

# Examining

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## *Asylum Seekers*

*A Health Professional's Guide  
to Medical and Psychological  
Evaluations of Torture*

*Physicians for Human Rights*

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This manual has been created for professional use, to assist health practitioners in conducting evaluations of asylum applicants. It is not intended for general audiences because of the traumatic nature of the contents. It is important for any reader of this document to be prepared to process the strong emotional reactions that this material may evoke.

## **Physicians for Human Rights**

Physicians for Human Rights (PHR) promotes health by protecting human rights. PHR believes that human rights are essential for the health and well-being of all people.

Using medical and scientific methods, we investigate and expose violations of human rights worldwide and we work to stop them.

We support institutions to hold perpetrators of human rights abuses, including health professionals, accountable for their actions.

We educate health professionals and medical, public health, and nursing students and organize them to become active in supporting a movement for human rights and creating a culture of human rights in the medical and scientific professions.

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# PREFACE

This volume should not need to be written. It is a sad comment on human history that at the dawn of the 21<sup>st</sup> century, police, military, and security officials across the globe continue to inflict horrific pain and suffering on those in their custody.

From its beginnings 15 years ago, Physicians for Human Rights has campaigned to document, expose, prevent and punish the crime of torture. We have provided forensic evidence of deaths due to torture, we have examined survivors, we have studied and reported on the collusion of health professionals in the practice of torture, and we have advocated for justice and treatment for those who have suffered these inhumane and illegal acts.

Assuring the right of asylum is a crucial component of the ongoing campaign to abolish torture. Those who flee persecution and seek safe haven in the United States or elsewhere must have their trauma acknowledged and their rights guaranteed. Health professionals, working with lawyers, have enabled hundreds of torture survivors to make their claims. It is one important way to provide a measure of justice and give voice to the pain and indignity suffered by victims of human rights abuses.

This manual is dedicated both to those who survive torture, and to those who carefully attend to their needs. We publish it with the hope that in our time, its use will no longer be necessary.

Susannah Sirkin  
Deputy Director, Physicians for Human Rights

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Physicians for Human Rights wishes to acknowledge the editors, authors and participants who are responsible for the development of the *Manual on the Effective Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, also known as the “Istanbul Protocol.” Several chapters (III, IV and V) and appendices (II and III) in a *Health Professional’s Guide to Assisting Asylum Seekers* consist largely of excerpts from the Istanbul Protocol. The Protocol promises to serve as the international “gold standard” for medical legal documentation of torture and ill treatment. The conceptualization and preparation of the Istanbul Protocol was a collaborative effort between forensic doctors, physicians, psychologists, human rights monitors and lawyers working in Chile, Costa Rica, Denmark, England, France, Gaza, Germany, India, Israel, the Netherlands, South Africa, Switzerland, Turkey, and the United States. Although it is not possible to name each participant, special acknowledgement is due to the Istanbul Protocol project coordinators, Vincent Iacopino; Onder Özkalipici, M.D., Human Rights Foundation of Turkey, Istanbul; and Caroline Schlar, Action for Torture Survivors (HRFT), Geneva. Special acknowledgement

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# I. INTRODUCTION

Each year, thousands of people who have suffered from torture and other forms of ill treatment, at the hands of government officials or without government protection, flee their countries of origin and seek asylum in the United States. Asylum seekers and their attorneys face daunting challenges in negotiating the complex set of statutes, asylum evaluations regulations, and administrative and court decisions that comprise the general immigration laws in this country. Among the most sensitive of these are the legal requirements regarding proof of refugee status.

Health professionals can often provide critical documentation of torture and ill treatment that may be crucial in an asylum proceeding. This type of documentation involves a thorough clinical evaluation of an asylum seeker's physical and/or psychological health. Medical-legal documentation of torture and ill treatment requires a careful clinical history and examination by a health professional who is sensitive to cross-cultural issues and interpersonal dynamics between traumatized individuals and persons in positions of authority. The examiner should also be knowledgeable about the medical and psychosocial consequences of torture and violence.

*A Health Professional's Guide to Assisting Asylum Seekers* is a guidebook for physicians and mental health professionals seeking to develop the knowledge and skills needed to conduct clinical evaluations of asylum seekers and assess physical and psychological evidence of torture and ill treatment. Several sections of this guidebook are based on recent international guidelines for medical-legal documentation of torture that are contained in the *Manual on the Effective Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, or the "Istanbul Protocol." These include the sections 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.

The 1999 Istanbul Protocol was the first document to provide international guidelines for documentation of torture. The 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 representing 40 organizations and institutions from 15 countries. Its creation was spurred after a March 1996 international symposium titled "Medicine and Human Rights" at the Department of

Forensic Medicine at Cukurova University Medical Faculty in Adana, held by the Turkish Medical Association. In August of 1999, the Protocol was officially endorsed by the UN High Commissioner for Human Rights in Geneva, and in June 2001 it was published as a UN document.

*A Health Professional's Guide to Assisting Asylum Seekers* represents a detailed expansion of the segments of the Istanbul Protocol that deal specifically with health professionals' evaluations of asylum seekers. While the sections on evaluation procedures and evidence collection retain much of their original substance from the Istanbul Protocol, this Guide also provides extensive information about the legal framework in which the INS and the health professionals must work, detailed guidelines on providing testimony in court, and a number of sample medical and psychological affidavits that may serve as examples for potential evaluators. Where the Istanbul Protocol provides general principles for understanding and documenting torture, this Guide is intended for practical application by physicians and other health professionals planning to evaluate asylum seekers and requiring specific guidance for that task.<sup>1</sup>

## Overview of Torture

Among human rights abuses, torture is one of the most traumatic and destructive human experiences. Its deliberate purpose is to destroy not only the physical and emotional well-being of individuals but also, in some instances, the dignity and will of entire communities. It concerns all members of the human family because it impugns the very meaning of our existence and our hopes for a brighter future.<sup>2</sup> Although international human rights and humanitarian law consistently prohibit torture under any circumstance, torture and ill treatment are practiced in more than half of the world's countries.<sup>3,4</sup>

Torture, according to the United Nations Convention Against Torture

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<sup>1</sup> *Manual on the Effective Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, or the "Istanbul Protocol," Physicians for Human Rights, 1999. Further Information about the Istanbul Protocol: The Istanbul Protocol provides international guidelines on the assessment of individuals who allege torture and ill treatment, on the investigation of cases of alleged torture, and on reporting the findings of such investigations to the judiciary and any other bodies. These guidelines represent a consensus among clinicians working in the fields of human rights documentation and treatment of individuals who have been tortured. The documentation methods contained in the Protocol also apply to other contexts, including human rights investigations and monitoring, assessment of individuals seeking political asylum, the defense of individuals who "confess" to crimes during torture, and assessment of needs for the care of torture victims. In the case of health professionals who are coerced to neglect, misrepresent, or falsify evidence of torture, the Protocol also provides an international point of reference for health professionals and adjudicators alike. Copies of the Istanbul Protocol may be obtained via the Physicians for Human Rights web site ([www.phrusa.org](http://www.phrusa.org)) or on the United Nations Human Rights web site ([www.unhcr.ch](http://www.unhcr.ch)).

and Other Cruel, Inhuman or Degrading Treatment or Punishment is defined as “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.”

Another definition of torture frequently cited is that of the World Medical Association from the Declaration of Tokyo. In this Declaration, torture is defined as “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.”

Individuals subjected to torture may have been persecuted for a variety of reasons, either actual and imputed, including race, religion, nationality, membership in a particular social group or political opinion. Reported torturers often include police and national security officials, military personnel, and members of rival political organizations. Commonly reported forms of abuse include being severely beaten; subjected to electric shock; suspended or restrained in painful positions for long periods; disfigured with acid; burned; submerged in water or asphyxiated by other means; sexually assaulted; subjected to mock executions; and forced to witness the torture and execution of others, including family members.

Victims of torture often suffer from significant physical health consequences as a result of their abuse. Some of the physical manifestations of torture include broken bones, joint and muscle pain, headaches, dizziness, bumps and scars, neurological damage, such as hearing or vision loss and loss of sensation. Psychological and emotional sequelae of torture may include depression, memory disturbances, difficulty with concentration, lack of energy, social withdrawal, insomnia, flashbacks or phobias. Specific mental health disorders from which survivors of torture may suffer include Major Depression, anxiety disorders, and Posttraumatic Stress Disorder.

Physical signs of injury resulting from torture, such as scars or neurological findings, when present, provide important evidence of prior abuse. Many forms of torture, however, such as mock executions or electric

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<sup>2</sup> Iacopino V., “Treatment of Survivors of Political Torture Commentary,” *The Journal of Ambulatory Care Management*, 1998; 21(2):5-13.

<sup>3</sup> Amnesty International, Report 1999, London: AIP, June 16 1999.

<sup>4</sup> Basoglu M., “Prevention of Torture and Care of Survivors: An Integrated Approach,” *JAMA* 1993; 270:606-611.

shocks, may leave no physical marks. With other forms of abuse, such as beatings or even burns, the physical signs of injury may change over time. This is important because most medical evaluations of asylum applicants are conducted a considerable period of time after the alleged abuse. Thus, physical evidence may not be detectable even for the most experienced clinician. Psychological symptoms, on the other hand, when present, are often profound and enduring in nature, and therefore play a critical role in documenting evidence of torture.

While torture can have devastating health consequences, it is important to recognize that there is variability in the degree to which physical and psychological symptoms and findings occur in a particular individual. Individuals respond to and recover from traumatic events, including torture, in a variety of ways. While the presence of physical and psychological findings can provide important documentation of prior abuse, the absence of such findings does not mean the torture did not occur.

Individuals who fear persecution if forced to return to their countries of origin may seek asylum in the United States. The US law relating to refugees and asylum is part of the general immigration law which is set forth in a multitude of statutes, regulations, and administrative and court decisions and is enforced by officials of the Justice, State and Labor Departments. Even for a lawyer trained and experienced in immigration law, understanding these numerous sources of law and how they operate together can be difficult and frustrating.

The challenges facing asylum seekers and those who assist them have been dramatically increased by the 1996 enactment of the Illegal Immigration Reform and Immigrant Responsibility Act (the "1996 law"). The 1996 law has seriously undermined the ability of persecuted individuals to seek asylum in the United States by imposing a one-year filing deadline on asylum applications and an expedited removal procedure on asylum seekers who arrive without valid travel documents.

This chapter is intended not for lawyers representing refugees or asylum seekers, but rather for health care professionals and physicians examining or treating such individuals or consulting on their cases. The chapter, therefore, offers only an introduction to the relevant substantive and procedural legal issues involved in asylum cases and focuses on the role of health care professionals in those cases.

# II. U.S. ASYLUM LAW

Individuals who fear persecution if forced to return to their countries of origin may seek asylum in the United States. The US law relating to refugees and asylum is part of the general immigration law which is set forth in a multitude of statutes, regulations, and administrative and court decisions and is enforced by officials of the Justice, State and Labor Departments. Even for a lawyer trained and experienced in immigration law, understanding these numerous sources of law and how they operate together can be difficult and frustrating.

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## Background

US asylum law derives from international law. The United States is a signatory to the 1967 Protocol Relating to the Status of Refugees, and as such is bound by the provisions of the Protocol and the 1951 Convention Relating to the Status of Refugees. In 1980 the United States enacted the Refugee Act as part of the Immigration and Nationality Act in an attempt to conform to international standards, but later passed the oppressive 1996 law severely undermining the rights of asylum seekers who seek protection in the United States.

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<sup>5</sup> *INS v. Cardozo-Fonseca*, 480 U.S. 421 (1987).

<sup>6</sup> *Matter of Mogharrabi*, 19 I. & N. Dec. 439 (BIA 1987).

## **Asylum Standard and Relief Available**

The United States may, at its discretion, grant asylum to an individual who meets the “refugee” definition under US law. The definition requires the applicant to demonstrate unwillingness or inability to return to his/her home country due to past persecution or a well-founded fear of future persecution. This persecution must be based on one or more of the five grounds enumerated in the statute: race, religion, nationality, political opinion or membership in a particular social group. The definition of a refugee is set forth and explained in more detail later in this chapter.

The burden of proof lies on the applicant to establish eligibility for asylum. He/she must demonstrate that there is a “reasonable possibility” that he/she will face persecution upon return to his/her home country.<sup>5</sup> An applicant for asylum may establish that his/her fear is well-founded by showing that a reasonable person in his/her circumstances would fear persecution.<sup>6</sup> Unlike withholding of removal, discussed below, asylum may be denied a person in the exercise of discretion even if he/she has established eligibility for relief.

Asylum provides more permanent protection than withholding of removal. A person who is granted asylum, known as an asylee, may apply for permanent residence after one year and may eventually become a US citizen. An asylee may also bring his/her spouse and children to the United States.

## **Withholding of Removal Standard and Relief Available**

According to the Immigration and Nationality Act, the government may not remove a person to a country where his/her life or freedom would be threatened because of his/her race, religion, nationality, political opinion or membership in a particular social group. The applicant for withholding of removal must show a clear probability of persecution or, in other words, that it is more likely than not that he/she will be persecuted if returned to his/her home country.<sup>7</sup> This standard is more difficult to satisfy than the well-founded fear standard required for asylum.

While a grant of asylum is discretionary, a grant of withholding of removal is mandatory if the Attorney General determines that the applicant’s life or freedom would be threatened in that country. The grant of withholding of removal, unlike asylum, does not give the individual an automatic right to remain in the United States, nor may he/she apply for permanent residency or bring his/her spouse and children to the country. An individual granted withholding may be removed to a third country if he/she will not be at risk of persecution in that country and if that country is willing to accept him/her. He/she may also be held indefinitely in deten-

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<sup>7</sup>INS v. Stevic, 467 US 407 (1984).

<sup>8</sup>Immigration and Nationality Act (INA) § 101(a)(42)(A).

tion in the United States or sent to a third country. The relief granted under withholding of removal is generally the same as that accorded by the US regulations enforcing the United Nations Convention Against Torture, discussed at greater length later in this chapter.

## The “Refugee” Definition

### “Refugee”

The statutory definition of a “refugee” used in US law is derived from international law, and reads as follows:

*Any person who is outside any country of such person’s nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of that country, because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group or political opinion.*<sup>8</sup>

The core of the definition is its requirement that the applicant have suffered or fear persecution on account of one of the five protected grounds, i.e. race, religion, nationality, membership in a particular social group or political opinion. Each element of this requirement is discussed below.

The refugee definition was amended in 1996 to ensure protection for individuals fleeing coercive population control methods. The revised definition includes the following provision:

*For purposes of determinations under this Act, a person who has been forced to abort a pregnancy or to undergo involuntary sterilization, or who has been persecuted for failure or refusal to undergo such a procedure or for other resistance to a coercive population control program, shall be deemed to have been persecuted on account of political opinion, and a person who has a well-founded fear that he/she will be forced to undergo such a procedure or subject to persecution for such failure, refusal or resistance shall be deemed to have a well-founded fear of persecution on account of political opinion.*<sup>9</sup>

### “Persecution”

The concept of “persecution” is central to refugee law. In order to qualify for asylum, an applicant must demonstrate either past persecution or a well-founded fear of future persecution.

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<sup>9</sup> Id.

<sup>10</sup> Matter of Kasinga, Int. Dec. 3278 (BIA 1996).

