for the cuts I had above my left eye and on the back of my left hand. I was planning to tell them about what happened to me, but I was afraid to after my experience with the police.

Recently, a friend in Kalma insisted that my daughter and I get some help. She can see that we are very troubled. She also suggested we take legal action against those who hurt us.

4. **Review of Torture Methods**
The following history should be revealed only on further questioning, unless asked in the context of the trauma history:

- **Sexual Assault:**
  - Condoms were not used by any of the perpetrators.
  - No anal intercourse
  - No menstrual period for the past three months
  - [History of infibulation prior to marriage and reinfibulation after the birth of her child.]

- **Head trauma:** handgun butt to the left side of her face, just above the left eyebrow, no loss of consciousness. There was blood on my face and a cut above my left eyebrow. The area was very tender and swollen for about one to two weeks.

- **Laceration injury to the dorsum (backside) of the left hand:** I am not sure how or when this happened but I noticed that it had bled. The injury became infected, swollen and
drained pus about a week later. I was treated as an outpatient with antibiotics. The doctors opened it and packed it with gauze. Eventually it healed.

- The review of torture methods is negative for the all other torture methods, physical and psychological.

5. Physical Symptoms (Acute and Chronic) and Disabilities

**Acute Symptoms:**
- Blood in the urine for about 3 days following the incident, then it resolved completely. No vaginal discharge, no menstrual period since the assault.
- Unable to move the right side of my face [or close my right eye] for about 2 weeks.
- Observed bruises where beaten, black and blue marks that resolve after about 2 weeks. [IF ASKED, RESPOND: Some of the bruises on the back and chest were long in shape, like the hose that was used to beat her. Each of the bruises had two parallel lines about 1-2 cm wide and a clear area in the middle of the lines.]

**Chronic Symptoms:**
- Chronic headaches [IF ASKED, RESPOND: in the front of the head, throbbing, lasts a few hours, once to a few times per day, improved with acetaminophen, similar headaches in the past with stress, but only occasionally.]
- Difficulty concentrating and irritable
- Having problems sleeping (see psychological evaluation below)

**Disabilities:**
- None noted

6. Psychological Evaluation and Mental Status

**Mental Status:**
Mrs. Yousif was appropriately dressed and groomed and looked her stated age. She was alert, fully oriented, pleasant and cooperative throughout the evaluation. There were no gross abnormalities in movement or posture on observation. She appeared to possess average intellectual ability, with good insight and judgment. Her speech was clear and fluent. There was no evidence of delusions, hallucinations or psychotic thought processes. Memory was intact. Attention and concentration appeared intact. Her mood and affect conveyed a watchfulness and some apprehension, and were congruent, but she was open enough to be able to describe her experiences willingly. At times, she wept when she was discussing emotionally painful aspects of her experience. There was no evidence of suicidal or homicidal ideation.

**Psychological Findings:**
1. Symptoms of Post-traumatic Stress Disorder:
- Persistent Re-experiencing of Traumatic Events and Avoidance Behaviour: Mrs. Yousif reported frequent nightmares from which she awakens in a sweat with her heart pounding. The nightmares usually refer to a grave threat to herself and her daughter. The content of her dreams includes trauma-related material to varying degrees but usually not precise repetitions of actual events. For example, the night prior to the examination she dreamt that thieves had entered her domicile carrying knives, beating her with sticks, and threatened her and her daughter. She awakens from her nightmares gripped with fear and finds it difficult to fall asleep again. She often experiences intrusive recollections of the sexual assault that she experienced. Mrs. Yousif indicated that she has a profound sense of guilt over what happened to her daughter and is often preoccupied with thoughts of what she should have done
differently. Sometimes when she sees police or security forces, she feels anxious and starts thinking about what happened to them. She tries to avoid intrusive recollections through prayer. Also, she avoids talking to her daughter and others about what happened to them as it often precipitates recollections of her abuse and makes it difficult to fall asleep.

- **Persistent Symptoms of Increased Arousal:** As mentioned above, Mrs. Yousif suffers from difficulties falling asleep and from poor sleep throughout the night, often waking up hourly throughout the night. In the morning, she often feels exhausted. She also startles easily, feeling very jumpy in response to any kind of sudden noise. She indicated that: “Sometimes when I am in a room like this, I feel that someone may just storm in.” She feels that her concentration is impaired since being raped. For example, she used to like to read and talk to friends, but now has difficulty following conversations and reading. Often she forgets that she has already taken her headache medicine and subsequently takes a second dose. She misplaces things and sometimes takes days to find them. She is no longer good with directions and indicated that she cannot find her way even after a second time. “I have trouble following what is said in conversation and forget names of people I know, or what I had eaten the previous night,” she said. She sometimes feels irritable and has outbursts of anger without a clear reason. Her daughter has been unable to speak since the rapes; she spends hours alone staring straight ahead and she seems to be unaware of her surroundings. Mrs. Yousif is worried that her daughter is losing her mind. She tries to coax her daughter to eat and talk with her and she tries hard to keep her own despair secret in order to reassure her daughter. Nevertheless, Mrs. Yousif finds that she has outbursts of anger and crying that she cannot prevent. Somatic Complaints: Mrs. Yousif suffers from frequent headaches that respond well to aspirin.

2. **Major Depression:** Mrs. Yousif demonstrated symptoms of major depression, including depressed mood, diminished interest or pleasure in activities, decreased appetite resulting in weight loss [IF ASKED, RESPOND: about 4 Kilos], insomnia, fatigue and loss of energy, frequent crying and difficulty concentrating. She denied suicidal ideation and suicide attempts. Mrs. Yousif explained that her sadness stems largely from her inability to protect her daughter and what this means for her future. Though she wants justice for what has been done to them, she is afraid to take legal action. In the days after she had been raped, she spent hours bathing herself to cleanse herself of the shame she felt. Mrs. Yousif blames herself for what happened. She regrets not insisting that her daughter stay in the camp. She also expressed considerable anger over the camp-related security issues. She asked, “Why do we have to go where it is dangerous to get what we need?”

7. **Physical Examination** (All photos taken on the day of examination)

NOTE: Images of “virtual physical examination” findings will be presented in a separate room using PPT slides

- Slide #1: Note 1 cm hyperpigmented, linear scar above left eyebrow consistent with an old laceration injury.

- Slide #2: Note complex, atrophic scar, approximately 4 x 6 cm over the dorsum of the left hand associated with hypopigmentation and subcutaneous fibrosis.

8. **Interpretation and Conclusion**
Per trainee’s assessment
## MODULE 8

### CASE EXAMPLE #02

### OBJECTIVES

- To conduct a complete medical evaluation of an alleged torture victim using Istanbul Protocol standards, including assessments of physical and psychological evidence of torture
- To develop essential interview skills including: effective communication, earning trust, balancing empathy and objectivity, applying appropriated questioning techniques, obtaining informed consent, ensuring procedural safeguards, providing an appropriate and comfortable setting, respecting gender considerations, taking steps to avoid re-traumatisation
- To understand the relevant transference and counter-transference issues that may arise in the course of conducting medical evaluations of alleged torture victims
- To identify possible reasons for difficulties recalling and recounting the story and/or inconsistencies in the story of the alleged victim
- To provide a well-reasoned interpretation of findings and conclusions regarding torture and ill-treatment.
- To appreciate the possible difficulties that may arise during an interview with an alleged torture victim
- To identify and address individual interviewing strengths and weaknesses in conducting an interview

### CONTENT

- See Introduction and Preliminary Considerations and Materials below
- Review of Case Summary #02 by students
- Interview of individual role-player (alleged torture victim) by students or instructors (NOTE: role-players use Case Narrative #02 to act their parts)
- Instructor supervision/demonstration of interview(s) using Guidelines for Instructors Case #02 (see Guidelines for Instructors file)
- Debriefing between interviewers and role-players
- Class discussion
- Assignment: Ask students (individuals or groups) to write up a medical report of evaluation findings to be used in Module #9

### DISCUSSION TOPICS

- Interviewing skills: How did the interviewers feel they performed? What observations/comments can the instructor and/other students share?
- Interview content: was the interview complete? Was there any relevant components left out?
- Role-players should share their reactions to the interview, followed by the interviewers
- Discuss strategies to effectively address transference and counter-transference issues that arise in the course of interviewing survivors of torture.
- Discuss your most significant concerns in conducting a psychological evaluation. Discuss how you can address them.
TEACHING FORMATS

- **Group Activity:**
  - See Introduction and Preliminary Considerations and Materials below
  - See Discussion Topics above
- **Individual Research/Assignment:**
  - Discuss your most significant concerns in conducting a psychological evaluation. Discuss how you can address them
  - **Journal Entry:** (Instructor to assign) Write a few paragraphs -- no more than a page
  - Consider how transference and counter-transference reactions may affect routine medical encounters between patients and clinicians.
  - What are your most significant concerns in conducting a psychological evaluation? Discuss how you can address them.