<sup>11</sup> Pitchenkaia v. INS, 118 F.3d 641 (9th Cir. 1997).

<sup>12</sup> Fatin v. INS, 12 F.3d 1233 (3d Cir. 1993).

<sup>13</sup> US Dept. of Justice, Immigration and Naturalization Service, *The Basic Law Manual*.

While the term is not defined by statute, regulation or treaty, it is clear that persecution connotes the infliction of harm or suffering by a government or by persons a government is unwilling or unable to control.<sup>10</sup> Persecution does not require bodily harm or a threat to life or liberty<sup>11</sup>, but it also does not encompass all treatment that our society finds unfair, unjust or even unlawful or unconstitutional.<sup>12</sup>

Certain types of harm are so severe that they almost always constitute persecution. These include killing and torture, as well as other serious violations of basic human rights protected under international law. Thus, there is no question that persecution includes death, torture and other cruel and inhuman treatment, genocide, slavery and slave trade, and prolonged detention without notice of an opportunity to contest the grounds for detention.

Other conduct may contribute to an overall pattern of persecution, especially if it is cumulative. The following are examples of such conduct cited by the Immigration and Naturalization Service (INS) in its Basic Law Manual: arbitrary interference with a person's privacy, family, home or correspondence, relegation to substandard dwellings, exclusion from institutions of higher learning, enforced social or civil inactivity, passport denial, constant surveillance and pressure to become an informer.<sup>13</sup>

Because persecution depends on the particular circumstances of the case, no type of harm by a persecutor should be ruled out in assessing whether an applicant has suffered persecution. However, any potential persecution is only relevant to establishing refugee status if it is shown to be "on account of" one of the five enumerated grounds for asylum. For example, many women asylum seekers are rape survivors or survivors of domestic violence. While it would seem self-evident that these forms of gender-based violence would constitute persecution, the asylum seeker must be able to show that the violence she was subject to was on account of one of the five enumerated grounds and that the persecutor is the government or someone the government is unable or unwilling to control.

### *Past Persecution*

Past persecution is sufficient in and of itself to establish eligibility for asylum. Past persecution also creates a presumption that the applicant has a well-founded fear of future persecution. However, if the government can show that, since the time the persecution occurred, conditions in the applicant's home country have changed to such an extent that the applicant no longer has a well-founded fear of being persecuted, asylum may be denied. To avoid deportation in such a situation, known as "changed country conditions," the applicant must demonstrate compelling reasons for being

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<sup>10</sup> INS v. Cardozo-Fonseca, 480 US 421 (1987).

<sup>11</sup> Castillo v. INS, 951 F.2d 1117 (9th Cir. 1991); Mogharrabi, supra.

unable to return to his/her home country arising out of the severity of the past persecution. In past persecution cases, the testimony, by affidavit or in person, of a treating clinician or evaluator can be extremely influential. Expert testimony to the effect that the applicant experienced severe physical or psychological trauma, the effects of which are still prevalent, can help to convince a decision-maker of the appropriateness of a grant of asylum.

### *Well-Founded Fear of Future Persecution*

Regardless of whether the applicant has suffered past persecution, he/she can qualify as a asylee by establishing a well-founded fear of persecution in the future. In *INS v. Cardozo-Fonseca*, the Supreme Court declined to define “well-founded fear,” explaining that the term’s ambiguities should be worked out on a case-by-case basis. The Court noted that in some cases an applicant’s fear would be “well-founded” where there was as little as a 10% chance of the feared event’s taking place.<sup>14</sup> Subsequently, the courts have held that an applicant establishes a well-founded fear of persecution if he/she shows that a reasonable person in his/her circumstances would fear persecution.<sup>15</sup>

An applicant need not provide evidence that he/she has been specifically targeted for persecution in order to establish that his/her fear is reasonable. Rather, the applicant’s burden of showing that his/her fear of persecution is well-founded can be satisfied if:

- he/she establishes that there is a pattern or practice in his/her country of persecution of groups of persons similarly situated to his/her on account of race, religion, nationality, membership in a particular social group or political opinion; and
- he/she establishes his/her own inclusion in and identification with such group of persons such that his/her fear of persecution is reasonable.

### **The “On Account Of” Requirement**

An asylum applicant must also demonstrate that the persecution he/she suffered or fears is “on account of” his/her race, religion, nationality, membership in a particular social group or political opinion. This is also referred to as the “nexus requirement.” That means that the persecution must be motivated by one of those five characteristics. While an asylum applicant is not required to prove the exact motivation of his/her persecutor, he/she must “provide some evidence of it, direct or circumstantial.”<sup>16</sup>

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<sup>16</sup> *INS v. Elias-Zacarias*, 502 US 478 (1992).

<sup>17</sup> *Refahiyat v. INS*, 29 F.3d 553 (10th Cir. 1994).

<sup>18</sup> *Abedini v. INS*, 971 F.2d 188 (9th Cir. 1992).

<sup>19</sup> *Canas-Segovia v. INS*, 970 F.2d 599 (9th Cir. 1992).

## The Five Grounds for Asylum Eligibility

### *Race*

The term “race” in the refugee definition is usually interpreted in its widest sense to include all kinds of ethnic groups that are referred to as “races” in common usage. The INS, in its Basic Law Manual, cites apartheid in South Africa, the Holocaust and slavery as examples of persecution on the basis of race.

### *Religion*

Persecution on account of religion may assume various forms, including the prohibition of membership in a religious community, of worship in private or in public, of religious instruction, or serious measures of discrimination imposed on persons because they practice their religion or belong to a particular religious community. Mere membership in a particular religious community, however, will not normally be enough to make out an asylum claim.<sup>17</sup> Likewise, an applicant’s refusal to accept the religion of the government will not necessarily qualify him/her as a refugee.<sup>18</sup>

Conscientious objectors who refuse to perform military service for religious reasons and who are punished for their refusal to serve must show that the motivation of their persecutor was to harm them because of their religious beliefs and not just to punish them for not serving.<sup>19</sup>

### *Nationality*

Nationality refers both to citizenship and to membership in an ethnic or linguistic group and may overlap with race. Examples of persecution on account of nationality might include ethnic Albanians in Kosovo or ethnic Russians in the now independent republics of the former Soviet Union.

### *Membership in a Particular Social Group*

There is no clear definition of “membership in a particular social group.” Different courts have interpreted this phrase differently. The following are some of the suggested definitions:

- Persons of similar background, habits or social status;

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<sup>20</sup> Gebremichael v. INS, 10 F.3d 28 (1st Cir. 1993).

<sup>21</sup> In re H-, Int. Dec. 3276 (BIA 1996) (Somali clan).

<sup>22</sup> In re Kasinga, Int. Dec. 3278 (BIA 1996) (defining the applicable social group as “young women of the Tchamba-Kunsuntu tribe who have not had female genital mutilation (FGM), as practiced by that tribe, and who oppose the practice”); Fatin v. INS, 12 F.3d 1233 (3d Cir. 1993) (finding that gender meets the requirements of particular social group status, but that the applicant had not submitted sufficient evidence to make out a gender-based claim).

<sup>23</sup> In re Toboso-Alfonso, 20 I. & N. Dec. 819 (BIA 1990).

<sup>24</sup> Sangha v. INS, 103 F.3d 1482 (9th Cir. 1997); Bolanos-Hernandez v. INS, 767 F.2d 1277 (9th Cir. 1985).

- Persons who share a common, immutable characteristic;
- Persons closely affiliated with each other, who are actuated by some common impulse or interest; and
- Persons who possess some fundamental characteristic in common which serves to distinguish them in the eyes of the persecutor – or in the eyes of the outside world in general.

The following groups are some of those that have been recognized by the courts in social group claims: members of a family<sup>20</sup> members of a tribe or clan,<sup>21</sup> gender-based social groups,<sup>22</sup> and people of a common sexual orientation.<sup>23</sup>

### *Political Opinion*

A person may express his/her political opinions through actions, as well as through words. Whether or not a person views him/herself as a political “dissident” or a “resister,” he/she may still be able to make an asylum claim based on political opinion if his/her views run contrary to those of the government or someone the government is unable or unwilling to control. Several federal courts have recognized that neutrality resulting from conscious choice qualifies as political opinion. Neutrality that results from apathy, ignorance or indifference does not.<sup>24</sup>

Individuals may also be persecuted for political opinions they are erroneously believed to hold. Such an “imputed” political opinion can satisfy the requirement of persecution on account of political opinion.<sup>25</sup> Imputed political opinion issues often arise in the context of families; that is, members of a government may wrongly assume that all members of a family hold the same beliefs.

Additionally, the statutory definition of refugee now states that persons who have suffered or who fear persecution for resistance to coercive population control measures have a well-founded fear of persecution on account of their political opinion.

## **Ineligibility for Asylum and Withholding of Removal**

### *Asylum – Discretionary Denials*

In addition to meeting the requirements of the refugee definition (i.e., that he/she has suffered past persecution or has a well-founded fear of persecution on account of one or more of the five enumerated grounds), the asylum applicant has the burden of establishing that the favorable exercise of discretion is warranted in his/her case. The Board of Immigration Appeals has held that the totality of the circumstances and the actions of

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<sup>25</sup> *Singh v. Ilchert*, 69 F.3d 375 (9th Cir. 1995); *Matter of S-P*, Int. Dec. 3287 (BIA 1996).

<sup>26</sup> *Matter of Pula*, 19 I. & N. Dec. 467 (BIA 1987).

<sup>27</sup> “An alien is considered to be firmly resettled if, prior to arrival in the United States, he/she entered another nation with, or while in that nation received, an offer of permanent resident status, citizenship or some other type of permanent resettlement.” 8 CFR § 208.15.

the applicant should be examined in determining whether a favorable exercise of discretion is warranted.<sup>26</sup>

Factors of particular importance in the analysis are: (1) whether the applicant engaged in fraud to circumvent orderly refugee procedures; (2) commission of a crime that is not a bar to asylum but is still a negative factor; and (3) general humanitarian considerations, such as age, health and the severity of past persecution. A health professional's testimony regarding the applicant's continued physical and psychological problems attributable to his/her persecution can be enlightening to the decision-maker.

### *Statutory Bars to Asylum and Withholding of Removal*

An applicant may be barred from receiving asylum and/or withholding of removal due to the existence of one or more disqualifying grounds. These grounds include: commission of a particularly serious crime, participation in the persecution of others, danger to the security of the United States and firm resettlement in another country before coming to the United States.<sup>27</sup>

## **Meeting the Burden of Proof and Credibility Issues**

### *Burden of Proof*

As explained above, the burden of proof is on the applicant for asylum to establish that he/she meets the definition of a refugee. The asylum applicant must meet this burden by demonstrating that he/she has suffered past persecution or has a well-founded fear of future persecution. The applicant for asylum must demonstrate that a reasonable person in his/her circumstances would fear persecution on account of one of the five enumerated grounds if returned to his/her home country.

A complete application for asylum includes the INS application (Form I-589), a sworn affidavit or declaration and corroborating evidence. Corroborating evidence might include: (1) personal documents relating to the applicant's claim, e.g., a document showing that he/she was a member of a particular political party; (2) evidence of human rights conditions in the country of origin, such as newspaper articles, reports from human rights organizations, and expert testimony; and (3) testimony of a health care professional.

Where there is other corroborating evidence available which could bolster the applicant's claim, it is becoming more and more frequent that a court will require that he/she submit it, or provide a reasonable explanation for the failure of production.

### *Credibility of Applicant's Testimony*

The primary source of evidence in an asylum application is the applicant's own statements, conveyed in the asylum application (Form I-589) and a

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<sup>28</sup> Matter of Y-B-, Int. Dec. 3337 (BIA 1998).

sworn affidavit or declaration as well as in person at the interview or hearing. International standards emphasize the special weight that must be given to the applicant's testimony, since it is often the only evidence he/she can produce.

According to the Justice Department and the courts, the testimony of an asylum applicant, if credible, may be sufficient to sustain the applicant's burden of proof without corroboration, if the testimony is believable, consistent and sufficiently detailed to supply a plausible and coherent account of the basis of the fear. An applicant, however, cannot meet his/her burden of proof by presenting general or meager testimony.<sup>28</sup>

Credibility of written testimony may not be sufficient to establish a right to asylum. A particularly disturbing line of recent decisions by the US Board of Immigration Appeals has called for increasing amounts of documentation to be submitted by asylum seekers – documentation that is often impossible for genuine refugees to produce.

Another problem for victims of torture or other severe trauma is that they may be poor witnesses for themselves. Their shame and humiliation, anxiety, memory impairments and/or lack of trust can lead to confusion and inability to recall times, dates and events. Lack of emotional affect may also make their testimony seem unconvincing to those who are unfamiliar with the behavior of torture survivors. Testimony from health care professionals is particularly critical in such cases.

## **US Asylum Procedure**

### **One-Year Filing Deadline**

As a result of the 1996 Law, all asylum applications must be filed within one year of the applicant's arrival in the United States. There are, however, two exceptions to the one-year filing deadline. An application filed beyond the one-year deadline may be considered if the applicant demonstrates either: (1) the existence of changed circumstances which materially affect the applicant's eligibility for asylum; or (2) extraordinary circumstances relating to the delay in filing the application within the one-year period.<sup>29</sup>

Changed circumstances may include changes in conditions in the applicant's home country, such as a coup d'état or natural disaster, or changes in objective circumstances relating to the applicant in the United States, such as changes in the applicable US law. Extraordinary circumstances include, but are not limited to, serious illness or mental or physical disability of significant duration during the one-year period after arrival or ineffective assistance of counsel.

The latter exception may be granted, for example, to a victim of torture who suffers from Posttraumatic Stress Disorder or other effects of abuse.

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<sup>29</sup> 22 CFR § 41.101.

In such cases, a medical professional's affidavit describing the applicant's physical or mental health, and how his/her ability to prepare an asylum application was impeded by the effects of the abuse, may be helpful.

Therefore, an asylum seeker who has already been in the United States more than one year and has not filed for asylum may still be eligible. However, it is critical that he/she obtain a lawyer's assistance in preparing his/her application, and he/she should be urged to do so immediately. There is no one-year filing requirement for withholding of removal or relief under the Torture Convention.

### **The Affirmative Asylum Process**

The affirmative application process is available to individuals who are physically present in the United States and who have not been detained by the INS. Affirmative applicants file an application with the INS. They are then interviewed in a "non-adversarial" setting by an INS asylum officer. Applicants are allowed legal representation; however, the lawyer is not generally permitted to speak during the interview. The lawyer is given time to ask clarifying questions of the applicant or to make a closing statement at the end of the interview.

Although the asylum interview is not supposed to be adversarial, it can still be a very difficult experience for the applicant, particularly for a torture survivor. Asylum officers often ask extremely detailed questions about very personal experiences and some officers lack sensitivity in their manner of questioning. Applicants should be aware of this in advance and should be prepared for the difficulties of the interview. Interviews may be as short as 45 minutes in duration, but can extend to 1.5 hours or longer.

On some occasions, the asylum seeker's counsel may call upon the medical professional to testify in person when an asylum seeker's case is before the asylum office. Although asylum officers generally only want to speak with the applicant him/herself, in some cases, the asylum seeker's counsel may believe that it is important to have the medical professional actually come to the asylum office interview. For example, the medical professional might be needed if the asylum seeker is still suffering from the effects of the torture and has difficulty remembering details or will be better able to discuss his/her case if the medical professional is present. The medical professional might also be needed if his/her evidence is a particularly important aspect of the case.