PRIMARY RESOURCES

- The Istanbul Protocol
- Case Example #02 (Case Summary, Narrative and Guidelines for Instructors)

Introduction & Preliminary Considerations (see Module 7)

Materials

Case Summary/Referral #02 (distribute to students who conduct the interviews)

*(strong physical, moderate psychological and strong historical evidence; medical evaluation 7 days after alleged torture)*

Note: This case example #02 is written for male role-player. All names included in the narrative are fictitious.

Name: **Mr. Hassan Bashir Adam**  
Date Reporting to the Center: **dd/mm/yyyy** (today’s date)  
Date of Birth: **dd/mm/yyyy** (age 25)  
Age: 25 yrs  
Marital Status/Children: Single, no children  
Religion: Muslim  
Ethnic Group: Darfurian, Zagawa tribe  
Profession: Student, Khartoum University  
Political/Social Affiliation: Member of Student Democratic Front (SDF)  
Date of Detention: **dd/mm/yyyy** (7 months prior to the exam date),  
Place of Detention: XXX police station  
Period of Detention: 3 days
Trauma History:
On dd/mm/yyyy (7 months prior to the exam date), Mr. Adam as arrested by four officers from the NSA. He was placed in a truck with blackened windows, blindfolded and taken to a police station. His mobile phone and ID card were confiscated. His hands were restrained and he was punched, kicked and beaten with black water hoses and electric wires. They suspended him by his wrists and applied electric shocks to his genitals.

Alleged Perpetrators: Security personnel from the NSA, including Abdel Salih, and Kaleel Rahim, also 2 perpetrators referred to as Rasoul and Mujahid.

Reasons for visit: Treatment for problems related to torture and to take legal action against the perpetrators. The client has already met with SOAT legal advisors, and they have requested a medical evaluation of the client’s allegations of torture.

Effects of Torture: Musculoskeletal pain, multiple bruises and burns.

Case Narrative #02 (distribute to role-players only)

Note: Case example #02 is written for male role-players. All names included in the narrative are fictitious.

Case Summary/Referral Information:

Name: Mr. Hassan Bashir Adam
Date Reporting to the Center: dd/mm/yyyy (today’s date)
Date of Birth: dd/mm/yyyy (age 25)
Age: 25 yrs
Marital Status/Children: Single, no children
Religion: Muslim
Ethnic Group: Darfuri, Zagawa tribe
Profession: Student, Khartoum University
Political/Social Affiliation: Member of Student Democratic Front (SDF)
Date of Detention: dd/mm/yyyy (7 months prior to the exam date)
Place of Detention: XXX police station
Period of Detention: 3 days

Trauma History:
On dd/mm/yyyy (7 months prior to the exam date), Mr. Adam as arrested by four officers from the NSA. He was placed in a truck with blackened windows, blindfolded and taken to a police station. His mobile phone and ID card were confiscated. His hands were restrained and he was punched, kicked and beaten with black water hoses and electric wires. They suspended him by his wrists and applied electric shocks to his genitals.

Alleged Perpetrators: Security personnel from the NSA, including Abdel Salih, and Kaleel Rahim, also 2 perpetrators referred to as Rasoul and Mujahid.

Reasons for visit: Treatment for problems related to torture and to take legal action against the perpetrators. The client has already met with SOAT legal advisors, and they have requested a medical evaluation of the client’s allegations of torture.

Effects of Torture: Musculoskeletal pain, multiple bruises and burns.
1. Identification

My name is Hassan Bashir Adam. I live in Khartoum, and I am 25 years-old.

Additional Information:
- Date of Birth: dd/mm/yyyy (age 25)
- Citizenship: Sudanese
- Marital Status/Children: I am single, and I do not have children.
- Place of Birth: Nyala
- Place of Residence: Khartoum
- Highest Level of Education: Currently a student at Khartoum University.
- Occupation: Student
- Religion: Muslim
- Identification: ID confiscated
- Ethnic Group: Darfurian, Zagawa tribe
- Physician Examiner Name and License #: Fill out
- Individuals Present in the Examination Room and Reason for Presence: Fill out
- Language spoken: Zagawa
- Name of Interpreter: None
- Restrictions Noted: This depends on the response of the interviewer.
- Detainee Status: Detained by police and released

2. Past Medical/Surgical History and Psychosocial History Pre-Arrest

Past Medical/Surgical History:
Before I was arrested, I had no medical problems, no major illnesses or injury, no surgery, broken bones or head injury. I never had any mental problems, nor has anyone in my family. I am not on any medications. I do not use any illegal drugs or drink alcohol. I smoke about one pack of cigarettes per day.

NOTE: Provide information in parentheses only if specifically asked by the interviewer.

Psychosocial History Pre-Arrest:
I was born in Nyala and have two younger brothers. My father owns a small grocery store in Nyala and my mother helps him out at the store. I was good in school and decided to go to Khartoum University for business studies. I have had various part-time jobs, but I have never worked for my parents. My plan was to have a good job with a large company in the future. I have been an active member of the SDA (Student Democratic Front) for the past two years. Many of my friends and I were detained after the student elections last year. I was beaten, but not as bad as the others. One of my brothers was killed by security forces in Darfur about 9 months ago. My parents worry about me, because they know I am an active member of the SDF and they do not approve.

3. Trauma History

NOTE: At the time of arrest, there was no arrest warrant or subpoena order, search warrant, or resistance by the accused.

On dd/mm/yyyy (7 months prior to the exam date), at about 10:00 pm, four officers from the NSA came to the flat that I share with two other students. They told me that they needed to ask me some questions. I asked them if I was being charged with a crime. One of them, Abdel Salih, told me “Keep your mouth shut if you know what’s good for you.” Another one of them was named Kaleel Rahim.
I was placed in a truck with blackened windows and taken to XXX police station.
They took my mobile phone and ID card. When we arrived, they locked me in a room, about one meter by one meter and a half in size. The room was filthy and smelled of urine. There were no light and the ventilation in the room was very poor. During the time that I was detained, I had difficulty sleeping and was given only a small amount of poor quality food.

Later that night, they took me to an interrogation room and started asking questions about members of the SDF, who I knew and worked with and the nature of our work. I had made a speech recently on the situation in Darfur and they told me, “You may think you are free to criticize us, but we are free to do anything we like. We could kill you tonight and no one would care.” They tied my hands with rope and started beating me with punches, kicks, black water hoses and electric wires. This went on for more than an hour. One of them, “Rasoul,” put a plastic bag over my head and I was gasping for air. He repeated this 3 or 4 more times and I passed out.

When I woke up, they started beating me again (punches, kicks, and hoses). They forced me to take off all of my clothes. My hands were tied behind my back with a rope that was hanging from the ceiling. They lifted me off the ground; the pain was unbearable. They continued beating me while I was suspended. Then they sprayed cold water over me with a hose and forced it in my mouth and nose so I had trouble breathing. One of the agents attached a clip with some wires to my penis and my right foot. He said insulting things (Like “you won't be needing this anymore.”). My whole body cramped violently when they shocked me. I lost consciousness after they shocked me about five or six times. When I woke up, I was on the floor. I felt several burning sensations on my right forearm. One of them had a lit cigarette in his hand. He burned my arm again and again. One of them told me, “You better stop making speeches or you will end up like your brother.” I was locked in a cell for two days before I was released. I am not guilty of anything, and no one should be treated this way. That is why I had the courage to take legal action against the people who tortured me.

4. **Review of Torture Methods**
The following history should be revealed only on further questioning, unless asked in the context of the trauma history:

- The review of torture methods is negative for the all other torture methods, physical and psychological.

5. **Symptoms (Acute and Chronic) and Disabilities**

   **Acute Symptoms:**
   - Multiple bruises over my arms, legs and back, no injuries to the head. The bruises are red and swollen and still visible on my body. (No cuts or bleeding)
   - Pain in the shoulders, arms and wrists.
   - A number of burn marks on my right forearm, which took about 2-3 weeks to heal.
   - I did not observe any lesion on the penis where they shocked me.
   - Difficulty lifting objects due to pain in my arms and numbness in my right arm for a few months, but this resolved.

   **Chronic Symptoms:**
   - Scars noted on right forearm from cigarette burns.
   - Difficulty having erections, i.e. not able to perform sexually but has noted erections upon waking for sleep.

   **Disabilities:**
6. Psychological Evaluation and Mental Status

Mental Status:
Mr. Adam was appropriately dressed and groomed and looked his stated age. He was alert, fully oriented, pleasant and cooperative throughout the evaluation. There were no gross abnormalities in movement or posture on observation. Sensory functions and motor functions appeared to be intact. He appeared to possess above average intellectual ability, with good insight and judgment. His speech was clear and fluent. There was no evidence of delusions, hallucinations or psychotic thought processes. Memory was intact. Attention and concentration appeared intact. His mood was apprehensive in the presence of the police officer who escorted him to my office, but then calm during the evaluation. There was no evidence of suicidal or homicidal ideation.

Psychological Findings:
Mr. Adam did not admit to any symptoms of post-traumatic stress disorder or major depression. Though his affect was calm throughout most of the interview, he expressed considerable anger toward those who tortured him and the loss of his brother. Mr. Adam indicated that since being tortured, he is less sure of his future plans. He is now considering altering his career path to become more active politically. His parents have expressed strong disapproval, however; they consider his political activity to be "foolish and dangerous." This has resulted in considerable discord between them. He and his father have not spoken to one another in the past several weeks.

7. Physical Examination

NOTE: Images of “virtual physical examination” findings will be presented in a separate room using PPT slides.

Slide #1 and #2 (day of exam): Hyperpigmented, circumferential scars above both wrists, highly consistent with wrist abrasions from alleged restraint with rope and suspension

Slide #3 and #4 (day of exam): Multiple hyperpigmented circular scars (about 1 cm in diameter) with indistinct margins and no central palor or atrophy. The characteristics of the lesions and location on one arm only are highly consistent with the alleged cigarette burns.

Slides #5 and #6 (6 days following alleged torture): Linear “tram-track” lesions with peripheral echymosis and central palor, consistent with acute signs of beating to the back with a water hose.

8. Interpretation and Conclusion

Per trainee’s assessment
# MODULE 9

**Report Writing and Testifying in Court**

## OBJECTIVES

- To understand how to convey physical and psychological evidence in a written medical report
- To be familiar with the content of written forensic reports
- To be able to formulate appropriate interpretations and conclusions in a medical report and convey them to adjudicators
- To be able to address the problem of inconsistencies in an individual’s case
- To be familiar with general guidelines in providing expert medical testimony in court

## DISCUSSION TOPICS

- Written reports
  - General Considerations
  - Content of Written Reports
  - Conclusions
  - Guidelines for Medical Evaluations of Torture and Ill-treatment (Istanbul Protocol, Annex IV)
  - Inconsistencies
- Providing testimony in court
  - Court testimony guidelines and maxims
- Course Evaluation

## TEACHING FORMATS

- **Group Activity**: Students will have the opportunity to practice “testifying in court” on their evaluation findings from Modules 7 and 8. They should have written up their findings (as individuals or small groups) for both (or one as per the instructor) in advance of the Module 9 class so they can use it for their expert testimony. Ideally, each student should have an opportunity to practice testifying on their medical evaluation findings for at least one case. Depending on the time available instructors should consider the following options:
  - Student groups can be divided so that there are between 2 and 4 students per group. The instructor(s) should periodically check on each group to assess progress and address any questions or concerns that may arise. One or more students should
assume the role of the medical expert and one or more students should assume the role of a cross-examining lawyer (or prosecutor/judge). Consider the following questions for the “cross-examining lawyer:”

- Describe your qualifications as a clinician, in general, and as an expert on the physical and psychological evidence of torture.
- Were you paid to conduct this evaluation?
- Did the attorney, with whom you are working, prepare you for this court hearing? If so, how?
- Describe your primary findings (physical and psychological).
- What are the possible causes of the findings you described? Are there other possibilities?
- Is it possible that the physical injuries were self-inflicted, by another inmate, or in the course of a struggle with police/security forces?
- Is it possible that other traumatic experience which happened before or after the alleged torture are the cause of the detainees psychological symptoms?
- Was a proper chain of custody maintained for the collection of evidence?
- What are your conclusions regarding the detainee’s allegations of torture and ill-treatment?
- Did you find the detainee credible? Why or why not?
- Were there any inconsistencies observed in your evaluation? How do you explain these?
- How do you know that the detainee is not faking the symptoms that he/she alleges?
- Do you have any additional recommendations?

- If there is adequate time, both cases (Case #01 and #02) should be presented and each student should have the opportunity to assume the role of the medical expert and the cross-examining lawyer at least once. If there is insufficient time, it may be advisable to have half of the students work on Case #01 and the other half work on Case #02.
- Alternatively, one or two demonstration(s) may be conducted for the entire class and students asked to volunteer for the role of the medical expert and the cross-examining lawyer. The instructor may choose to have students work in teams to ensure that each student has an opportunity to serve as medical expert and the cross-examining lawyer.
- A single demonstration evaluation by the instructor may be another possibility, with student interaction during and/or at the end of the testimony.
- Individual online users of the Model Curriculum may review all materials contained in Modules 9 complete their own medical report and answer practice with a friend to answer the suggested questions by the cross-examining lawyer above.

Individual Research/Assignment:
- Individual online users of the Model Curriculum may review all materials contained in Modules 9 complete their own medical report and answer practice with a friend to answer the suggested questions by the cross-examining lawyer above.
- Discuss international and country-specific challenges for torture prevention and accountability.
- Discuss on the role of health professionals in improving:
  - Investigation and documentation of torture and ill-treatment
  - Country-specific measures for torture prevention and accountability
  - The protection and promotion of human rights
- Provide a plan of action with short- and long-term strategies for torture prevention and accountability.

Journal Entry: (Instructor to assign; Write a few paragraphs -- no more than a page)
- Respond to one or more of the Discussion Topics
- What is the overall value of this course and how can it be improved?
1. Written Reports

1.1 General Considerations

The purpose of written reports and oral testimony is to assess claims, document evidence of torture and ill-treatment, and effectively communicate this evidence to adjudicators. The purpose is not to "prove" or "disprove" the individual’s allegations of abuse. The health professional provides expert opinions on the degree to which the his/her findings correlate with the individual's allegation of abuse. Clinical evaluations are often critical in enabling adjudicators to make accurate and just decisions in medico-legal cases. In addition, each written report and oral testimony represents an opportunity for clinicians to educate adjudicators on physical and psychological evidence of torture.

Expert medical reports and testimony can be of value in an number of different contexts:

- The prosecution in national or international courts of perpetrators alleged to be responsible for torture
- Claims for reparation
- Challenging the credibility of statements extracted by torture
- Identifying the need for further care and treatment
- Identifying national and regional practices of torture in human rights investigations
- Support of allegations of torture in asylum applications.

Medico-legal (or forensic) evaluations should be conducted with objectivity and impartiality, and this should be reflected in written reports and testimony. The evaluations should be based on clinical expertise and professional experience. As mentioned in Module 2, the ethical obligation of beneficence demands uncompromising accuracy and impartiality in order to establish and maintain professional credibility. When gathering information to prepare a report, it is important not to over-interpret the findings and so diminish the quality of the evidence. That is to say, however sympathetic the health professional may be to the individual, the report or certificate should not say more than can be supported by the evidence and the level of competence of the report writer to interpret it, or the case might be undermined.