Within a few weeks after the interview, the asylum officer will send a decision to the applicant or the applicant will return to the asylum office to pick up the decision. The decision will be either a recommended grant of asylum (pending fingerprint and security checks) or a "referral" to an immigration judge for adjudication in removal proceedings. A referral means that the INS will now seek to remove the applicant from the United States and an immigration judge will decide whether to remove him/her.

## Immigration Court Proceedings

There are many ways to have one's case end up in immigration court, but there are three principle groups of individuals who appear in immigration court for the adjudication of their asylum claims: 1) affirmative applicants whose cases were not granted by the asylum office and were instead "referred" by the asylum officer to immigration court; 2) arriving asylum seekers who are detained pursuant to expedited removal/credible fear procedures discussed below; and 3) those arrested by INS who are applying for asylum for the first time in immigration court.

These individuals must make their cases before an immigration judge in an adversarial setting. The merits hearing, as well as other evidentiary hearings on applications for asylum, are open to the public, unless the applicant requests that they be closed. During the hearing, the applicant will be examined under oath and may present evidence or witnesses on his/her own behalf. Witnesses may include experts on the applicant's country of origin or medical professionals who have examined or treated the applicant in connection with his/her persecution. The applicant has the right to an interpreter if he/she cannot speak English fluently.

As in the case of the asylum interview, testifying before an immigration court can be a very difficult and frightening experience for an asylum seeker. The applicant is subject to cross-examination about the persecution he/she suffered, and may be questioned in excruciating detail. His/her credibility may also be challenged by introduction of evidence of his/her "prior statements," e.g., statements made to INS officials upon arrival at the airport. The applicant may be questioned by the immigration judge as well as the INS trial lawyer.

Increasingly, immigration judges are requesting that medical professionals testify at hearings, in addition to providing written affidavits. In some cases, immigration judges have declined to consider critical evidence included in the medical professional's affidavit if the professional was not also present at the hearing and available for cross-examination by the INS trial attorney. This approach is widely considered inappropriate by medical professionals, most of whom perform these services for indigent asylum seekers on a *pro bono* basis. Some immigration judges have permitted medical professionals who are not otherwise available to testify by telephone; others have not. While it is often difficult for medical professionals with already hectic schedules to make time to testify at hearings, their evidence is crucial and can often make the difference between the grant and denial of asylum for a torture survivor.

In preparing to testify, the medical professional should work closely with the asylum seeker's attorney and discuss not only the direct testimony that will be covered, but also the cross-examination questions that the INS trial attorney may ask. One typical area for cross-examination is the health care professional's qualifications. For instance, an INS trial attorney

ney might object that the professional does not specialize in the area of torture survivors. The applicant's attorney would then question the professional about his/her qualifications and related experiences, including work with victims of trauma, training and any prior experience working with torture survivors. The attorney might also explain, for example, that, given the professional's credentials, he/she is quite able to confirm a fracture or describe a scar.

## **Appeal**

The applicant has a right to appeal an adverse decision to the Board of Immigration Appeals (BIA). He/she must file a notice of appeal which the BIA must receive within thirty days of the negative decision of the immigration judge. The filing of a notice of appeal automatically "stays" the deportation order which means the applicant will not be deported while his/her appeal is pending at the BIA. It may be as long as one or more years before the applicant's appeal is decided, due to a backlog of cases before the BIA; however, detained cases move less slowly.

If the BIA denies the claim, the final step is an appeal to the federal Circuit Court of Appeals for the jurisdiction where the immigration court hearing was held.

## **IIRIRA: Expedited Removal, Credible Fear & Detention**

As noted above, the 1996 law, which went into effect on April 1, 1997, significantly changed numerous aspects of asylum law and procedure in the United States.

### *Expedited Removal*

One of IIRIRA's most controversial provisions established what is known as "expedited removal." It is a summary exclusion procedure which allows the government to remove a non-citizen who arrives at an airport or other port of entry with false documents or no documents. Many genuine refugees have no choice but to flee without valid travel documents. The decision to deport an arriving non-citizen in this type of situation is left to immigration officials working at the airports or other ports of entry.

When an asylum seeker informs the immigration official at the airport that he/she is fleeing persecution or seeking asylum, he/she is referred to a second immigration official who conducts the secondary inspection. This low-level INS official can order the person deported, subject only to a supervisor's approval. There is no further review of the secondary inspector's removal order. No judge or other government official reviews the decision to deport, and such an order carries with it a five-year bar to reentry in the United States.

The secondary inspector is required by law to refer anyone who claims either an intent to apply for asylum or a fear of persecution to the next

stage of the process, specifically the credible fear interview which is discussed below. If the secondary inspector neglects to do so, the asylum seeker has no recourse.

Reports indicate that refugees have been treated improperly during secondary inspection. Immigration officers have reportedly intimidated asylum seekers by shouting at them, making racially derogatory comments and threatening them with imprisonment and/or deprivation of food. These initial interviews are often held in public and sometimes without adequate interpreters to assist in the interview process. Women asylum seekers who are rape survivors, for example, may not feel comfortable recounting such a personal tragedy in a public place to a male official of the US government.

### *Credible Fear Interview*

Credible fear interviews generally take place at INS detention facilities within a few days of the asylum seeker's arrival in the United States. Credible fear is defined as "a significant possibility, taking into account the credibility of the statements made by the (individual) in support of (his/her) claim and such other facts as are known to the officer, that (the individual) could establish eligibility for asylum."<sup>30</sup>

The credible fear interview is often difficult for asylum seekers who arrive traumatized and unable to speak English. The process moves so quickly that it is impossible for most asylum seekers to be represented during the credible fear interview process. Asylum seekers also may not understand the process or why they are being questioned about their persecution and fears of return.

If any applicant does not pass the credible fear interview, he/she may request review of that determination by an immigration judge to present his/her claim for asylum. The review is to be conducted within one to seven days of the negative credible fear determination. This, unfortunately, does not give the applicant sufficient time to locate counsel or additional evidence.

Once an individual is found to have a "credible fear of persecution," he/she is referred for a full hearing before an immigration judge. While awaiting that hearing, he/she will generally be detained at either an INS detention facility or at a state or county prison.

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<sup>30</sup> 8 U.S.C.A. § 1225(b)(1)(B)(v).

<sup>31</sup> See generally Somini Sengupta, "Limits on Parole Dash Refugees' Hopes," *N.Y. Times*, Nov. 2, 1998, at B3; Michael Huspek, "The INS's Futile Detention Practices," *San Diego Union-Tribune*, October 7, 1998, at B9.

<sup>32</sup> See generally Human Rights Watch, United States: *Locked Away, Immigration Detainees in Jails in the United States*, Sept. 1998; Kerwin, Donald M. & Wheeler, Charles "IIRIRA's Detention Mandates: An Exercise in Overkill," *75 Interpreter Releases*, 1433 Oct. 19, 1998.

### *Detention*

The practice of detaining arriving asylum seekers expanded dramatically in the 1980's, and was reinforced by the restrictive provisions of the 1996 law. The expedited removal provisions of that law have led to the widespread detention of asylum seekers who arrive in the United States without valid travel documents from their countries of origin.

According to the law, those who establish a credible fear of persecution are eligible for parole. Nonetheless, most asylum seekers are held in detention for months, or even years, while their cases are being decided.<sup>31</sup> Numerous recent reports by human rights organizations have described the inhumane conditions and treatment in the detention centers.<sup>32</sup> In particular, concerns about lack of medical care and inadequate food and recreation have received substantial media attention recently.

Women detainees make up only seven percent of the detention population and, as a result, their needs are frequently neglected. Women asylum seekers receive fewer vital services than their male counterparts; they are sometimes denied English classes, interpreters and even adequate medical attention, particularly gynecological care.<sup>33</sup>

### **The United Nations Convention Against Torture**

In 1994, the United States ratified the United Nations Convention Against Torture, which prohibits the removal of an individual to another country where he/she would be tortured. Five years later, the Department of Justice finally published regulations implementing the Convention. These regulations went into effect on March 22, 1999, and they provide an alternate form of relief to those asylum seekers in immigration court proceedings. No relief is available, however, to affirmative asylum applicants at the asylum office stage of their application.

A person granted relief under the Torture Convention may not be removed to a country where he/she is likely to be tortured. Torture under the Torture Convention is defined broadly, and unlike asylum or withholding of removal, there are no bars to protection under the Torture Convention and there is no requirement that the torture be on account of race, religion, nationality, membership in a particular social group or political opinion. However, relief under the Torture Convention is not as favorable a form of relief as a grant of asylum. An individual granted relief under the Torture Convention may, at the discretion of the INS, be held indefinitely in detention, and he/she will not be eligible to apply for permanent residency or US citizenship.

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<sup>33</sup> Gini Sikes, "Why Are Women Who Escape Genital Mutilation Being Jailed in America?," *Marie Claire*, May 1998.

# III. GENERAL INTERVIEW CONSIDERATIONS

## Introduction

When an allegedly tortured person is interviewed, a number of issues and practical factors should be taken into consideration. These general considerations apply to all health professionals carrying out interviews, whether they are medical doctors, psychologists, or other clinicians. The following section addresses this “common ground” and includes the purpose of the examination, the refugee experience, preparing for the interview, issues of establishing rapport and earning trust, techniques of questioning, taking and assessing the history, the use of interpreters, gender issues, taking photographs, making referrals, and the risk of retraumatization for the interviewee.

Interviews in which a torture victim recounts the events of his/her abuse are often extremely stressful and potentially traumatic for the victim. Listening to accounts of torture/trauma can be very stressful for the interviewer as well. Consequently, it may take several sessions with a survivor of torture/ill treatment to establish rapport and elicit a thorough and complete history. For logistical reasons, however, this may not be feasible.

It is important to keep in mind that there is often variability in the amount and detail of information that an individual will recall with regard to the events of the trauma. This is often the case when an individual was subjected to repeated episodes of torture/abuse. Furthermore, individuals may have been detained under conditions in which they lose a sense of time/place, for example, being kept blindfolded or held in solitary confinement in a dark cell, or were in a very weakened state as a result of being deprived of food, water or sleep. Furthermore, interviewers should use judgment about how much specific detail is needed to document the alleged abuse. For example, if someone was repeatedly tortured or raped, it is not necessary, nor perhaps appropriate, to try to elicit all of the details about every single episode.

There is also variability with regards to the degree of physical and psychological signs, symptoms or consequences which a survivor of torture/ill treatment will manifest. Similarly, there is variability in the manner in which survivors of torture conduct themselves in interviews in recounting the events of their abuse. For example, some survivors may react with great emotion and frequently become tearful. Others may appear

extremely calm or detached, describing the events as if they had happened to someone else.

### **Purpose of Inquiry, Examination and Documentation**

The broad purpose of the medical evaluation of asylum applicants is to establish the facts relating to alleged incidents of torture and evaluate and document corroborating physical and psychological evidence of the torture. The purpose of the written or oral testimony of the clinician is to provide expert opinions on the degree to which medical findings correlate with the applicant's allegation of abuse and to effectively communicate the clinician'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 community on the physical and psychological sequelae of torture. The examiner should be prepared to do the following:

- Elicit a thorough history of the torture and related traumatic events;
- Assess asylum applicants for possible injuries and abuse;
- Document physical and psychological evidence of injuries and abuse;
- Correlate the degree of consistency between examination findings and specific allegations of abuse by the applicant;
- Correlate the degree of consistency between medical examination findings and the statements of an individual with specific knowledge of torture methods used in a particular region and their common after-effects;
- Render expert interpretations of the findings in medical-legal evaluations and provide expert opinions regarding possible causes of sequelae in asylum hearings; and
- Utilize information obtained in an appropriate manner to enhance fact-finding and further documentation of torture.

Asylum evaluations should be conducted by licensed clinicians. An asylum applicant's primary symptoms and the availability of examiners often determines whether the examination is conducted by a medical doctor, such as a primary care physician (e.g., internist, family practitioner) or a specialist (e.g., gynecologist, dermatologist, neurologist); and/or a mental health professional (e.g., psychiatrist, psychologist, social worker).

Assessments of physical and psychological evidence of torture and ill treatment may be conducted by one or more clinicians depending on their qualifications. With adequate training, a physician may qualify as an expert on both physical and psychological evidence of torture. For example, it is certainly appropriate for a primary care physician to evaluate

physical findings as well as common mental health problems, such as anxiety and depression. Whenever possible, interviewers should be prepared to comment on both the physical and psychological findings.

Medical evaluations of asylum applicants should be conducted with objectivity and impartiality. The evaluations should be based on the health professional'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 asylum applicants 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 applicant was allegedly tortured and should be familiar with the common after-effects of torture. Physicians for Human Rights and other medical and human rights organizations sponsor trainings on methods of documenting torture.

The health professional should not assume that the individual requesting a medical-legal evaluation, such as the asylum applicant or his/her attorney, has related all of the material facts. It is the clinician's responsibility to discover and report any material findings that he/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 medical-legal report under any circumstance.

## **The Refugee Experience**

In order to better appreciate the asylum seeker's perspective, it may be helpful to reflect on experiences that are common among asylum seekers. Although asylum seekers come from all parts of the world, they often share some of the following characteristics:

- They have migrated to the host country looking for a safe haven because they have a reasonable fear of being arrested, persecuted, tortured or even killed if they return to their countries of origin.
- They often have a history of discrimination that may be associated with poverty, chronic unemployment, low levels of education, and illness due to a lack of access to medical care.
- They may be additionally traumatized by the emigration process, especially those who enter the host country unlawfully. The journey may have taken several days or months, perhaps through jungle, desert, or combat zones in countries torn by civil war, often without any means of support.

- They may have crossed dangerous seas in small boats with little food or water, risking attack by pirates. Many are assaulted, beaten, robbed or raped in the course of their journey, and people they know and love may have died or been killed or abused along the way. Many asylum seekers have been detained by immigration authorities and kept in custody in detention facilities in the United States or in other countries along the way for several days, months or years.
- Most asylum seekers are considered “illegal aliens” by host countries and therefore can not work legally and support themselves and their families. Although many may have been technicians or professionals in their countries of origin, they usually work in positions below this level of expertise in the host country, if they are able to work at all.
- They may live in poor neighborhoods, sometimes in areas with high levels of crime and racial tension in which they may become victims of crime. They may have to change dwellings frequently, and some are homeless.
- Often they have emigrated alone because of the need for a rapid departure, thus leaving the nuclear and extended family in their countries of origin.
- They have migrated to a country with a culture and language unknown to them.
- The host country, in some cases, may have supported and trained the regime that is responsible for the applicant’s torture. The applicant may experience intense fear about being targeted by people within the host country who are linked to the group that tortured him/her.

These and other factors may be superimposed on the history of torture that may be conveyed in the course of an asylum evaluation. The resettlement and survival issues, such as those mentioned above, may be of more immediate concern than the torture story and its aftermath.<sup>34</sup> In fact, obtaining political asylum for survivors of torture may be the single most important intervention because political asylum often represents:

- Security: Obtaining asylum enables survivors of torture to live without fear of being detained and tortured again.
- The possibility of family reunion: Typically, the family unit is the most important social support for a refugee. The nuclear family will generally be permitted to migrate to the host country.

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<sup>34</sup> Quiroga, J. & Gurr, R., *Approaches to Torture Rehabilitation: A Desk-Study, Covering Effects, Cost Effectiveness, Participation and Sustainability*; Danida, Danish Government, 1998.

- **Permission to work:** The individual can obtain a living wage to support his/her family after he/she is granted asylum.
- **New opportunities:** Individuals have the opportunity to rebuild their lives in the host country.
- **Some vindication of their moral position and recognition of the legitimacy of their suffering.**

## **Preparation for the Interview**

In preparation for the interview, it is useful to review appropriate documents/affidavits that the asylum applicant's attorney may have prepared. Adequate time should be set aside for conducting the interview, particularly if an interpreter is required. One should also try to anticipate and when possible address potential barriers to effective communication that could drastically influence the value and/or process of an interview. Possible barriers to communication include:

- **Environmental barriers**, such as lack of privacy or a comfortable interview setting, inadequate time for the interview;
- **Physical barriers**, such as pain or other discomfort the individual may be experiencing as a result of his/her abuse: for example, physical pain, difficulty sitting for extended periods, fatigue, sensory deficits such as blindness or deafness;
- **Psychological barriers**, such as fear or anxiety, mental health disorders, such as depression, Posttraumatic Stress Disorder, or cognitive deficits; and
- **Sociocultural barriers**, such as the gender of interviewer (particularly important with victims of sexual assault) and language issues including sensitivity and accuracy of interpreter.

## **Establishing Rapport and Earning Trust**

Establishing rapport with the asylum seeker is essential for conducting an effective and complete evaluation. The clinician should introduce the interview process in a manner that explains in detail the procedures to be followed (i.e., questions will be asked about medical psychosocial history including history of torture and current physical and psychological functioning) and that prepares the individual for the difficult emotional reactions that the questions may elicit. Priorities should be negotiated. For example, issues regarding time limitations should be clarified. Detecting and addressing barriers to communication before the beginning of the interview is important. (See above.)

The individual needs to be given the opportunity to request breaks, interrupt the interview at any time, and be able to leave if the stress level becomes intolerable, with the option of a follow-up appointment. Clinicians need to be sensitive and empathic in their questioning while remaining objective in their clinical assessment. At the same time, the interviewer should be aware of potential personal reactions to the survivor and the descriptions of torture that might influence his/her perceptions and judgments.

The interview process may remind the survivor of being interrogated during torture. Therefore, strong negative feelings toward the clinician may be evoked such as fear, rage, revulsion, helplessness, confusion, panic and hatred. The clinician should allow for the expression and explanation of such feelings and express understanding for the individual's difficult predicament.

The location of the interview and examination should be as safe and comfortable as possible. A two to four hour interview may not be sufficient time to conduct an evaluation of either physical or psychological evidence of torture. Furthermore, situation-specific variables such as the dynamics of the interview, feelings of powerlessness in the face of having one's intimacy intruded upon, fear of future persecution, shame about the events, and survivor guilt may simulate circumstances of a torture experience. This may enhance the patient's anxiety and increase his/her resistance to disclosure of relevant information. A second, and possibly a third, interview may need to be scheduled to complete the evaluation.

Trust is an essential component for 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, courteousness 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 be revealing for the first time. In addition to providing a comfortable setting, adequate time for the interviews, refreshments and access to toilet facilities, the clinicians should explain what the patient can 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 developed); and the clinician should acknowledge the patient's freedom to take a break if needed or to choose not to respond to any question he/she may not wish to answer.

Health professionals and interpreters have a duty to maintain confidentiality of information and to disclose information only with the patient's consent. Each asylum applicant should be examined individually, in private. He/she should be informed of any limits on the confidentiality of the evaluation that may be imposed by state or judicial authorities. The purpose of the interview needs to be made clear to the applicant. 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 person has the right to refuse the evaluation. In such circumstances, the clinician should document the reason(s) for refusal of an evaluation.

Asylum applicants 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 health professionals 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 applicant.

## **Techniques of Questioning**

Several basic rules must be respected during the interview:

- Information is certainly important, but the well-being of the person being interviewed is more important;
- Listening is more important than asking questions;
- To the asylum applicant, it may be more important to talk about family than to talk about torture. This should be duly considered, and time should be allowed for some discussion of personal matters;
- Torture, particularly sexual torture, is a very intimate subject, and may not come up before a follow-up visit - or even later. Individuals should not be “forced” to talk about any form of torture if they feel uncomfortable about it;
- Whenever possible, one should utilize open-ended questions (e.g., “Can you tell me what happened?”; “Tell me more about that”) and allow the individual to tell his/her story with as few interruptions as possible. This may result in a more accurate and detailed disclosure of information than moving too quickly to a rapid-fire form of questioning, which may, in fact, mimic interrogation. Further details can be elicited with appropriate follow up questions.

## **Taking the History**

### **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 he/she thinks he/she was detained and tortured.

### **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.

### **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 operated by different security/police/armed forces, and clarifying what events happened in which places may help give 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.

### **Circumstances of Detention(s)**

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.

### **Prison/Detention 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 other people can corroborate the asylum seeker's 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, presence of others, 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?

### **Methods of Torture and Ill Treatment**

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 person.

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?
- Were you blindfolded?
- 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/changes 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 and 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 the condition of the person at the end of the "session." Could he/she walk? Did he/she have to be helped or carried back to the cell? Could he/she get up the next day? How long did the feet stay swollen? These elements give a certain completeness to the description, which a "check list" of torture methods does not.

For positional torture, the history should include the date(s), how many times, and for how many days the torture lasted, the period of each episode, the style of the suspension (reverse-linear, being covered by thick cloth-blanket, being tied directly by a rope, putting weight on the legs or pulling down), or other position. In suspension torture, ask what sort of material was used (rope, wire and cloth leave different marks, if any, on the skin after suspension). The examiner must remember that statements of the length of the torture session by the torture survivor are subjective and may not be correct, since disorientation of time and place during torture is a generally observed finding.

Was the person sexually assaulted in any manner? Elicit what was said during the torture. For example, during electric shock torture to the genitals perpetrators often tell their torture victims that they will no longer have normal sexual function, or something similar.

After eliciting a detailed narrative account of events, it is advisable to review other possible torture methods. It is essential for the interviewer to learn about regional practices of torture so that he/she can be alert for hints of abuses the applicant may have suffered, but has not related. Questioning about specific forms of torture is helpful when:

- Psychological symptoms cloud recollections;
- The trauma was associated with impaired sensory capabilities;
- The survivor may have suffered organic brain damage due to torture; or
- There are mitigating educational and cultural factors.

The distinction between physical and psychological methods is obscure. For example, sexual torture generally causes both physical and psychological symptoms, even when there has not been any physical assault. The list of torture methods provided below shows some of the categories of abuse possible. It 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 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. Torture methods to consider include, but are not limited to:

- Blunt trauma: punch, kick, slap, whips, wires, truncheons, falling down
- Positional torture: suspension, stretching limbs apart, prolonged constraint of movement, forced positioning
- Burns: cigarettes, heated instrument, scalding liquid, caustic substance
- Electric shock
- Asphyxiation: wet and dry methods, drowning, smothering, choking, chemicals
- Crush injuries: smashing fingers, heavy roller to thighs/back
- Penetrating injuries: stab and gunshot wounds, wires under nails
- Chemical exposures: salt, chili, gasoline (in wounds, body cavities)
- Sexual: violence to genitals, molestation, instrumentation, rape
- Traumatic removal of digits and limbs
- Medical: amputation of digits or limbs, surgical removal of organs
- Pharmacologic torture: toxic doses of sedatives, neuroleptics, paralytics, etc.

Conditions of detention:

- Small or overcrowded cell
- Solitary confinement
- Unhygienic conditions
- No access to toilet facilities
- Irregular and/or contaminated food and water
- Exposure to extremes of temperature
- Denial of privacy

- Forced nakedness
- Deprivations:
  - Of normal sensory stimulation, such as sound, light or sense of time via hooding, isolation, manipulating brightness of the cell
  - Of physiological needs: restriction of sleep, food, water, toilet facilities, bathing, motor activities, medical care
  - Of social contacts: isolation within prison, loss of contact with outside world (victims often are kept in isolation in order to prevent bonding and mutual identification and to encourage traumatic bonding with the torturer)
- Humiliations: verbal abuse, performance of humiliating acts
- Threats: of death, harm to family, further torture and/or imprisonment, mock executions
- Threats of, or arranging conditions for attacks by animals such as dogs, cats, rats, and scorpions
- Psychological techniques to break down the individual: forced “betrayals,” learned helplessness exposure to ambiguous situations and/or contradictory messages, etc.
- Violation of taboos (e.g., forced sexual intercourse between family members, forced removal of one or more articles of clothing, cutting of a Sikh man’s hair)
- Behavioral coercion
- Forced to engage in practices against one’s religion (e.g., forcing Muslims to eat pork)
- Forced to harm others: e.g., the torture of others or other abuses
- Forced to destroy property
- Forced to betray someone by placing him/her at risk for harm
- Forced to witness torture or atrocities being inflicted on others

### **Review of Symptoms**

Obtain a detailed review of physical and psychological symptoms and disabilities at the time of the abuse, subsequently and up to the present time. All complaints of the torture survivor 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 associ-

ated with specific forms of abuse and the subsequent healing processes should be documented.

### **Psychosocial History – Post-Arrest**

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, or inability to return to work or school. Obtain summary information concerning the events of the individual fleeing his/her native country and arrival in the United States.

### **Assessment of the History**

Torture survivors may have difficulty recounting the specific details of the torture for several important reasons, including:

- Factors during torture itself, such as blindfolding, drugging and lapses of consciousness;
- Fear of placing oneself or others at risk;
- Lack of trust for the examining clinician and/or interpreter;
- Psychological impact of torture and trauma such as high emotional arousal, and impaired memory secondary to trauma-related mental illnesses such as depression and Posttraumatic Stress Disorder;
- Neuropsychiatric memory impairment from beatings to the head, suffocation, near drowning, or starvation;
- Protective coping mechanisms such as denial and avoidance; and
- Culturally prescribed sanctions that allow traumatic experiences to be revealed only in highly confidential settings.<sup>35</sup>

Inconsistencies in a person's story may arise from any or all of these factors. If possible, the clinician should ask for further clarification. When this is not possible, the clinician 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 clinician such as dates, times, frequencies, and exact identities of perpetrators, overall themes of the traumatic events and torture will emerge and stand up over time.

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<sup>35</sup> Mollica & Caspi-Yavin; "Overview: The Assessment and Diagnosis of Torture Events and Symptoms" in Basoglu M. (editor), *Torture and Its Consequences, Current Treatment Approaches*; Cambridge, Cambridge University Press, 1992; 38-55.

## Use of Interpreters

Evaluations for asylum applications often require the use of an interpreter. Although the interviewer and the interviewee may share a little of a common language, the information being sought is often too delicate to risk the errors that come from incomplete understanding of each other. In addition to language difference, cultural differences can also pose significant challenges. Two different approaches are commonly utilized with interpreting. First, the interviewer can use literal, word for word translations provided by an interpreter. Alternatively, the interviewer can employ a bicultural approach to interviewing. This approach consists of utilizing an interviewing team composed of the investigating clinician and an interpreter who provides linguistic interpretation and facilitates an understanding of cultural meanings attached to events, experiences, symptoms and idioms. Because the clinician will often not recognize relevant cultural, religious, and social factors, a skilled interpreter will be able to point out and explain these issues to the clinician. If the interviewer is relying strictly on literal word for word translations, this type of in-depth information will not be available. On the other hand, if interpreters are expected to point out relevant cultural, religious and social factors to the clinician, it is crucial that they do not attempt to influence in any way the applicant's responses to the clinician's questions. When literal translation is not used, the clinician needs to be sure that the interviewee's responses, as communicated by the interpreter, represent exclusively the meaning of what the person said, without additions or deletions by the interpreter.

Regardless of the approach, the interpreter's identity and ethnic, cultural, and political affiliation are important considerations in the choice of an interpreter. Ultimately, the asylum applicant and interpreter have to work together to communicate accurately and effectively. The clinician should choose an independent interpreter; under no circumstances should the interpreter be a law enforcement official or government employee. For the sake of privacy, a family member should not be used as an interpreter either. When visiting detention facilities or prisons, as a general rule, co-detainees should not be used for interpretation, unless it is obvious that the person has chosen someone he/she trusts.

Interpreters must be advised that what they hear and interpret in interviews is strictly confidential. It is the interpreters who get all the information, first hand and uncensored. Individuals must be given assurances that neither the clinician nor the interpreter will misuse his/her information in any way.

When the interpreter is not a professional one, there is always the risk of the clinician "losing control" of the interview. Individuals may get "carried away" talking to the person who speaks their language, and the interview may divert from the issues at hand. There is also a risk that an

interpreter with a bias might lead the interviewee or distort the replies. Loss of information, sometimes relevant, sometimes not, is inevitable when working through interpretation. In extreme cases, it may even be necessary for clinicians to refrain from taking notes during interviews, and carry out interviews in several short sessions, so as to have time to write notes in between the main points of what has been said.

Clinicians should remember to talk “to” the torture survivor, and to keep eye contact with him/her, even if he/she has a natural tendency to speak to the interpreter. It helps to use the first person through the interpreter, for example, “What did you do next?” rather than the third person, “Ask him what happened next.” All too often, clinicians fill out their notes during the time when either the interpreter is translating the question, or the subject is answering it. Some clinicians do not appear to be listening, as the interview is going on in a language they do not understand. This should not be the case, as it is essential that clinicians observe not just the words, but the body language, facial expressions, tone of voice and gestures of the interviewee, if they are to get a full picture.

Clinicians should familiarize themselves with torture-related words in the person’s language so as to show that they know about the issue. Reacting, rather than showing a blank face, when hearing a torture-related word such as “submarino” (asphyxiation by suffocation) or “falanga” (torture to the feet) will add to the clinician’s credibility.

## **Gender Issues**

Ideally, the asylum applicant should be able to choose the gender of the clinician and, where necessary, the interpreter. This is particularly important when a woman has been detained in a situation where rape or sexual assault is known to happen, even if she has not, so far, complained of it. Even if no sexual assault has taken place, most torture has sexual aspects. It will often add to the retraumatization 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 clinician to question a female, and this must be respected. However, in many 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 they want. In such a case it is essential that the interpreter, if used, is female. Some interviewees may also prefer that the interpreter be from outside their immediate locality, both to avoid being reminded of their torture and because of a perceived threat to their confidentiality. If no interpreter is necessary, then a female member of the investigating team should be present as a chaperone at least during the physical examination and, if the patient wishes, throughout the entire interview.

When the applicant is male and has been sexually abused, the situation is 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 they fear other men so much, while others would not want to discuss such personal matters in front of a woman.

## **Photography**

With the informed consent of the applicant, color photographs should be taken of all injuries allegedly caused by torture. A measuring tape or some other means of showing scale on the photograph is essential. Photographs must be taken as soon as possible, even with a basic camera as some physical signs fade rapidly. Instantly-developed photos may decay over time. More professional photos are preferred and should be taken when the equipment becomes available. If possible photographs should be taken using a 35 millimeter camera with an automatic date feature. The chain of custody of the film, negatives and prints must be fully documented.