Clinicians who conduct evaluations of alleged torture victims should have specific essential training in forensic documentation of torture and other forms of physical and psychological abuse. They should also have knowledge of prison conditions and torture methods used in the particular region where the individual was imprisoned and the common after-effects of...
torture. The written reports and oral testimony should be factual and carefully worded. Jargon should be avoided. All medical terminology should be defined so that it is understandable to lay persons. Many words have a specific meaning in medico-legal reports that differ from their use in everyday speech, such as ‘history’ or ‘laceration’. It may be necessary to append a glossary to the report, so that readers do not misinterpret some of the words by applying their everyday definitions.

The clinician should review the declaration (testimony) and any relevant medical or legal materials that the alleged torture victim has presented to the court, as it generally includes information that may be compared with the clinician’s evaluation. Any discrepancies that may arise should be pursued with the individual and/or the individual’s attorney to a point of clarity. Adjudicators often interpret inconsistent testimony as a lack of credibility on behalf of the alleged torture victim, when, in fact, such inconsistencies are often related to the presence of psychological, cultural, linguistic or other factors.

Effective written reports and oral testimony not only require knowledge of torture and its after-effects, but they also require accurate and effective communication skills. Such skills are not typically part of clinical training. Written reports and oral testimony of clinicians should not include any opinion(s) that cannot be defended under oath or during cross-examination. Furthermore, the quality of any testimony, whether written or oral, can only be as good as the interview and examination conducted.

Physical and psychological evaluations of alleged torture victims may provide important confirmatory evidence that a person was tortured. However, the absence of such physical evidence should not be construed to suggest that torture did not occur, since such acts of violence against persons frequently leave no marks or permanent scars. Historical information such as descriptions of torture devices, body positions and methods of restraint, descriptions of acute and chronic wounds and disabilities, and identifying information about perpetrators and the place(s) of detention may be very useful in corroborating an individual’s allegations of torture. In the clinician’s interpretation of findings, he/she should relate various categories of evidence, i.e., physical and psychological evidence of torture, and historical information as well.

1.2 Content of Written Reports

The examiner should be prepared to address the following in his or her written report or affidavit:

- Assess possible injury and abuse, even in the absence of specific allegations by individuals, law enforcement or judicial officials;
- Document physical and psychological evidence of injury and abuse;
- Correlate the degree of consistency between examination findings and specific allegations of abuse by the patient;
- Correlate the degree of consistency between individual examination findings with the knowledge of torture methods used in a particular region and their common after-effects;
- Render expert interpretation of the findings of medico-legal evaluations and provide expert opinion regarding possible causes of abuse in court hearings, criminal trials and civil proceedings;
- Use information obtained in an appropriate manner to enhance fact finding and further documentation of torture

First, the affidavit should recite the educational and professional qualifications of the medical professional. Prior experience examining survivors of torture and trauma should be
highlighted, as should any experience working with individuals who suffer from common psychological symptoms such as PTSD and Major Depression. In addition, the professional’s participation in training (such as this Model Curriculum) and seminars relating to torture survivors should be included. If the professional is working in consultation with, or under the supervision of, other medical professionals or specialists, those professionals should also be listed. If the professional conducted the examination on a *pro bono* basis, or was referred to the case through a human rights organisation, these facts should be included. A copy of the medical professional’s resume or *curriculum vitae* (CV) should be attached to the affidavit. Some courts may require that the expert witness list the reason for the interview, who requested it, and a list of any background documents read beforehand.

Generally a written report contains the following components:

- **The account of the event(s) as described by the individual.** As explained in Module 3, this should detail events during arrest and conditions of any detention (e.g. prolonged solitary confinement) since these conditions in themselves may produce physical and psychological sequelae. The account should further detail specific events and methods of torture, both physical and psychological, during actual interrogation. If there are internal inconsistencies in the narrative, or if it contradicts testimony given elsewhere (for example, to a legal adviser), this must be explained.

- **A description by the individual of his or her physical and psychological symptoms and signs at the time of alleged ill-treatment, and an account of how these symptoms evolved with or without medical treatment.**

- **A description of the individual’s physical and mental health at the time of the interview(s) and, if he or she has been seen over a period of time, how they have changed with treatment and as a consequence of concurrent events.**

- **A note of any medical treatment in detention, or any treatment that was requested but denied.**

- **An account of the physical and psychological findings from the interview(s).** This should include the demeanour at different times of the process (including any contact before and after the interview(s)), the results of any psychological assessments, a detailed account of the physical examination, and the results of any investigations performed.

- **The professional opinion on the likely causes of these findings, discussing other relevant possible causes of those lesions attributed to torture.** There should also be a summary, and the conclusions of the overall evaluation. (Note: it is advisable to separate the findings and the opinion into separate sections, as this makes it clear to any court which is which.)

- **Provide any relevant recommendations for additional tests, consultations, and/or the need for treatment services.**

Depending on the intended forum, a summary of the findings of other team members could also be needed, or each might need to provide a separate report. Copies of x-rays, photographs or other reports also can be attached to the affidavit where appropriate and available.

Some trial attorneys and judges have objected to affidavits in which medical professionals recite information provided by the alleged torture victim to the professional. It is generally preferable for the medical professional to avoid a detailed recitation of every statement made to him/her by the individual. The individual’s own affidavit in the case will provide those details. Some statements will, of course, need to be included in order to explain the medical professional’s conclusions. To the extent that the professional needs to include this information to explain the basis for his/her conclusions, the professional should be careful to
state only that the individual “states” or “reports” that a specific incident occurred. Such an approach is the safest, because, even if the professional believes the individual, the clinician is only reporting “hearsay” information. Failure to use such language has sometimes been used to undermine the credibility of medical affidavits.

When writing reports, health professionals should comment on the emotional state of the person during the interview, symptoms, history of detention and torture, and personal and family history prior to torture. Factors such as the onset of specific symptoms in relation to the trauma, the specificity of any particular psychological findings, as well as patterns of psychological functioning should be noted. Additional factors such as forced migration, resettlement, difficulties of acculturation, language problems, loss of home, family, social status, as well as unemployment should be described. If a formal psychiatric diagnosis is given, the reasons should be explained. See Clinical Interpretation, Module 6, for a more detailed discussion of the interpretation of psychological evidence of torture.

1.3 Conclusions

At the end of the report, the health professional must give his or her opinion of the totality of his or her findings, both physical and mental. He or she can say how strongly the findings support or do not support the allegations. The report may have corroborative value when it is added to the other evidence in the case.

All the available information should then be brought together in order to prepare the final report, including:

- Copies of any previous court decisions about the individual
- Correspondence from other health professionals to whom the patient has been referred
- Background information about the situation in the country to which the allegations of torture relate (e.g. from the UNHCR (United Nations High Commissioner for Refugees) or Amnesty International)
- The account of the event(s) as described by the individual
- Notes on the individual’s description of his or her physical and mental health
- Records of the psychological and physical findings from the interview(s)
- The results of any clinical investigations
- Recommendations for further treatment.

This will then allow the health professional to give an opinion of the likelihood that the alleged victim had been tortured in the way that he or she described, to the standard of proof required by the appropriate forum. Ultimately, the court decides whether the individual is credible, but health professionals must not ignore the issue. Credibility is not an all-or-nothing concept - there is a continuum between the absolute truth and the complete fabrication of events, with at least three points in-between:

a) A mixture of falsehood and truth, e.g. a fabricated history of a recent detention added to a genuine one in the past
b) Conscious or subconscious exaggeration - saying that the ill-treatment was more frequent and more severe than actually happened
c) Genuine errors arising from mistakes and misunderstandings. The health professional should then make a final statement summarising the opinion.
The components of written reports are elaborated throughout this Curriculum. The following guidelines are based on the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the “Istanbul Protocol”), Appendix IV. These guidelines are not intended as a fixed protocol. Rather, they should be applied with due consideration to the purpose of an individual evaluation and a reasonable assessment of available resources. Please note that assessments of physical and psychological evidence of torture and ill-treatment may be conducted by one or more clinicians depending on their qualifications.