## **Indications for Referral**

Where possible, examinations to document torture for medical-legal reasons should be combined with assessment for other needs, including referrals to specialist physicians and psychologists, physiotherapists, or to those who can offer social advice and support. Individuals who appear to be in need of further medical or psychological care should be referred for appropriate services. Clinicians should be aware of local rehabilitation and support services. A list of Torture Rehabilitation Centers is included in Appendix III.

## **Risk of Retraumatization of the Interviewee**

(See also “The Psychological/Psychiatric Evaluation” in Chapter V) The presence of psychological sequelae in torture survivors, particularly the various manifestations of Posttraumatic Stress Disorder, may cause the torture survivor to fear experiencing a re-enactment of his/her torture during the interview, physical examination or laboratory studies. Explaining to the torture survivor what he/she should expect prior to the medical examination is an important component of the process.

Those who survive torture and remain in their country may experience intense fear and suspicion of being re-arrested and are often forced to go “underground” to avoid being arrested again. Those who are exiled, or who escape, may leave behind their native language, culture, families, friends, work, and everything that is familiar to them.

The torture survivor’s personal (transference) reactions to the interviewer (and the interpreter, in cases where one is utilized) can have an effect on the interview process and, in turn, the outcome of the evalua-

tion. Likewise, the personal reactions of the clinician (countertransference) toward the subject can also affect the process of the interview and outcome of the evaluation. (See also Chapter V for a discussion of transference and countertransference issues.) It is important to examine the potential barriers to effective communication and understanding which these personal reactions might impose on the evaluation. The clinician should continue to assess the interview process and, when appropriate, consult with colleagues familiar with the assessment and treatment of torture survivors. This type of peer collaboration can be an effective means of monitoring the interview and evaluation process for biases and barriers to effective communication and obtaining accurate information.

Despite all precautions, physical and psychological examinations by their very nature may re-traumatize the patient by provoking and/or exacerbating symptoms of posttraumatic stress by eliciting painful affect and memories. Questions about psychological distress and, especially, about sexual matters are considered taboo in most traditional societies, and the asking of such questions is regarded as irreverent or insulting. If sexual torture was part of the violations incurred, the claimant may feel irredeemably stigmatized and tainted in his/her moral, religious, social, and psychological integrity. The expression of one's respectful awareness of these conditions, as well as the clarification of confidentiality and its limits are, therefore, of paramount importance for a well-conducted interview. A subjective assessment has to be made by the evaluator about the extent to which pressing for details is necessary for the effectiveness of the report in court, especially if the claimant demonstrates obvious signs of distress in the interview.



# IV. PHYSICAL EVIDENCE OF TORTURE

## Introduction

Witness and survivor testimony are necessary components in the documentation of torture. To the extent that physical evidence of torture exists, it provides 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. The following section provides an overview for documenting physical evidence of torture both by eliciting a detailed history as well as conducting a thorough physical examination. The physical manifestations of frequently reported forms of torture are reviewed. A review of ancillary diagnostic tests is also provided, although access to such diagnostic tests may be limited for economic or other reasons.

## Medical History

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 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 and methods of restraint, descriptions of acute and chronic wounds and disabilities, and identifying information about perpetrators and the place(s) of detention. While it is essential to obtain accurate information regarding a torture survivor's experiences, open-ended interviewing methods require that an individual disclose these experiences in his/her own words using free recall. An individual who has survived torture may have trouble expressing in words his/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 utilize such checklists, there are numerous questionnaires available; however, none are specific to torture victims.

The examiner should elicit a narration of symptoms and disabilities fol-

lowing torture by the individual alleging torture. All complaints of the torture survivor are of significance and should be reported whether or not there are any correlations with the physical findings. 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. Examples of injuries include bleeding, bruising, swelling, open wounds, lacerations, fractures, dislocations, joint stress, hemoptysis, pneumothorax, tympanic membrane perforation, genitourinary system injuries, burns (color, bulla, necrosis according to the degree of burn), electrical injuries (size and number of lesions, their color and surface characteristics), chemical injuries (color, 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, including whether or not they left scars. Acute symptoms should be described, too, including the survivor's state of health on release. Was she able to walk, confined to bed? If confined, for how long? How long did wounds take to heal? Were they infected? What, if any, treatment was received? Was it administered by a doctor or a traditional healer? Note that the individual's ability to make such observations may have been compromised by the torture itself or its after-effects and should be documented.

### **Chronic Symptoms**

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

### **Physical Examination**

Torture victims may display 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 leav-

ing no scars or 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 examinations may be “within normal limits,” but this in no way negates allegations of torture. In fact, a normal physical examination would, in such cases, be expected. A detailed account of the patient’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.

Subsequent to the acquisition of historical information and after the patient’s informed consent has been obtained, a complete physical examination by a qualified physician should be performed. Where possible the patient should be able to choose the gender of the doctor and, where used, the interpreter. If the doctor is not the same gender as the patient, a chaperone who is the same gender as the patient should be present unless the patient objects. The patient must understand that he/she is in control and has the right to limit or stop the examination at any time.

In this section, there are many references to specialist referral and further investigations. Unless the patient is in detention, it is important that clinicians have, wherever possible, access to physical and psychological treatment facilities (see Appendix III), so any identified need can be satisfied. In many situations, certain diagnostic test techniques will not be available, and their absence must not invalidate the report. See Appendix I for further details of possible diagnostic tests.

In rare cases with allegations of recent torture, the clothes worn during the perpetration of torture are still being worn the torture survivor. In these circumstances the clothes should be taken for examination without washing, and a fresh set of clothes should be provided.

Where possible, the examination room should be equipped with sufficient illumination and the medical equipment necessary 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 Appendix II). Some forms of torture, such as electrical shock and/or blunt trauma, may initially not leave readily apparent scars but may be detected on subsequent/follow-up examination findings. Although it will rarely be possible to photographically record lesions of those in custody of their torturers, such photography should otherwise be a routine part of examinations. If a camera is available, it is always better to take poor quality photographs than to take none. This should be followed up with professional photographs as soon as possible.

## Skin

The examination should include the entire body surface to detect signs of:

- Generalized skin disease including signs of vitamin A, B and C deficiencies;
- Pre-torture lesions; and
- Lesions inflicted by torture, such as abrasions, contusions, lacerations, puncture wounds, burns from cigarettes or heated instruments, electrical injuries, alopecia and nail removal.

Torture lesions should be described by their localization, symmetry, shape, size, color and surface (e.g. scaly, crusty or ulcerating) as well as their demarcation and level in relation to the surrounding skin. Photography is essential whenever possible. Ultimately, the examiner must offer an opinion as to the origin of the lesions as being inflicted, self-inflicted,<sup>36, 37</sup> accidental or the result of a disease process.

## The Face

Facial tissues should be palpated for evidence of fracture, crepitation, swelling or pain. The motor and sensory components (including smell and taste) of all cranial nerves should be examined. Computerized tomography (CT), rather than routine radiography, is the best modality to diagnose and characterize facial fractures, determine alignment, and diagnose associated soft tissue injuries and complications. Intracranial and cervical spinal injuries are often associated with facial trauma.

## Eyes

There are many forms of trauma to the eyes, including conjunctival hemorrhage, lens dislocation, subhyeloid hemorrhage, retrobulbar hemorrhage, retinal hemorrhage, and visual field loss. Given the serious consequences of lack of treatment or improper treatment, ophthalmologic consultation should be obtained whenever there is a suspicion of ocular trauma or disease.

CT is the best modality to diagnose orbital fractures and soft tissue injuries to the bulbar and retrobulbar contents. Nuclear magnetic resonance imaging (MRI) may be an adjunct for soft tissue injury. High resolution ultrasound is an alternative method for evaluation of trauma to the eye globe.

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<sup>36</sup> Rasmussen, O.V., "Medical Aspects of Torture," *Danish Medical Bulletin* 1990; 37 Supplement 1, 1-88.

<sup>37</sup> Bunting, R., "Clinical Examinations in the Police Context," in W.D.S. McLay (editor), *Clinical Forensic Medicine*, London, Greenwich Medical Media, 1996; 59-73.

### *Ears*

Trauma to the ears, and especially rupture of the tympanic membrane, 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. Prompt examination is necessary to detect tympanic membrane ruptures less than 2 mm in diameter, which may heal within 10 days. Fluid may be observed in the middle and/or external ear. If otorrhea 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 audiometry technician. The radiographic examination of fractures of the temporal bone or disruption of the ossicular chain is best determined by CT, then hypocycoloidal tomography, and lastly linear tomography.

### *The Nose*

The nose should be evaluated for alignment, crepitation, and deviation of the nasal septum. For simple nasal fractures, standard nasal radiographs should be sufficient. For complex nasal fractures and when the cartilaginous septum is displaced, CT should be performed. If rhinorrhea is present, CT and/or MRI are recommended.

### *Jaw, Oropharynx and Neck*

Mandibular fractures and/or dislocations may result from beatings. Temporomandibular joint syndrome is a frequent consequence of beatings about the lower face and jaw. The patient should be examined for evidence of crepitation of the hyoid bone or laryngeal cartilages resulting from blows to the neck. Findings concerning the oropharynx should be noted in detail, including lesions consistent with burns from electrical shock or other trauma. Gingival hemorrhage and the condition of the gums should also be noted.

### *Oral Cavity and Teeth*

Examination by a dentist should be considered a component of periodic health examination in detention. This examination is often neglected, but is an important component of the physical examination. Dental care may be purposefully withheld to allow caries, gingivitis or tooth abscesses to worsen. A careful dental history should be taken, and if dental records exist, these should be requested. Tooth avulsions, fractures of the teeth, dislocated fillings and broken prostheses may result from direct trauma or electric shock torture. Dental caries and gingivitis should be noted. Poor quality dentition may be due to conditions in detention, or may have pre-

ceded the detention. The oral cavity must be carefully examined. During electric current application, the tongue, gingiva or lips may be bitten. Lesions might be produced by forcing objects or materials into the mouth, as well as by applying electric current. X-rays and MRI are suggested for determining the extent of soft tissue, mandibular and dental trauma.

### **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 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 respiratory disorders commonly develop.

### **Musculoskeletal System**

Complaints of musculoskeletal aches and pains are very common in survivors of torture.<sup>38</sup> They may be the result of repeated beatings, suspension, or other positional torture,<sup>39</sup> or of the general physical environment of the detention. They also may be somatic (see Chapter V, “Common Psychological Symptoms”). They are non-specific, but should be documented. They often respond well to sympathetic physiotherapy.<sup>40</sup>

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. Suspected dislocations, fractures and osteomyelitis should be evaluated with radiographs. For suspected osteomyelitis, routine radiographs followed by three-phase bone scintigraphy should be performed. Injuries to tendons, ligaments, and muscles are best evaluated with MRI but arthrography can also be performed. In the acute stage, MRI can detect hemorrhage and possible muscle tears. Muscles usually completely heal without scarring; thus, later imaging studies will be negative. On MRI and CT, denervated muscles and

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<sup>38</sup> Rasmussen, O.V., “Medical Aspects of Torture,” *Danish Medical Bulletin* 1990; 37 Supplement 1, 1-88.

<sup>39</sup> Forrest, D., “Examination for the Late Physical After Effects of Torture,” *Journal of Clinical Forensic Medicine* 1999; 6, 4-13.

<sup>40</sup> Rasmussen, O.V., “Medical Aspects of Torture,” *Danish Medical Bulletin* 1990; 37 Supplement 1, 1-88.

chronic compartment syndrome will be imaged as muscle fibrosis. Bone bruises can be detected by MRI or scintigraphy. Bone bruises usually heal without trace findings.

### **Genitourinary System**

Genital examination should only be performed with the additional consent of the patient, and if necessary, should be postponed to a later examination. A chaperone must be present if the examining clinician gender is different from that of the patient. Ultrasonography and dynamic scintigraphy can be used for detecting genitourinary trauma.

### **Central / Peripheral Nervous System**

The neurologic examination should evaluate the cranial nerves, sensory organs and peripheral nervous system, checking for both motor and sensory neuropathies related to possible trauma, vitamin deficiencies or other disease. Cognitive ability and mental status also must be evaluated (see also Chapter V, “The Psychological/Psychiatric Evaluation”). In patients who report being suspended, special emphasis on examination for brachial plexopathy (asymmetrical hand strength, wrist drop, arm weakness with variable sensory and tendon reflexes) is necessary. Radiculopathies, other neuropathies, cranial nerve deficits, hyperalgesia, parasthesias, hyperaesthesia, changes 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.

Radiologic evaluation should include MRI or CT. MRI is preferred over CT for radiologic evaluation of the brain and/or posterior fossa.

### **Examinations and Evaluations Following Specific Forms of Torture**

The following discussion is not meant to be an exhaustive discussion of all forms of torture, but is intended to describe in more detail the medical aspects of many of the more common forms of torture. For each lesion where possible, and for the overall pattern of lesions, the clinician should indicate the degree of consistency between it and the attribution given by the patient. The following terms are generally used:

Not consistent:                      The lesion could not have been caused by the trauma described.

Consistent with:                      The lesion could have been caused by the trauma described, but it is non-specific and there are many other possible causes.

Highly consistent:	The lesion could have been caused by the trauma described, and there are few other possible causes.
Typical of:	This is an appearance that is usually found with this type of trauma, but there are other possible causes.
Diagnostic of:	This appearance could not have been caused in any way other than that described.

Ultimately, it is the overall evaluation of all lesions and not the consistency of each lesion with a particular form of torture that is important in assessing the torture story.

## **Beatings and Other Forms of Blunt Trauma**

### *Skin Damage*

Acute lesions are often characteristic since they show a pattern of inflicted injury that differs from non-inflicted injuries, e.g., by their shape, repetitiveness and distribution on the body. However, since most lesions heal within about six weeks of torture, leaving no scars or non-specific scars, a characteristic history of the acute lesions and their development until healing might be the only basis for a support of the allegation of torture.

Permanent changes in the skin due to blunt trauma are infrequent, non-specific, and usually without diagnostic significance.

A sequel of blunt violence which is diagnostic of prolonged application of tight ligatures is a linear zone extending circularly around the arm or leg, usually at the wrist or ankle. The zone contains few hairs or hair follicles, probably a form of cicatricial alopecia. No differential diagnosis in the form of a spontaneous skin disease exists, and trauma of this nature is not known to occur in everyday life.

Acute lesions and abrasions, which are superficial scraping lesions of the skin, may appear as scratches, brush-burn type lesions or larger scraping lesions. At times, abrasions may show a pattern that reflects the contours of the instrument or surface that inflicted the injury. Repeated or deep abrasions may lead to areas of hypo- or hyperpigmentation depending on skin type, for example inside the wrists if the hands have been tied together tightly.

Contusions or bruises are areas of hemorrhage into soft tissue due to rupture of blood vessels from blunt trauma. The extent and severity of a contusion depend not only upon the amount of force applied, but also the structure and vascularity of the tissue contused. Contusions are more readily incurred in areas with thin skin overlying bone and in fatty areas. Many medical conditions, including vitamin and other nutritional deficiencies, may be associated with easy bruisability or purpura.

Contusions, like abrasions, indicate that blunt force has been applied to a particular area. However, the absence of a bruise, just as the absence of an abrasion, does not indicate that there was no blunt force to that area. Contusions may also be patterned, reflecting the contours of the inflicting instrument. For instance, rail-shaped bruising may occur when an instrument such as a truncheon or cane has been used. Therefore, the shape of the object may be inferred by considering the shapes of the bruise(s).

As contusions resolve they undergo a series of color changes. Most bruises initially appear dark blue, purple or crimson. As the hemoglobin in the bruise breaks down, the color gradually changes to violet, green, dark yellow, pale yellow and finally disappears. It is very difficult, however, to accurately date the age of contusions. In some skin types bruises can lead to a hyperpigmentation that can last several years, while in others marks disappear rapidly.

Contusions that develop in the deeper subcutaneous tissues may not be observed for several days after an injury, when the extravasated blood has reached the surface. Therefore, in cases when there is an allegation but no sign of a contusion, re-examination after several days should be performed. It should be taken into consideration that the final position and shape of such bruises bear no necessary relation to the original trauma and that some lesions may have faded by the time of re-examination.<sup>41</sup>

Speculative judgments should be avoided in the evaluations of the nature and age of blunt traumatic lesions since a lesion may vary according to the age, sex, tissue characteristics, the condition and health of the patient, and the severity of the trauma. For example, well-conditioned, muscularly fit, younger individuals are more resistant to bruising than frail, older individuals.

Lacerations, a tearing or crushing of the skin and underlying soft tissues by the pressure of blunt force, 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. However, with sufficient force the skin can be torn on any portion of the body. Asymmetrical scars, scars in unusual locations, and a diffuse spread of scarring all suggest a deliberate cause.<sup>42</sup>

The scars seen as the result of whipping represent such healed lacerations. The scars are depigmented and often hypertrophic, surrounded by narrow, hyperpigmented stripes. The only differential diagnosis is plant dermatitis, but this is dominated by hyperpigmentation and shorter scars.

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<sup>41</sup> Gurpınar, S. & Korur, Fincancı S., "İnsan Hakları İhlalleri ve Hekim Sorumluluğu" ("Human Rights Violations and Responsibility of the Physician"), in *Birinci Basamak İçin Adli Tıp El Kitabı* (Handbook of Forensic Medicine for General Practitioners), Turkish Medical Association, Ankara, 1999.

<sup>42</sup> Rasmussen, O.V., "Medical Aspects of Torture," *Danish Medical Bulletin* 1990; 37 Supplement 1, 1-88.

By contrast, symmetrical, atrophic, depigmented linear changes of the abdomen, axillae and legs, which are sometimes claimed to be torture sequelae, are typical of striae distensae and are not normally related to torture.<sup>43</sup>

Burning is the form of torture that most frequently leaves permanent changes in the skin. Sometimes, burns may be of diagnostic value.

Cigarette burns often leave 5-10 mm large circular or ovoid macular scars with a hyper- or a hypopigmented centre and a hyperpigmented, relatively indistinct periphery. The burning away of tattoos with cigarettes has also been reported in relation to torture. The characteristic shape of the resulting scar and any tattoo remnants will help in the diagnosis.<sup>44</sup>

Burning via the application of hot objects produces markedly atrophic scars reflecting the shape of the instruments. They are sharply demarcated with narrow hypertrophic or hyperpigmented marginal zones corresponding to an initial zone of inflammation. This may, for instance, be seen after burning with an electrically heated metal rod or a gas lighter. It is difficult to imagine any differential diagnosis if many scars result. Spontaneously occurring inflammatory processes would lack the characteristic marginal zone and only rarely exhibit such a pronounced loss of tissue. Burning may also result in hypertrophic or keloid scars, as is reported following burning with alighted rubber.

When the nail matrix is burnt, subsequent growth produces striped, thin, deformed nails, sometimes broken up in longitudinal segments. If the nail is also pulled off, an overgrowth of tissue may occur from the proximal nail fold, resulting in the formation of pterygium. Changes in the nail caused by lichen planus constitute the only relevant differential diagnosis, but they will usually be accompanied by a widespread skin affection. Fungus infections, on the other hand, are characterized by thickened, yellowish, crumbling nails, different from the above changes.

Sharp trauma wounds are produced when the skin is cut with a sharp object such as a knife, bayonet or broken glass. Such wounds include stab wounds, incised or cutting wounds and puncture wounds. Sharp trauma wounds are usually easy to distinguish from lacerations, both acutely and on examination of scars after the wounds have healed, as the latter tend to be irregular and torn in appearance. Regular patterns of small incisional scars could be due to the methods of traditional healers.<sup>45</sup> If pepper or other noxious substances are applied to the open wounds, the scars may

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<sup>43</sup> Danielsen, L., "Skin Changes after Torture," *Torture* 1992; Supplement 1, 27-28.

<sup>44</sup> Id.

<sup>45</sup> Forrest, D., "Examination for the Late Physical After-Effects of Torture", *Journal of Clinical Forensic Medicine* 1999; 6, 4-13.

become hypertrophic. An asymmetric pattern and different sizes of scars are probably significant in the diagnosis of torture sequelae.

### *Fractures*

Fractures produce a loss of bone integrity due to the effect of a blunt mechanical force on various vector planes. A direct fracture occurs at the site of impact or at the site where the force was applied. The location, contours and other characteristics of a fracture reflect the nature and direction of the applied force. It is thus sometimes possible to distinguish fractures inflicted from accidental injury by the radiographic appearance of the fracture. Radiographic aging of relatively recent fractures should be done by an experienced trauma radiologist.

### *Head trauma*

Head trauma is among the most common forms of torture. With recurring head trauma, even if not always of serious dimensions, cortical atrophy, and diffuse axonal damage may be expected. In cases of trauma caused by falls, countercoup lesions (located in opposition to the trauma) of the brain may be observed; in cases of direct trauma, contusions of the brain may be observed directly under the region in which the trauma is inflicted. Scalp bruises are frequently not visible externally unless there is swelling. Bruises also may be difficult to see in dark-skinned individuals, but will be tender to palpation.

Having been exposed to blows to the head, the torture survivor may complain of continuous headaches. These are often somatic, or may be referred from the neck. He/she may claim to suffer pain when touched in that region, and diffuse or local fullness or increased firmness may be observed by means of palpation of the scalp. Scars can be observed in cases where there were lacerations of the scalp. Headache may also be the initial symptom of an expanding subdural hematoma. There may be associated acute onset mental status changes, and a CT scan should be performed urgently. Soft tissue swelling and/or hemorrhage will usually be detected with CT or MRI. It may also be appropriate to arrange psychological or neuropsychological assessment (see Chapter V, “The Psychological/Psychiatric Evaluation”).

Violent shaking as a form of torture may produce cerebral injury without leaving any external marks, although bruises may be present on the upper chest or shoulders where the victim or his/her clothing has been grabbed. At its most extreme, shaking has produced injuries identical to those seen in shaken baby syndrome – cerebral edema, subdural hematoma and retinal hemorrhages. More commonly, victims complain of recurrent headaches, disorientation, and mental status changes. Shaking episodes are usually brief – only a few minutes or less – but may be repeated many times over a periods of days to weeks.

### *Chest and Abdominal Trauma*

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.

In case of acute abdominal trauma, the physical examination should seek evidence of abdominal organ and urinary tract injury. However, the examination is often negative. Gross hematuria is the most significant indication of kidney contusion. Peritoneal lavage may detect occult abdominal hemorrhage. Free abdominal fluid detected on CT after peritoneal lavage may be from the lavage or hemorrhage, thus potentially invalidating the finding. On CT, acute abdominal hemorrhage is usually isointense, or equivalent to water density, unlike acute CNS hemorrhage, which is hyperintense. Organ injury may present as free air, extraluminal fluid or areas of low attenuation, which may represent edema, contusion, hemorrhage or a laceration. Peripancreatic edema is one of the signs of acute traumatic and nontraumatic pancreatitis. Ultrasound is particularly useful in detecting subcapsular hematomas of the spleen. Renal failure due to crush syndrome may be seen acutely as a result of severe beatings. Renal hypertension can be a late complication of renal injury.

### **Beatings of the Feet (*Falanga, Falaka, Basinado*)**

Falanga is the most common term for repeated application of blunt trauma to the feet (or, rarely, the hands or hips), usually applied with a t runcheon, length of pipe, or similar weapon. The most severe complication of falanga is closed compartment syndrome, which can cause muscle necrosis, vascular obstruction and gangrene of the distal portion of the foot or of the toes. Permanent deformities of the feet are uncommon but do occur, as do fractures of the carpals, metacarpals and phalanges. Because the injuries are usually confined to soft tissue, CT scan and MRI are the preferred methods for radiologic documentation of injury, but it must be emphasized that physical examination of falanga injuries in the acute phase should be diagnostic.

Falanga may produce chronic disability. Walking may be painful and difficult. The tarsal bones may be fixed (spastic) or have increased motion. Squeezing the plantar (sole) of the foot and dorsiflexion of the big toe may produce pain. On palpation, the entire length of the plantar aponeurosis may be tender. The distal attachments of the aponeurosis may be torn, partially at the base of the proximal falanges, partly at the skin; and the aponeurosis will not tighten normally. Consequently, walking may be difficult and muscle fatigue may follow. Passive extension of the big toe may reveal whether the aponeurosis has been torn. If it is intact, one should feel

the start of tension in the aponeurosis on palpation when the toe is dorsiflexed to 20 degrees; the maximum normal extension is about 70 degrees. Higher values suggest injury to the attachments of the aponeurosis.<sup>46, 47, 48, 49</sup>

On the other hand, limited dorsiflexion and pain on hyperextension of the big toe are findings of hallux rigidus, which results from dorsal osteophyte(s) at the first metatarsal head, the base of the proximal phalanx, or both.

Numerous complications and syndromes can result from falanga:

- **Closed Compartment Syndrome:** This is the most severe complication. Edema in a closed compartment results in vascular obstruction or muscle necrosis, which may result in fibrosis and/or contractures and gangrene of the distal foot and/or toes. It is usually diagnosed by measuring pressures in the compartment.
- **Crushed Heel and Anterior Footpads:** The elastic pads under the calcaneus and proximal phalanges are crushed during falanga, either directly or as a result of edema associated with the trauma. Also, the connective tissue bands that extend through adipose tissue and connect bone to skin are torn. Adipose tissue becomes deprived of its blood supply and atrophies. The cushioning effect is lost. The feet no longer absorb the stresses that arise from walking.
- **Rigid and irregular scars involving the skin and subcutaneous tissues of the foot after the application of falanga:** In a normal foot, the dermal and subdermal tissues are connected to the planter aponeurosis through tight connective tissue bands. However, these bands can be partially or completely destroyed due to the edema which ruptures the bands after exposure to falanga.
- **Rupture of the plantar aponeurosis and tendons of the foot:** The edema of the post-falanga period may rupture these structures. When such supportive function necessary for the arch of foot disappears, the act of walking becomes harder and foot muscles, especially quadratus plantaris longus, are excessively forced.

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<sup>46</sup> Sklyv, G., "Physical Sequelae of Torture," in Basoglu, M. (editor), *Torture and Its Consequences, Current Treatment Approaches*, Cambridge, Cambridge University Press, 1992; 38-55.

<sup>47</sup> Forrest, D., "Examination for the Late Physical After-Effects of Torture," *Journal of Clinical Forensic Medicine* 1999; 6, 4-13.

<sup>48</sup> Prip, K., Tived, L. & Holten, N., *Physiotherapy for Torture Survivors - A Basic Introduction*, Copenhagen, IRCT, 1995.

<sup>49</sup> Bojsen-Moller, F. & Flagstad, K.E., "Plantar Aponeurosis and Plantar Architecture of the Ball of the Foot," *Journal of Anatomy* 1976; 121:599-611.

- **Plantar Fasciitis:** This may occur as a further complication of injury. In falanga irritation is often present throughout the whole aponeurosis, causing chronic aponeurosis. In studies on the subject, prisoners released after 15 years of detention who claimed that they had been subjected to falanga application when first arrested, produced positive bone scans of hyperactive points in the calcaneus or metatarsal bones.<sup>50</sup>

Radiological methods such as MRI, CT scan and ultrasound can often support histories of trauma occurring as a result of falanga application. Positive radiological findings also may be secondary to other diseases or trauma. Routine radiographs are recommended as the initial examination. MRI is the preferred radiologic examination to detect soft tissue injury. MRI or scintigraphy may detect bone injury such as a bruise, which may not be detected on routine radiographs or CT.<sup>51</sup>

## Suspension

Suspension is a common form of torture that can produce extreme pain, but leave 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 neurologic deficits diagnostic of brachial plexopathy virtually prove the diagnosis of suspension torture.

Suspension can be applied in various forms:

- **Cross:** Applied by spreading the arms and tying them to a horizontal bar or beam
- **Butchery Suspension:** Applied by fixation of hands upwards, either together or one by one
- **Reverse Butchery Suspension:** Applied by fixation of feet upward, the head being downward
- **“Palestinian” Suspension:** Applied by suspending the individual with the forearms bound together behind the back with the elbows flexed 90 degrees, and the forearms tied to a horizontal bar or beam. Alternatively, the prisoner may be suspended from a ligature tied around the elbows or wrists with the arms behind the back. The origin of the term “Palestinian” suspension is not clear. It is thought to have originated in

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<sup>50</sup> Lok, V., Tunca, M., Kumanlioglu, K., et al., “Bone Scintigraphy as Clue to Previous Torture,” *Lancet* 1991; 337(8745) 846-7; See also: Tunca, M. and Lok, V., “Bone Scintigraphy in Screening of Torture Survivors,” *Lancet* 1998; 352(9143) 1859.

<sup>51</sup> See references 49, 50; also Lok, V., Tunca, M., Kapkin, E., et al., “Bone Scintigraphy as an Evidence of Previous Torture,” in *Treatment and Rehabilitation Center Report of HRFT*, 1994, Ankara; 91-96

Turkey and is used to refer to a particular method of suspension practiced in many regions of the world, though not commonly used by Palestinians or Israelis.

- **Parrot Perch:** Suspension of a prisoner by the flexed knees with a bar passed below the popliteal region, usually with the wrists tied to the ankles

Suspension may last from 15-20 minutes to several hours. “Palestinian” suspension may produce permanent brachial plexus injury in a brief period of time. The “parrot perch” may produce tears in the cruciate ligaments of the knees. Victims will often be beaten or otherwise abused while suspended. In the chronic phase, it is usual for pain and tenderness around the shoulder joints to persist and for lifting of weights and rotation, especially internal, to cause severe pain many years later.

Complications in the acute period following suspension include weakness of the arms and/or hands, pain and paresthesias, numbness, insensitivity to touch, superficial pain, and position and tendon reflex loss. Intense deep pain may mask the muscle weakness. In the chronic phase, weakness may continue and progress to muscle wasting, numbness and more frequent paresthesia. Raising the arms or weight-lifting conditions may cause pain, numbness, or weakness or may not be possible at all. In addition to neurologic injury, there may be tears of the ligaments in the shoulder joints, dislocation of the scapula or muscle injury in the shoulder region. On visual inspection of the back a “winged scapula” (prominent vertebral border of the scapula) may be observed with injury to the long thoracic nerve or dislocation of the scapula.