GUIDELINES FOR MEDICAL EVALUATIONS
OF TORTURE AND ILL-TREATMENT (see IP Annex IV)

I. Case Information
Date of Evaluation: ......................... Exam. Requested By (Name/Position): ............
Case ID/Report #: .......................... Duration of Evaluation: ......Hours, ......Minutes
Subject’s Given Name: .................... Birth Date: ...........; Birth Place: ...................
Subject’s Family Name: .................... Gender: female / male
Reason for Exam: .......................... Subject’s ID#: ..............................
Clinician’s Name: ............................ Interpreter Yes/No: Name: ......................
Informed Consent: Yes/No .......................... If “No,” Provide Reason: ......................
Subject Accompanied By (Name/Position): ..............................................................
Person(s) Present During Examination (Name/Position): ........................................
Subject Restrained During Exam: Yes/No; If “Yes,” How/Why? .........................
Medical Report Transferred to (Name/Position/ID#): ................................................
Transfer Date: ..............................; Transfer Time: ............................
Medical Evaluation/Investigation Conducted without Restriction (For Subjects in Custody): Yes/No
Provide Details of Any Restrictions: ........................................................................

II. Clinician’s Qualifications (For Judicial Testimonies)
1. Medical Education and Clinical Training
2. Psychological/Psychiatric Training
3. Experience in Documenting Evidence of Torture and Ill-treatment
4. Regional Human Rights Expertise Relevant to the Investigation
5. Relevant Publications, Presentations and Training Courses
6. Provide Curriculum Vitae

III. Statement Regarding Veracity of Testimony (For Judicial Testimonies):
For example: "I personally know the facts recited below, except as to those stated on information and belief, which I believe to be true. I would be prepared to testify to the above statements based on my personal knowledge and belief."

IV. Background Information:
1. General Information: (age, occupation, education, family composition, etc.)
2. Past Medical History
3. Review of Prior Medical Evaluations of Torture and Ill-treatment:
4. Psychosocial History Pre-Arrest

V. Allegations of Torture and Ill-treatment:
1. Summary of Detention(s) and Abuse
2. Circumstances of Arrest and Detention
3. Initial and Subsequent Places of Detention: (chronology, transportation, and detention conditions)
4. Narrative Account of Ill-treatment of Torture: (in each place of detention)
5. Review of Torture Methods

VI. Physical Symptoms and Disabilities:
Describe the development of acute and chronic symptoms and disabilities and the subsequent healing processes.
1. Acute Symptoms and Disabilities
2. Chronic Symptoms and Disabilities

VII. Physical Examination
1. General Appearance
2. Skin
3. Face/Head
4. Eyes/Ears/Nose/Throat
5. Oral Cavity/Teeth
6. Chest/Abdomen (including vital signs)
7. Genitourinary System
8. Musculoskeletal System
9. Nervous System (Central and Peripheral)

VIII. Psychological History/Examination:
1. Methods of Assessment
2. Current Psychological Complaints
3. Post-Torture History
4. Pre-Torture History
5. Past Psychological/Psychiatric History
6. Substance Use and Abuse History
7. Mental Status Examination
8. Assessment of Social Functioning
9. [Psychological Testing]
10. [Neuropsychological]

IV. Photographs

V. Diagnostic Test Results (see Appendix I for indications and limitations)

VI. Consultations

VII. Interpretation of Findings

1. Physical Evidence:
   A. Correlate the degree of consistency between the history of acute and chronic physical symptoms and disabilities with allegations of abuse.
   B. Correlate the degree of consistency between physical examination findings and allegations of abuse. (Note: the absence of physical findings does not exclude the possibility that that torture or ill-treatment was inflicted.)
   C. Correlate the degree of consistency between examination findings of the individual with knowledge of torture methods and their common after-effects used in a particular region.

2. Psychological Evidence:
A. Correlate the degree of consistency between the psychological findings and the alleged report of torture.

B. Provide an assessment of whether the psychological findings are expected or typical reactions to extreme stress within the cultural and social context of the individual.

C. Indicate the status of the individual in the fluctuating course of trauma-related mental disorders over time; i.e. what is the time frame in relation to the torture events and where in the course of recovery is the individual.

D. Identify any coexisting stressors impinging on the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role, etc.) and the impact these may have on the individual.

E. Mention physical conditions that may contribute to the clinical picture, especially with regard to possible evidence of head injury sustained during torture and/or detention.

XIII. Conclusions and Recommendations:

1. Statement of opinion on the consistency between all sources of evidence cited above (physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports, etc.) and allegations of torture and ill-treatment.

2. Reiterate the symptoms and/or disabilities that the individual continues to suffer as a result of the alleged abuse.

3. Provide any recommendations for further evaluation and/or care for the individual.

XIV. Statement of Truthfulness (For Judicial Testimonies):

For example, "I declare under penalty of perjury, pursuant to the laws of (XX country), that the foregoing is true and correct and that this affidavit was executed on X/X/X at (City), (State or Province)."

XV. Statement of Restrictions on the Medical Evaluation/Investigation (For Subjects in Custody):

For example, "The undersigned clinician(s) personally certify that they were allowed to work freely and independently, and permitted to speak with and examine (the subject) in private, without any restriction or reservation, and without any form of coercion being used by the detaining authorities;" or alternatively: "The undersigned clinician(s) had to carry out his/her/their evaluation/investigation with the following restrictions:...."

XVI. Clinician’s Signature, Date, Place

XVI. Relevant Appendices: e.g. Clinician’s Curriculum Vitae, Anatomical Drawings for Identification of Torture and Ill-treatment, Photographs, Consultations, and Diagnostic Test Results, among others.

In the process of correlating the degree of consistency between physical and psychological findings and allegations of abuse, it is helpful to use the following terms (adapted from IP, §125):

Not consistent: The finding could not have been caused by the trauma described. (If this term is used in a medico-legal report, the writer should explain why the individual’s account is considered to be credible, if that is the case, despite this inconsistency.)
Consistent with: The finding could have been caused by the trauma described, but it is non-specific and there are common alternative possible causes.

Highly consistent: The finding could have been caused by the trauma described and there are few other possible causes. (Depending on the level of proof required by the court, such findings may be sufficient to corroborate the individual’s testimony.)

Typical of: This phrase is used for lesions that are ‘highly consistent’ with the attribution and additionally the appearance is one that is usually found with this type of trauma (for example, cigarette burns).

Diagnostic of: This finding could not have been caused in any way other than that described. (This is strongly supportive of the individual’s account, but does not, by itself, confirm that torture has occurred because the status of the perpetrator and the purpose of the assault are also relevant.)

1.4 Inconsistencies

Torture survivors may have difficulties in recalling and recounting the specific details of the torture experience and other parts of the history for several important reasons. Clinicians should be familiar with such factors as they can manifest as inconsistencies in the interview. Difficulty recalling and recounting may be related to factors:

- Factors directly related to the torture experience
- Factors related to the psychological impact of torture
- Cultural factors
- Factors related to interview conditions or barriers of communication

It is extremely important for clinicians to clarify all inconsistencies prior to the report writing or testifying in court. Inconsistencies that are attributable to an individual’s torture experience may, in fact, support his or her allegations of abuse, rather than undermine it. Sometimes an individual’s account may conflict with one given previously, for example, to a legal adviser or other nonmedical interviewer. The medico-legal report should identify these inconsistencies and, if they are relevant, explain them. The report is a legal record of the interviews and should not be amended to minimise these inconsistencies if this reduces the report’s accuracy.

Sometimes an individual will say that an injury was caused by torture when clearly that is not the case. This may be because of a misunderstanding. For example, the person might not be aware of scars across the upper back from childhood chickenpox. When these are pointed out by a health professional, the might say they are the result of torture, believing all scars were a consequence of torture. Another individual may be claiming deliberately that a wound was caused by torture, knowing this is not the case. Perhaps he or she has no scarring from torture but thinks he or she will not be believed without some physical evidence. In this situation the health professionals should document the individual’s attribution, the health professional’s opinion, and the likely reasons for the difference of opinions. In the context of a complete medical evaluation of both physical and psychological evidence, the presence of other corroborating physical and psychological evidence will aid in assessing the overall veracity of an individual’s allegations. A false opinion supporting the individual’s attribution must never be given.

It is sometimes suggested that physical evidence is the result of self-inflicted injuries. True self-inflicted wounds are usually of two main types. One is where a person is deliberately harming him- or herself to support a false claim of assault. Such wounds are generally superficial and within easy reach of the dominant hand. Very rarely an accomplice might be asked to cause a wound in a place the person cannot reach, such as in the middle of the
back. The other form of self-harm is where the person has a mental illness. Such wounds can be complex, but generally the underlying mental health problem can be identified during the interview. Occasionally a person will have wounds from an unsuccessful suicide attempt in detention, perhaps a desperate response to an intolerable situation. Although the person might be unwilling initially to disclose the true cause of the wounds, if the clinician responds by using sensitive questioning, he or she will normally say what happened.

2. Providing Testimony in Court

The main purpose of appearing in court is to present orally the material that has been submitted in the written report and to respond to questions from lawyers and adjudicators. A judge may admit a written report into evidence without the health professional appearing in court personally. However, the judge may give the report limited weight or even refuse to accept the written document if the health professional does not appear in court because there is no opportunity for cross examination. For this reason, and because the oral testimony can more strongly substantiate the consistency with the clinician’s own testimony, it is preferable for the clinician to appear in court personally.

The tone and style of the hearing may vary considerably depending on the case, the judge, and the lawyers involved in the case. It is best for the health professional to be prepared for a challenging and even adversarial attitude, although this may not be the case. Prior to the court date, the individual’s attorney should arrange a meeting with the assessor to discuss the clinician’s testimony and to review the specific questions that the attorney might ask.

The clinician should bring to court all of the evidence that has been used in the affidavit, such as diagnostic imaging films, laboratory test reports, photographs and neuropsychological assessment reports.

Once in court, the first step is certifying the clinician as an expert witness. An expert witness is someone who, by virtue of knowledge, training, education, or experience, qualifies to offer expert testimony with regard to a particular subject area. Often, this certification will be a fairly simple process, with the clinician’s curriculum vitae serving as the basis for expertise. On other occasions, the judge or cross-examining attorney may challenge the clinician’s expertise. They may ask about the clinician’s specific area of expertise (e.g., torture, trauma, psychology, diagnosis). It is helpful to have considered this in advance with the attorney of the alleged victim and to arrive at a definition of expertise consistent with the clinician’s background and the needs of the case. Experience in assessing and working with trauma victims of any kind is, for example, relevant background.

The clinician’s testimony usually consists of a period of direct examination by the alleged victim’s attorney, during which time the clinician’s findings are presented, followed by cross-examination by the opposing attorney, and subsequent redirected questioning by the alleged victim’s attorney. Court proceedings may vary considerably. In some cases, the judge will interject his/her own questions at any point in the proceeding. Sometimes there will be very little questioning from the judge and cross-examining attorney, and sometimes there will be very extensive questioning. Questions may take the form of information-seeking, and the attorney may present the clinician with the opportunity to educate the court about physical and/or psychological evidence of torture, as well as about this particular individual’s case.
Questions may also take the form of challenges to the clinician’s findings or the basis for those findings. One line of questioning commonly taken is: “How do you know what happened to the alleged victim? Do you have first hand knowledge? Aren’t you simply reporting what the alleged victim told you?” This question provides the clinician with an excellent opportunity to educate the court about the sources of his/her knowledge, including all of the components which go into the evaluation of physical and psychological evidence and the relevance of any additional historical information, including consistency of symptomatology with that seen in other traumatised patients and with commonly accepted professional standards such as the DSM-IV or ICD-10 and other diagnostic criteria. It may also be helpful to refer to the clinician’s application of Istanbul Protocol standards in his or her medical evaluation.

Another area of questioning may relate to cross-cultural factors: “What do you know about the respondent’s culture, about his/her country, or about how psychological response to trauma manifests in that culture?” Here, the clinician may refer to the analysis presented earlier concerning cross-cultural factors in assessment. The clinician can mention 1) expertise that he/she has with respect to the culture in question; 2) cross-cultural research on psychological trauma and symptomatology indicating the valid application of, for example, PTSD criteria across cultures; 3) skills in clinical listening and assessment which allow exploration of cross-cultural experience without being a specialist in that particular culture; and 4) common sense and face value components of the assessment process. This last factor should not be underestimated. When an alleged victim breaks into tears, explains how she was raped, nearly suffocated, threatened with death and says she is afraid that this may happen again, one need not be a cross-cultural expert to draw conclusions about her mental status.

In court, the finding of credibility is a legal matter that is the responsibility of the judge. The expert witness is one resource that the judge draws upon to make that determination. The clinician need not feel the compulsion to make that determination for the judge, and, indeed, judges may resent an expert who tries to do so. What the clinician can do is answer the questions of the attorneys and the judge as thoroughly and professionally as possible, along with his/her opinion about credibility, and let the judge arrive at his/her own conclusion. Indeed, there are many other factors in addition to expert testimony that go into the final decision.

Some general guidelines for oral testimony include the following:
- Do not “react” to provocative statements.
- Clarify questions that you do not understand before providing an answer.
- Answer questions directly and succinctly. However, take the opportunity, when available, to editorialize and educate.
- Do not offer opinions on subjects about which you are not qualified to comment.
- Speak clearly, slowly, and make eye contact with whomever you are speaking.
An excellent resource for any clinician preparing to testify in court is Stanley Brodsky's *Testifying in Court: Guidelines and Maxims for the Expert Witness*; and *The Expert Expert Witness: More Maxims and Guidelines for Testifying in Court*. Dr. Brodsky prepares the psychological expert for the most aggressive cross-examination of the expert’s credentials and conclusions. Perhaps the most helpful aspect of the books is the presentation of attitudes and appreciation of one’s own credentials as an expert, as well as exact phrasing to counter potential efforts to impeach one’s testimony. Though these guidelines and maxims were developed for psychological experts who testify in the United States, they may apply to other judicial proceedings. See Court Testimony Guidelines and Maxims, appended to this Module.

Course Evaluation

Per Instructor
Appendix
Court Testimony Guidelines and Maxims


1. **The Admit – Deny**: Handle loaded and half-truth questions by first admitting the true part in a dependent clause and then strongly denying the untrue part in an independent clause.

2. **Advocacy: The "Bought Expert" Accusation**: Respond to implications of being a bought expert by showing awareness of the issue and assertively presenting the foundations of your objectivity.

3. **Advocacy: The Pull to Affiliate**: Check and recheck that routine pulls toward affiliation are not diminishing the impartiality of the expert role.

4. **Becoming Current**: Review current literature on the topic about which you will testify.

5. **Burden of Proof and Degree of Certainty**: Burdens of proof and degrees of defined certainty are legal concepts. Do not accept, define, or incorporate them into clinical, psychological, or scientific testimony (unless you really know what you are doing.)

6. **Challenges to Experience: Insufficient Experience**: When challenged about insufficient experience, keep track of the true sources of your expertise.

7. **Challenges to Experience: Challenges to Experience**: Be prepared to present the bases for generalizability of findings and demographic communalities in your testimony.

8. **The Case Against Experience**: Challenges to professional experience should be met with a knowledge of the literature and affirmations of the worth of your own experience.

9. **Changing your Mind**: Do not change a professional opinion on the basis of a cross-examination. Your opinions should always arise from your data.

10. **Child Sexual Abuse: Lying and Fantasy**: Questions about children’s lying and fantasies should be answered with open acknowledgement of their existence and the ways in which the clinical examination rules them out as causes of the allegations of abuse.

11. **Child Sexual Abuse: Anatomically detailed dolls**: In the controversial area of anatomically detailed dolls in the assessment of child sexual abuse, witnesses should know both the criticisms and supporting data, as well as the requisite professional competencies that accompany their use.

12. **Client Dissimulation: Clinic considerations**: Challenges about clients faking bad or faking good should be met with affirmative statements of clinical validity, sensitivity, and vigilance for client dissimulation.