Neurologic injury is usually not of the same extent in both arms. Brachial plexus injury manifests itself in motor, sensory, and reflex dysfunction:

- **Motor Examination:** Muscle weakness, more prominent distally in an asymmetric manner, is the most expected finding. Acute pain may make the muscle strength examination difficult to interpret. If the injury is severe enough, muscle atrophy may be seen in the chronic phase.
- **Sensory Examination:** Complete loss of sensation or paresthesias 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 3 weeks have passed since the abuse and deficiency and/or reflex loss/decrease are present, appropriate electrophysiological studies should be performed by a neurologist experienced in the use and interpretation of such methodologies.
- **Reflex Examination:** Reflex loss, a decrease in reflexes, or a difference between the two extremities may be present. In “Palestinian” suspen-

sion, 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, such as which arm is placed in a superior position and the method of binding. Although the current literature suggests that brachial plexopathies are usually unilateral, bilateral injury may be 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 hyper-extension, typically the lower plexus and then the middle and upper plexus fibers (if the force on the plexus is severe enough) are damaged. If the suspension is of a “crucifixion” type, but does not include hyper-extension, the middle plexus fibers are likely to be the first ones damaged due to hyper-abduction. Brachial plexus injuries may be categorized as follows:

- Damage of lower plexus: Deficiencies are localized in the forearm and hand muscles. Sensory deficiencies may be observed on the forearm and at fourth and fifth fingers of the hands medial side in an ulnar nerve distribution.
- Damage of middle plexus: Fore arm, elbow and finger extensor muscles are affected. Pronation of the forearm and radial flexion of the hand may be weak. Sensory deficiency is on the forearm and on the dorsal aspects of the first, second, and third fingers of the hand in a radial nerve distribution. The tricep reflexes may be lost.
- Damage of upper plexus: Shoulder muscles are affected especially. 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.

### **Other Positional Torture**

There are many forms of positional torture, all of which tie or restrain the victim in contorted, hyperextended or other unnatural positions that 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 radiologic findings despite the frequently severe chronic disability that follows.

All positional tortures are directed towards tendons, joints and muscles. Some examples of various methods include parrot-stand, banana stand or the classic “banana tie” over a chair or on the ground, motorcycle, forced standing, forced standing on a single foot, prolonged standing

with arms and hands stretched high on a wall, prolonged forced squatting, and motionless confinement in a small cage. In accordance with the characteristics of such positions, complaints are characterized as pain in the respective region of the body, limitation of joint movement, pain in back, hand and cervical parts of the body, swelling of lower legs, etc. The same principles of neurologic and musculoskeletal examination apply to these other forms of positional torture as apply to suspension.

MRI is the preferred radiologic modality for evaluation of injuries associated with all forms of positional torture.

### **Electric Shock Torture**

Electric current is transmitted through electrodes that may be placed on any part of the body. The most common areas are the hands, feet, fingers, toes, ears, nipples, mouth, lips and genital area. The power source may be a hand cranked or gasoline/diesel generator, wall source, stun gun, cattle prod or other electric devices.

Electric current follows the shortest route between the two electrodes. The symptoms that occur when electric current is applied are also in accordance with this characteristic. For example, if electrodes are placed on toes of the right foot and on the genital region, there will be pain, muscle contraction and cramps of the right thigh and calf muscles. Excruciating pain will be felt in the genital region. Since all muscles along the route of the electric current are tetanically contracted, dislocation of the shoulder and lumbar and cervical radiculopathies may be observed when the current is moderately high. However, the type, time of application, current and voltage of the energy used can not be determined with certainty on physical examination of the victim.

Trace electric burns are usually a red brown circular lesion from 1 to 3mm in diameter, usually without inflammation, which may result in a hyperpigmented scar. Involved skin surfaces must be carefully examined because the lesions are often not easily discernible. Torturers often pour water or use various kinds of gels on the body in order to increase the efficiency of the torture, extend the entrance point of the electric current on the body and prevent detectable electric burns.

The decision to biopsy recent lesions to prove their origin is controversial. 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 having been caused by an electrical burn. The decision to biopsy must be made on a case by case basis dependent upon whether or not the pain and discomfort associated with the procedure can be justified by the potential results. (see Appendix I)

### **Dental Torture**

Dental torture may be in the form of breaking or extraction of the teeth,

as well as applying electric current to the teeth. It may end in loss or breaking of the teeth, swelling of the gums, bleeding, pain, gingivitis, stomatitis, mandibular fractures or loss of fillings from teeth. Temporomandibular joint syndrome will produce pain in the temporomandibular joint, limitation of jaw movement, and in some cases subluxation of this joint due to muscle spasms occurring as a result of electric current and blows to the face.

### **Asphyxiation**

Near asphyxiation by suffocation is an increasingly common method of torture. It usually leaves no marks and recuperation is rapid. This method of torture has been so widely used in Latin America, that its Spanish name “submarino” is part of the human rights vocabulary. Normal respiration might be prevented through methods such as covering the head with plastic bag, closure of the mouth and the nose, pressure or ligature around the neck or forced aspiration of dusts, cement or hot peppers. This is also known as “dry submarino.” Various complications might result such as petechiae of the skin, nosebleeds, bleeding from the ears, congestion of the face, infections in the mouth and acute and chronic respiratory problems.

Forcible immersion of the head into water, often contaminated with urine, feces, vomit or other impurities, may result in near drowning or drowning. Aspiration of the water into the lungs may lead to pneumonia. This form of torture is also called “wet submarino.”

In hanging or in other ligature asphyxiations, patterned abrasions or contusions can often be found on the neck. The hyoid bone and laryngeal cartilage may be fractured in partial strangulation or from blows to the neck.

### **Sexual Torture, Including Rape**

Sexual torture begins with forced nudity, which in many countries is used constantly in torture situations to increase the victim’s sense of vulnerability. Nudity enhances the psychological terror of every aspect of torture, as there is always a conscious undertone of potential abuse and rape/sodomy. Verbal sexual threats, abuse and mocking are also part of sexual torture, as they enhance the humiliating and degrading aspects of it. Groping is traumatic in all cases and is considered torture also.

In the majority of political asylum applicants who allege sexual assault during torture, the traumatic event(s) will have occurred months or years before the medical examination. Therefore, most individuals will not have physical signs at the time of the examination. Although physical symptoms and signs may be present in some cases, psychological symptoms are much more common in this population.

There are some differences between sexual torture of men and sexual torture of women, but many of the same issues apply to both. Rape is always associated with the risk of developing sexually transmitted diseases,

particularly Human Immunodeficiency Virus (HIV).<sup>52</sup> At present the only effective prophylaxis against HIV needs to be taken within hours of the incident, and is not generally available in most countries where torture occurs routinely. In most cases there will be a lewd “sexual” component and in many 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. Men are often threatened with loss of masculinity and consequent loss of respect in society. Prisoners may also 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, if any exist. Additionally, prisoners may be forced to abuse each other sexually, which can be particularly difficult to cope with emotionally.

The concern of potential rape among women, given profound cultural stigmas associated with rape, can also exacerbate the trauma. Not to be neglected are the fears of potential pregnancy, loss of virginity, and inability to bear children, even if the victim can hide the rape from a potential husband and the rest of society.

Particularly in cases of sexual abuse, if the individual does not wish the event to be known due to socio-cultural pressures or personal reasons, the clinician who carries out the medical examination, investigative agencies and the courts have an obligation to co-operate in maintaining the privacy of the victim.

Establishing rapport with torture survivors who have recently been sexually assaulted requires special psychological education and requires appropriate psychological support. Any kind of treatment that would increase the psychological trauma of the torture survivor should be avoided. Before starting the examination, permission from the individual must be obtained for any kind of examination, and this should be checked again before the more intimate parts of the examination. The individual should be informed of 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 taken. However, there are some specific questions that are relevant only to an allegation of sexual abuse. These will be directed to elicit current symptoms resulting from a recent assault, e.g. bleeding, vaginal or anal discharge, and location of pain, bruises, and sores. For sexual assaults that occurred in the past, questions should be directed to elicit ongoing symptoms that resulted from the assault:

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<sup>52</sup> Lunde, D. & Ortmann, J., “Sexual Torture and the Treatment of Its Consequences,” in Basoglu, M. (editor), *Torture and Its Consequences, Current Treatment Approaches*, Cambridge, Cambridge University Press, 1992; 310-331.

- Urinary frequency or incontinence and/or dysuria;
- Irregularity of menstrual periods;
- Subsequent history of pregnancy, abortion, vaginal hemorrhage;
- Problems with sexual activity/intercourse; and
- Anal pain, bleeding and/or constipation or incontinence.

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

#### *Examination Following a Recent Assault*

It is rare that a victim of rape as a part of torture is released while 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 conflicted and confused about seeking medical or legal help due to their fears, socio-cultural concerns or the destructive nature of the abuse. In such a case, a doctor should explain all possible medical and judicial options to the victim, and should act in accordance with the victim's requests. The duties of the clinician include: to obtain voluntarily informed consent for the examination; to record all medical findings of abuse; and to obtain the required samples for forensic examination. Where possible the examination should be performed by an expert in documenting sexual assault. Otherwise the examining doctor should speak to such an expert or consult a standard text of clinical forensic medicine.<sup>53</sup>

Where the victim is of a different gender than the doctor, he/she should be offered the opportunity of having a chaperone of his/her own gender in the room. If an interpreter is to be used, then he/she may fulfill the role of chaperone as well. Given the sensitive nature of investigation into such assaults, a relative of the victim is not normally an ideal person to use in this role.

The patient should be comfortable and relaxed prior to the examination. A thorough physical examination should be performed, including meticulous documentation of all physical findings including their size, location

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<sup>53</sup> See, for example, Howitt, J. & Rogers, D., "Adult Sexual Offenses and Related Matters," in McLay, W.D.S. (editor), *Clinical Forensic Medicine*, London, Greenwich Medical Media, 1996; 193-218.

and color. Where possible, photographs of these findings should be taken and samples of specimens from the examination should be collected.

Physical examination should not initially be directed to the genital area. Upon examination, documentation of any deformities should be noted. Particular care must be taken to perform a thorough examination of the skin, looking for cutaneous lesions that could have resulted from the assault. These include bruises, lacerations, ecchymoses and petechiae from sucking or bites. This may help the patient to be more relaxed for a complete examination. On occasions when genital lesions are minimal, lesions located on other parts of the body may be the most significant evidence of an assault. Even on examination of the female genitalia immediately after rape there is identifiable damage in less than 50% of cases. Anal examination of males and females after anal rape shows lesions in less than 30% of cases. Where relatively large objects have been used to penetrate the vagina and/or anus, the probability of identifiable damage is predictably greater.

Where there is a forensic laboratory available, the facility should be contacted before the examination to discuss what types of specimens they are capable of testing, and therefore what samples should be taken and by what method. Many laboratories provide kits to allow doctors to take the necessary samples from individuals alleging sexual assault. If there is no laboratory available, it still may be worth obtaining wet swabs and letting them dry in the air. These samples can then be used for DNA testing at a later date. Sperm can be identified up to five days after the rape from a high vaginal swab and after up to three days from a rectal swab. Strict precautions must be taken to prevent allegations of cross-contamination where samples have been taken from several different individuals, and particularly if they are taken from alleged perpetrators. There must be complete protection and documentation of the chain of custody of all forensic samples.

#### *Examination after the Immediate Phase*

Where the alleged assault occurred more than a week prior to examination and there are no signs of bruises, lacerations, etc., 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, there may still be benefits in arranging proper photography of residual lesions if possible.

The history should be taken as described above, then examination and documentation of the general physical findings should be completed. 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 doctor can tell a considerable amount from the demeanor of a woman when she is describing her history and being exam-

ined.<sup>54</sup> It may take some time before the individual is willing to discuss those aspects of the torture that he/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.

### *Follow-up*

Many infectious diseases can be transmitted by sexual assault. Some of these infectious diseases include:

- Sexually Transmitted Diseases: chlamydia, condyloma acuminatum venereal warts, gonorrhea, hepatitis B and C, herpes simplex, HIV, syphilis
- Vulvovaginitis Associated with Sexual Abuse: enterobius vermicularis pinworms, gardenarella vaginitis, moniliasis vaginitis, trichomonas, urinary tract infections

Appropriate cultures and treatment should be considered in all cases of sexual abuse. In the case of Gonorrhea and Chlamydia, concomitant infection of the anus and oropharynx should be considered for at least culture purposes. Initial cultures and or serologic tests should be obtained in cases of sexual assault and appropriate therapy initiated.

Sexual dysfunction is common among survivors of torture, particularly, but not exclusively, among those who have suffered sexual torture or rape. Symptoms may be of physical or psychological origin, or a combination of both, and include:

- Aversion to members of the opposite sex;
- Fear of sexual activity;
- Decreased interest in sexual activity;
- Inability to trust a sexual partner;
- Fear that any sexual partner will “know” that the victim has been sexually abused;
- Fear of having been damaged sexually - torturers may have threatened this;
- Fear of homosexuality in men who have been anally abused (some heterosexual men have had an erection and, on occasion, ejaculated during non-consensual anal intercourse; they should be reassured that this is a physiological response);
- Disturbance in sexual arousal;

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<sup>54</sup> Hinshelwood, G., *Gender-Based Persecution*, Toronto, United Nations Expert Group Meeting on Gender-based Persecution, 1997.

- Erectile dysfunction;
- Dyspareunia (painful sexual intercourse in females); and
- Infertility due to acquired sexually transmitted disease, direct trauma to reproductive organs, or to poorly performed abortions of pregnancies secondary to rape.

### *Genital Examination of Females*

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 not be necessary to conduct an internal pelvic examination. Genital examination findings may include:

- Small lacerations or tears of the vulva: these may be seen acutely and are caused by excessive stretching. They normally heal completely, but if repeatedly traumatized they may result in 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 from inserted sharp objects.

It is rare to find any physical evidence when examining the female genitalia more than one week after an assault. Later, when the woman may well have had subsequent sexual activity, whether consensual or not, or delivered a baby, 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 historical information (i.e. correlation between allegations of abuse and acute injuries observed by the individual) and demeanor of the individual – bearing in mind the cultural context of the woman's experience.

### *Genital Examination of Males*

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

Testicular torsion also may 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, the late sequelae of this lesion may be observed.

Individuals who were subjected to scrotal torture may suffer from chronic urinary tract infections, erectile dysfunction, or atrophy of the testes. Symptoms of Posttraumatic Stress Disorder 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 in these locations, in particular, does not demonstrate the absence of torture. Also, the presence of scarring usually indicates that substantial trauma was sustained.

### *Examination of the Anal Region*

Anal rape or insertion of objects into the anus of either gender can cause pain and bleeding to occur for days or weeks afterwards. This often leads to constipation that can be exacerbated by the poor diet provided in many places of detention. Gastrointestinal and urinary symptoms also may occur. In the acute phase any examination beyond visual inspection may require local or general anesthesia, and should be performed by a specialist. In the chronic phase some symptoms may persist and 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 not normally possible to differentiate those caused by torture from those caused by other mechanisms.

On observation 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 a more specific finding 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 such 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 – can be the result of healing trauma;
- Purulent discharge from the anus – cultures should be taken for gonorrhea and chlamydia in all cases of alleged rectal penetration, regardless of whether a discharge is noted.

### **Specialized Diagnostic Tests**

Diagnostic tests are not an essential part of the clinical assessment of a person who alleges that he/she has been tortured. In many cases, a medical history and physical examination are sufficient. However, there are circumstances in which such tests are valuable supporting evidence, for example, where there is a legal case against members of the authorities or a claim for compensation. In these cases, a “positive” test might make the difference between a case succeeding and failing. If diagnostic tests are performed for therapeutic reasons, the results should be added to a clinical report.