13. **Client Dissimulation: Research Considerations**: Research on client dissimulation should be known and used in clinical work and testimony. Enough of the research findings are equivocal that caution in evaluations and witness statements are always in order.

14. **Collaborative Criticism**: Criticize your field as requested, but be poised and matter-of-fact and look for opportunities to regain control.

15. **Concepts and Definitions**: Good definitions are necessary but not sufficient bases for answering fundamental questions. Broader conceptual understanding is needed.
16. **Courtroom as Place Identity:** Witnesses often feel like aliens in the courtroom: The solution is to be present often and to develop a sense of place identity.

17. **Credentialing: Facts:** Prepare a list of professionally relevant and complete qualifying questions for the attorney to use in the opening of the direct examination.
   
   a) Education: Where, when, what degrees, specialities, relevant courses, postdegree formal education;
   
   b) Employment: What positions, what level or rank, what responsibilities, when and for how long, current position;
   
   c) Licensure or certifications;
   
   d) Memberships in professional or scientific societies: At what level, for how long, offices held;
   
   e) Honors, awards, and recognitions;
   
   f) Publications and presentations: Articles, chapters, books, talks, editorships;
   
   g) Grants: Subjects of study, source of funding, amount, how long, results;
   
   h) Skills: From workshops, supervision, postdegree training; Consultantships;
   
   i) Speciality knowledge: Of what methods, clientele, topics, how acquired;
   
   j) Experience: What kind, what populations, what role, how relevant to court case.

17. **Credentialing: Challenges:** Comfortably agree with accurate challenges to your credentials. Offer narrative explanations only when they are nondefensive and unforced.

18. **Culturally different clients:** Culture does affect the assessment of psychopathology. Witnesses should be culture educated while still clearly identifying and affirming the conventional foundations of their testimony.

19. **The direct examination:** Meet with the attorney prior to the direct examination and be involved in preparing the questions.

20. **Disaster relief:** After a disaster during testimony, correct the error as soon as you can. If you cannot, let it go.

21. **DSM Cautions:** Do not be befuddled if you do not know specific DSM cautions. Do affirm the underlying principles of such cautions in which you believe.

22. **Elder abuse and neglect:** Testimony about elder abuse calls for a mixture of specific expertise and visible empathy.

23. **Employment discrimination:** In equal opportunity cases, plaintiff witnesses need to focus on social context and defense witnesses on objective comparisons.

24. **Examiner Effects:** Cross-examinations about examiner effects call for the witness to explain how training and standardized procedures diminish such effects.

25. **Fishing expeditions:** When the attorney fishes for ignorance and insecurities, keep your knowledge limits clearly in mind.

26. **Fraternisation during the trial:** Neither fraternize nor discuss any element of the case with opposing counsel, other witnesses, clients, or jurors.

27. **Freud as an expert witness:** When testifying about something in which you believe, testify in a manner that shows that you believe in it.

28. **The historic hysterical gambit:** The historic hysterical gambit is an indication that nothing else has worked for the attorney. Respond with poise, either declining to discuss the historical events or dismissing them as obsolete and not applicable.

29. **How you know what you know:** From the earliest stage of legal activity, be certain to have mastered the foundations of your knowledge and role.

30. **Humor:** If you are humorous at all on the witness stand, keep it gentle, good-natured, and infrequent.

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95 **DSM**: Diagnostic and Statistical Manual of Mental Disorders.

96 Meaning, he attorney resorts to attacking the whole discipline or profession of the witness.
31. **The idealism hazard:** When minimum professional standards are the issue, do not become a visionary advocate of idyllic and rarely attainable services.

32. **Intimidation:** When attorneys try to intimidate, respond with controlling answers, proper manners, and clinical reflections.

33. **Just before the court appearance:** Explicitly relax or engage in productive work just before your court appearance.

34. **The language of testimony: General principles:** Effective language usage comes about when the witness personalizes answers, varies the format, uses narrative well, and produces convincing spoken and transcribed testimony.
   a) Personalize your own testimony
   b) Be wary of the format of your answers
   c) Look for opportunities to give fairly long, narrative answers during cross examinations
   d) Use pronouns purposefully

35. **The language of testimony: Fluent testimony:** Gain control of fluency on the witness stand.
   a) Vary the loudness
   b) Speak slowly
   c) Stress syllables
   d) Ease into your breath pattern

36. **The learned treatise gambit:** Never accept the learned treatise as expertise unless you are master of it.

37. **The limits of expertise:** Agree to be an expert only when genuine expertise is present.

38. **Listening well:** Listen with care to the wording of the attorneys’ questions and use this knowledge in the interests of precision and control.

39. **Negative Assertions:** When the time is right to disagree with cross-examination questions, do so with strength, clarity, and conviction.

40. **Orientation to the Courtroom:** Effective witnesses are familiar with expected trial procedures, interpersonal transactions, and the dynamics of testifying.

41. **Power and Control on the Witness Stand: The Process:** Cross-examining attorneys will use substantive and psychological means to gain control over witnesses. Witnesses, in turn, need to be free of such control to perform well and feel good about their testimonies.

42. **Power and Control: Time and the Art of Testifying:** Take a breath and explicitly think about questions that require thought.

43. **Power and Control: Gaze and Eye Contact:** Look at the jury during narrative answers and avoid being captured in eye contact by the cross-examining attorney.

44. **Power and Control: Personal Space:** Make the courtroom environment familiar and create an opportunity for control by sitting tall and owning personal space.

45. **The Primary Source Gambit:** If you do not know primary sources, worry not. Instead, stay with current knowledge and clinical conclusions.

46. **Probes for Guilt and Shame:** Cross-examination probes for guilt and shame are effective only if you respond with guilt and shame. Stay on-task and nondefensive.

47. **The Professional Witness:** Talented professional witnesses can model authoritative expertise for other experts. They are described as:
   a) always interesting to watch and hear;
   b) able to reconfirm statements of their findings from practical experience;
   c) truly abreast of the latest literature;
   d) skilled at neutralizing vicious cross-examination attacks,
   e) composed and relaxed.
48. **Psychotherapists as Expert Witnesses:** It is normal for psychotherapists to be reluctant or ambivalent when testifying about their clients. Testimony should include the strengths of the participant-observer role and the extended opportunities to observe their clients.

49. **The Push-Pull:** When the cross-examination question is true but is asked in a pushy and negative manner, consider agreeing strongly.

50. **Quiet Moments on the Stand:** Quiet times on the stand can be used to observe carefully, stretch personal limits, and incorporate successes.
   a) Anticipate difficult questions
   b) Observe with safety: Unchallenged times on the stand give you a chance to look carefully at courtroom dynamics and processes;
   c) Experiment;
   d) Hold the moment.

51. **The Rumpelstiltskin Principle:** Know the names and faces of the attorneys, judge, and other participants in the courtroom events.

52. **Saying “I don’t know”:** When you truly do not know, say so.

53. **Scientist Challenges:** Both the teeming masses and esteemed scientific standards cross-examinations should be met with a comfortable affirmation of accepted and meaningful standards of practice.

54. **The Star Witness Fantasy:** A witness’s self-centeredness about the importance of personal testimony can serve as blinders that interfere with clarity, self-assurance, and nondefensiveness.

55. **Termination of Parental Rights:** The heated emotionality of termination of parental rights hearings calls for exceptionally well-prepared and constructive testimony.

56. **Transformative Moments:** Key moments can positively and negatively transform the credibility and acceptance of testimony.

57. **The Well-Dressed Witness:** Dress for court in clothes that are familiar, comfortable, and professional.

58. **When it is over:** Make the last impression a good one.

59. **When your Attorney is Indifferent or Incompetent:** With indifferent attorneys, be assertive. With incompetent attorneys, decline the case or educate them.

60. **While Lawyers Fuss:** When lawyers fuss, stay uninvolved.

61. **Ziskin & Faust Are Sitting on the Table:** The Ziskin and Faust reviews have an adversarial component and consequently may not meet the respected minority test. Nevertheless, they have made us more accountable and that can be acknowledged constructively.

62. **Arbitrary Pigeonholes:** Do not allow your reports or testimony to be recast into simple-minded and arbitrary groupings of the attorney’s choice.

63. **Asked and Answered:** When the court limits what you can explain, neither panic nor become angry or defensive; rather, testify as confidently as you can within those constraints.

64. **Back to One:** Self-critical judgements and zealous attachments to the results distract from effective testimony. Seek to become authentically yourself as a professional and as a witness.

65. **Bulletproofing:** The techniques here are not an impenetrable shield for unprepared witnesses. Weaknesses in methodology can and should be exposed by competent probing in the adversarial process.

66. **Confabulations:** Never make up answers, keep your answers carefully within the context of what you know and remember, and never automatically reply within attorneys’ frames of reference.

67. **Context: 1. Choosing a Phrase:** Keep the context of your assessments and findings as a foreground issue in expert testimony.

69. Daubert Hearings: Under Daubert, professional and scientific experts should be prepared with peer-reviewed research to defend the nature of their theories, principles and methodologies.

70. Discovery and Discoveries: Never accept attorney condensation, summary, or conclusions as your only working materials. The expert’s responsibility is to review and assess the case personally and professionally.

71. Ethics in Expert Witness Testimony: Keep your ethical priorities in order. Attending to scientific and professional truths always comes before responsibility to the court, and these court obligations always precede responsibilities to retaining counsel and to protecting one’s self-esteem.
   a) Assume a special responsibility to be fair and accurate;
   b) Avoid partisan distortion or misrepresentation;
   c) Actively disclose all sources of information;
   d) Be prepared to distinguish between one’s own expert testimony and legal issues and facts.

72. Evasive Responses: Hopeless but Not Serious: In the normal and inevitable moments of feeling pulled toward evasiveness, concentrate carefully, and answer the difficult question.

73. Experience Does Not Count: Do not defend experience itself as proof of being accurate in forensic conclusions. Instead, report your career experience if asked and address the specific skills and means of reaching your conclusion.

74. Expert Witness as Master Teacher: Part of being a great witness is to be a great teacher on the witness stand, and being a great teacher is the result of concerted effort.
   a) Dynamic communication. Static presentation of findings leave to the jury and occasionally the judge the burden of making the content meaningful.
   b) Styles of relating on the stand that involve the audience. Some witnesses have the impact of a bag of concrete mix. They need other ingredients to be useful. Ineffective witness-teachers are so wrapped up in themselves and their results that they do not connect with the courtroom audience. Unwrapping one’s knowledge with the pleasure and adventure of unwrapping holiday gifts permits the jury to feel they are part of what is happening.
   c) Clear Communication. It is not necessary to employ the academic tool of using eight elegant words when one clear, simple word will do. If it is not understood, most of the time it will not be accepted. I say ‘most of the time’ because sometimes cases come up in which no juror can truly understand the complexity of the issues.
   d) Authenticity about who you are as a scientist or professional. Witnesses who are bad teachers strain to be something they are not, and find that courtroom pressures misshape them. For all of the above advice about what to do, the overriding rule is to seek ways to be on the witness stand that present you at your natural best.

75. Floccinaucinihilipilification: Anticipate cross-examination efforts to portray essential elements of your testimony as worthless.

76. For Better and Worse: Overprepare: As in marriage, personal complacency can keep you from coping effectively with courtroom strife.

77. Gender Labels: In the difficult moments in which women are patronized on the witness stand, they may gain control by restating their status as doctors without being strident and within the context of the questioning.

78. Illusory Documentation: Do not construct illusory support for opinions or methods and do not be intimidated by such illusory constructions by attorneys.

79. Inflamatory Questions: Inflammatory questions are best answered with calm explanations that demonstrate a confident sense of professional competence. Do not heat up on the stand.

80. Integrity Checks: Challenges to one’s impartiality may be addressed by having calculated (for intrinsic reasons) the percentage of times one’s expert opinions are contrary to those of retaining attorneys.

81. Internet Vulnerabilities: When confronted with your own fanciful and playful remarks, place them in context as fanciful and playful.

82. It Would Be So Nice If You Weren’t Here: Whether it indeed would be nicer if one were not on the stand comes powerfully from the sense of shunning imposed by the attorneys and the witness’s own internal self-
assessments. Our transient self-judgments in response can be shaped and aided by experience and successes.

83. Language: It’s a Virus: Listen well: To ward off language viruses, you need to be ‘much, much better’ at discerning meaning of words and phrases.

84. The Last Word: When the attorney comments on one’s testimony, having the ‘last word’ can empower the witness and reduce a sense of helplessness.

85. Lawyer Bashing: Avoid anti-lawyer jokes and quips on the witness stand. They are high-risk comments, to be reserved for rare and exactly fitting moments.

86. Lay Witnesses: Hostile attacks on one’s character are best met with clear affirmations of worth and restatements of the essential issues.

87. Offensive Language: Flagrantly offensive language never has to be met passively. Options include going to the judge, recording statement, confronting the speaker, consulting with colleagues, withdrawing from the case, or using the information as part of one’s testimony.

88. Personal Attacks: Scholarly preparation, composure, and negative assertions are preferred responses to personal attacks.

89. Practice Answers: Maintaining integrity on the stand calls for careful listening, avoidance of anticipatory answers, and staying faithful to your findings and knowledge.

90. Pulling and the Push-Pull: Pulling in a push-pull exchange is an art that requires non-defensive responding and meaningful practice.

91. Real and Apparent Ambiguities: Real ambiguities exist in understanding and interpreting behaviours of defendants and litigants. Opposing experts who disagree with you are not necessarily corrupt, dim or myopic.

92. Reconstructing Your Testimony: Assumptions about what and how you are communicating on the stand need to be checked and rechecked.

93. Shifts in Testifying and Consulting Expertise: Evaluating experts can legitimately give up their roles as expert witnesses to become jury or trial consultants, but should never assume both roles, or shift from jury or trial consultants to becoming testifying experts.

94. Silent Treatments: Silence becomes us when we are not intimidated by it in cross-examination and can use it comfortably toward our own effective testimony.
   a) Silences are not the opposite of speech, but rather the environment surrounding spoken language.
   b) Silences serve the function of contrast or emphasis of spoken language.
   c) Lengthy silences can be attention grabbing.
   d) Silence helps you put thoughts into words and to experience a greater awareness of yourself and the courtroom.
   e) Silence is a central part of turn-yielding behaviors and is part of turn-requesting in conversations as well.

95. Sleight of Hand: Witnesses are not obliged to answer all questions that appear to be related to their fields. Instead, witnesses need to attend to the direct applicability of the question and the extent to which the substance truly falls within their expertise.

96. Social Construction of Illnesses and Disorders: Psychological disorders and labels are socially constructed, and the prepared expert knows the nature and limits of the constructs.

97. Taints: Questions about allegations of misconduct should be met forthrightly, indignantly and openly.

98. Tape Recording of Evaluations: Evaluations that are tape-recorded may be useful for maintaining an accurate and accountable record of questions and statements of both examiners and subjects.

99. Telephone and Videotape Testimony: Rather than feeling dis-empowered by the absence of visual cues in telephone and videotape testimony, seek by practice and training to master your performance in the medium.
100. **To Cry, to Faint:** Address fears of crying and fainting on the stand by habituating to the courtroom, by drawing on an ally, by gaining perspective, and by calling for a break in your testimony, if necessary.

101. **Traps of Common Sense:** Do not be immediately agreeable to affirmation of common sense until you have thought through the specific meanings of the questions for your data, conclusions, and opinions.

102. **Trivial Pursuits:** Attorneys’ pursuit of trivial topics during depositions is neither a cause for catastrophizing nor concern. Answer without suspiciousness as much as you can without jeopardizing the limits of your expertise.

103. **Ultimate Opinion Testimony:** Ultimate issue testimony should be approached with caution and considered a rare event that is dependent on the situation.

104. **What I Don’t and Do Like to See in an Expert Witness:** Decide for yourself what it is you dislike in yourself as an expert and what you like. Then, take active steps to diminish the aspects that do not work and enhance the ones that do.