It must be recognized that, as with physical findings, the absence of a positive diagnostic test result must not be used to suggest that torture has not occurred.

There are many situations in which diagnostic tests are not available for technical or financial reasons, but their absence should never invalidate an otherwise properly written report. It is also inappropriate to use limited diagnostic facilities to document injuries for legal reasons alone when there are greater clinical needs for those facilities.

For further details, see Appendix I.



# V. PSYCHOLOGICAL EVIDENCE OF TORTURE

## General Considerations

The overall goal of a psychological evaluation is to assess the degree of consistency between an individual's account of torture and the psychological findings observed during the course of the evaluation. To this end, the evaluation should provide a detailed description of the individual's history (see Chapter III, "Taking the History" and Chapter IV, "Medical History"), mental status exam, assessment of social functioning, and the formulation of clinical impressions. A psychiatric diagnosis should be made if appropriate. Because psychological symptoms are so prevalent among survivors of torture, it is highly advisable that all evaluations of torture include a psychological assessment.

The assessment of psychological status and the formulation of a clinical diagnosis should always be made with an awareness of the cultural context. Awareness of culture-specific syndromes and native language-bound idioms of distress through which symptoms are communicated is of paramount importance for both conducting the interview and formulating the clinical impression and conclusion. When the interviewer has little or no knowledge about the applicant's culture, the assistance of an interpreter is essential. Ideally, an interpreter from the applicant's country knows the language, customs, religious traditions and other beliefs that will need to be considered during the evaluation.

The interview may induce fear and mistrust on the part of the individual and possibly remind him/her of previous interrogations. To reduce the effects of retraumatization, the clinician should communicate a sense of understanding of the individual's experiences and cultural background. It is not appropriate to observe the strict "clinical neutrality" that is used in some forms of psychotherapy during which the clinician is inactive and says little. The clinician should communicate that he/she is an ally of the individual and adopt a supportive, non-judgmental approach.

Psychological evaluations can provide critical evidence in torture investigations for several reasons:

- Torture often causes devastating psychological symptoms;
- Torture methods are often designed to leave no physical lesions; and

- Physical methods of torture may result in physical findings that either resolve or lack specificity.

It is a widely held view that torture is an extraordinary life experience capable of causing a wide range of physical and psychological suffering. Most clinicians and researchers agree that the extreme nature of the torture event is powerful enough on its own to produce mental and emotional consequences, regardless of the individual's pre-torture psychological status. The psychological consequences of torture, however, occur in the context of personal attribution of meaning, personality development, and social, political and cultural factors. For this reason, one cannot assume that all forms of torture have the same outcome. For example, the psychological consequences of a mock execution are not necessarily 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. Nevertheless, there are clusters of symptoms and psychological reactions that have been observed and documented in torture survivors with some regularity.

Perpetrators often attempt to justify their acts of torture and ill treatment by the need to gather information. Such conceptualizations obscure the purpose of torture and its intended consequences. Most victims of torture do not have any relevant information to reveal, a fact of which the torturer is aware. Torture reduces the individual to a position of extreme helplessness and distress that can lead to a deterioration of cognitive, emotional and behavioral functions.<sup>55</sup>

Torture is a means of attacking the individual's fundamental modes of psychological and social functioning. The torturer strives not only for physical incapacitation of the victim, but for the disintegration of the individual's personality. The torturer attempts to destroy the victim's sense of being grounded in a family and society as a human being with dreams, hopes and aspirations for the future. The aim of torture is to dehumanize the victim, break his/her will, and at the same time, set horrific examples for those who come in contact with the victim. In this way, torture can break or damage the will and coherence of entire communities. In addition, torture can profoundly damage intimate relationships between spouses, parents, children and other family members, and relationships between the victims and their communities.

It is important to recognize that not everyone who has been tortured develops a diagnosable mental illness. However, many victims experience profound emotional reactions and psychological symptoms. The main

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<sup>55</sup> Fischer, G. & Gurriss, N.F., "Grenzverletzungen: Folter und sexuelle Traumatisierung," in W. Senf & M. Broda (editors), *Praxis der Psychotherapie-Ein integratives Lehrbuch fuer Psychoanalyse und Verhaltenstherapie*, Stuttgart, Thieme, 1996.

psychiatric disorders associated with torture are Posttraumatic Stress Disorder (PTSD) and Major Depression. While these disorders are present in the general population, their prevalence is much higher among traumatized populations.<sup>56</sup>

The unique cultural, social and political meanings that torture has for each individual influence his/her ability to describe and speak about it. These are important factors that contribute to the impact that the torture has psychologically and socially and that must be considered when performing an evaluation of an individual from another culture. Cross-cultural research reveals that phenomenological or descriptive methods are the most useful approaches to employ when attempting to evaluate psychological or psychiatric disorders. What is considered a disorder or a disease in one culture may not be viewed as pathological in another.<sup>57, 58</sup>

In recent years, 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. Expert opinion indicates that care must be taken in applying this diagnosis in non-Western cultural groups, as symptom presentation and overall psychological response may vary. While recognizing such precautions, evidence suggests that there are high rates of PTSD and depression symptoms among traumatized refugee populations from multiple different ethnic and cultural backgrounds, and that these diagnoses are clinically meaningful. The World Health Organization's cross-cultural study of depression provides a helpful guiding principle: even where symptoms of a psychiatric syndrome may be present across different cultures, they may not be the primary concern of the individual who manifests them.

## **Psychological Consequences of Torture**

### **Cautionary Remarks**

Before entering into a technical description of symptoms and psychiatric classifications, it should be noted that such classifications are generally considered Western medical concepts and that the application, either implicitly

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<sup>56</sup> Kessler, R., "Posttraumatic Stress Disorder: The Burden to the Individual and to Society," *Journal of Clinical Psychiatry*, 2000; 61 (sup. 5); Kessler, R., Sonnega, A., Brom, E., et al., "Post-traumatic Stress Disorder in the National Comorbidity Survey," *Archive of General Psychiatry*, 1995; 52:1048-1060.

<sup>57</sup> Kleinman, A., "Anthropology and Psychiatry: The Role of Culture in Cross-Cultural Research on Illness and Care," paper delivered at WPA regional symposium, *Psychiatry and its Related Disciplines*, 1986; and Engelhardt, H.T., "The Concepts of Health and Disease," in H.T. Engelhardt & S.F. Spicker (editors) *Evaluation and Explanation in the Biomedical Sciences*, D. Reidel Publishing Co., Holland, 1975; 125-141.

<sup>58</sup> Westermeyer, J., "Psychiatric Diagnosis across Cultural Boundaries," *American Journal of Psychiatry*, 1985; 142(7), 798-805.

or explicitly, to non-Western populations presents certain difficulties. It can be argued that Western cultures suffer from an undue medicalization of psychological processes. The idea that mental suffering represents a “disorder” that resides in an individual and features a particular set of typical symptoms may not be acceptable to many members of non-Western societies. Nonetheless, there is considerable evidence for biological changes that occur in PTSD and, from that perspective, PTSD is a diagnosable syndrome amenable to treatment both biologically and psychologically.<sup>59</sup> Furthermore, because the DSM-IV is the recognized professional standard for psychiatric diagnosis in the United States, it is important to utilize it, with appropriate elaboration of qualification, for psychological evaluations presented to United States immigration courts. If an applicant is uncomfortable with perceived medicalization of his/her experience, this should be respectfully discussed as part of the clinical process.

As much as possible, the evaluating physician or psychologist should attempt to relate to mental suffering in the context of the individual’s beliefs and cultural norms. This includes respect for the political contexts as well as cultural and religious beliefs. Given the severity of torture and its consequences, when performing a psychological evaluation, one should adopt an attitude of informed learning rather than rush to diagnose and classify. Ideally, such an attitude will communicate to the individual that his/her complaints and suffering are being recognized as real and expectable under the circumstances. In this sense, a sensitive empathic attitude may offer the victim some relief from experiences of alienation.

## Common Psychological Responses

### *Re-experiencing the Trauma*

- Flashbacks or intrusive memories, i.e. the subjective sense that the traumatic event is happening all over again, even while the person is awake and conscious
- Recurrent nightmares that include elements of the traumatic event(s) in either their original or symbolic form
- Distress at exposure to cues that symbolize or resemble the trauma. This may include lack of trust and fear of persons of authority, including physicians and psychologists. In countries or situations where authorities participate regularly in human rights violations, lack of trust and fear of authority figures should not be assumed to be pathological

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<sup>59</sup> Friedman, M. & Jaranson, J., “The Applicability of the Post-Traumatic Concept to Refugees” in Marsella, A.J., et al. (editors) *Amidst Peril and Pain: The Mental Health and Wellbeing of the World’s Refugees*, Washington, DC, American Psychological Association Press, 1994; 207-227.

### *Avoidance and Emotional Numbing*

- Avoidance of any thoughts, conversations, activities, places or people that arouse recollection of the trauma
- Profound emotional constriction
- Profound personal detachment and social withdrawal
- Inability to recall an important aspect of the trauma

### *Hyperarousal*

- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response
- Generalized anxiety
- Shortness of breath, sweating, dry mouth, dizziness
- Gastrointestinal distress

### *Symptoms of Depression*

- Depressed mood
- Anhedonia: markedly diminished interest or pleasure in activities
- Appetite disturbance and resulting weight loss
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue and loss of energy
- Feelings of worthlessness and excessive guilt
- Difficulty in attention, concentration and memory
- Thoughts of death and dying, suicidal ideation, suicide attempts

### *Damaged Self-Concept and Foreshortened Future*

- A subjective feeling of having been irreparably damaged<sup>60</sup> and of having undergone an irreversible personality change

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<sup>60</sup> Holtan, N.R., "How Medical Assessment of Victims of Torture Relates to Psychiatric Care," in Jaranson & Popkin (editors) *Caring for Victims of Torture*, Washington, DC, American Psychiatric Press, 1998; 107-113.

- A sense of foreshortened future: not expecting to have a career, marriage, children or a normal life span

### *Dissociation, Depersonalisation and Atypical Behavior*

- Dissociation: 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/herself from a distance.
- Depersonalisation: feeling detached from oneself or one's body
- Impulse control problems, resulting in behaviors that the survivor considers highly atypical with respect to his/her pre-trauma personality; a previously cautious individual may engage in high-risk behavior

### *Somatic Complaints*

Somatic symptoms such as pain and headache and other physical complaints, with or without objective findings, are common problems among torture victims. Pain may be the only presenting complaint. It may shift in location and vary in intensity. Somatic symptoms can be a direct physical consequence of torture, be of psychological origin or both. Typical somatic complaints include:

- Headaches: a history of beatings to the head and other head injuries are very common among torture survivors. These injuries often lead to post-traumatic headaches that are chronic in nature. Headaches may also be caused by or exacerbated by tension and stress.
- Back pain
- Musculoskeletal pain

### *Sexual Dysfunction*

Sexual dysfunction is common among survivors of torture, particularly but not exclusively, among those who have suffered sexual torture or rape. (See Chapter IV, "Examinations & Evaluations Following Specific Forms of Torture")

### *Psychosis*

Cultural and linguistic differences may be confused with psychotic symptoms. Before labeling someone as psychotic, one must evaluate the symptoms within the individual's unique cultural context. Psychotic reactions may be brief or prolonged. The psychotic symptoms may occur while the person is detained and tortured as well as afterwards. The following is a list of possible findings:

- Delusions
- Hallucinations: auditory, visual, tactile, olfactory
- Bizarre ideation and behavior
- Illusions or perceptual distortions: These may take the form of pseudo-hallucinations and may border on true psychotic states. False perceptions and hallucinations that occur on falling asleep or on waking are common among the general population and do not denote psychosis. It is not uncommon for a torture victim to report occasionally hearing screams, his/her name being called, or seeing shadows, but not have florid signs or symptoms of psychosis.
- Paranoia and delusions of persecution
- Recurrence of psychotic disorders or mood disorders with psychotic features: These may develop among those who have a past history of mental illness. Individuals with a past history of bipolar disorder, recurrent major depression with psychotic features, schizophrenia and schizoaffective disorder may experience an episode of that disorder.

### *Substance Abuse*

Alcohol and drug abuse often develops secondarily in torture survivors as a way of obliterating traumatic memories, regulating affect and managing anxiety.

### *Neuropsychological Impairment*

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 neuropsychological consequences that may not be readily assessed during the course of a medical examination. As in all cases of brain impairment that can not be documented through head imaging or other medical procedures, neuropsychological assessment and testing may be the only reliable method for documenting its effects. Frequently, the target symptoms for such assessments have significant overlap with the symptomatology arising from PTSD and major depressive disorder. Fluctuations or deficits in level of consciousness, ori-

entation, attention, concentration, memory and executive functioning may result from functional disturbances as well as organic causes. Therefore, specialized skill in neuropsychological assessment as well as awareness of problems in cross-cultural validation of neuropsychological instruments is necessary when such distinctions are to be made. (See Chapter V, “Components of the Psychological/Psychiatric Evaluation.”)

## Diagnostic Classifications

While the chief complaints and most prominent findings among torture survivors are widely diverse and relate to the individual’s unique life experiences and his/her unique cultural, social and political context, it is wise for evaluators to become familiar with the most commonly diagnosed disorders among trauma and torture survivors. Also, it is not uncommon for more than one mental disorder to be present, as there is considerable comorbidity among trauma-related mental disorders. Various manifestations of anxiety and depression are the most common symptoms resulting from torture. Not infrequently the symptomatology described above will be classified within the categories of anxiety and mood disorders. The two prominent classification systems are the *International Classification of Disease (ICD-10)*<sup>61</sup> *Classification of Mental and Behavioral Disorders* and the American Psychiatric Association’s *Diagnostic and Statistical Manual, Fourth Edition (DSM-IV)*.<sup>62</sup> For complete descriptions of diagnostic categories, the reader should refer to ICD-10 and DSM-IV. This review will focus on the most common trauma related diagnoses, PTSD, major depression, and enduring personality changes.

### *Depressive Disorders*

Depressive states are almost ubiquitous among survivors of torture. In the context of evaluating the consequences of torture, it is problematic to assume that PTSD and major depressive disorder are two separate disease entities with clearly distinguishable etiologies. Depressive disorders include Major Depressive Disorder, Single Episode or Major Depressive Disorder, Recurrent (more than one episode). Depressive disorders can be present with or without psychotic, catatonic, melancholic or atypical features. According to DSM-IV, in order to make a diagnosis of Major Depressive Episode, five or more of the following symptoms must be present during the same two week period and represent a change from previous functioning (at least one of the symptoms must be depressed mood or loss of interest or pleasure). The symptoms must cause significant distress or impaired social or occupational functioning, not be due to a physiological disorder, and can not be accounted for by another DSM-IV diagnosis:

- Depressed mood
- Markedly diminished interest or pleasure in all or almost all activities

- Weight loss or decreased or increased appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to think or concentrate
- Recurrent thoughts of death or suicide

### *Posttraumatic Stress Disorder*

The diagnosis most commonly associated with the psychological consequences of torture is Posttraumatic Stress Disorder (PTSD). The association between torture and this diagnosis 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 is the main psychological consequence of torture.

The DSM-IV definition of PTSD relies heavily on the presence of memory disturbances in relation to the trauma such as intrusive memories, nightmares and/or the inability to recall important aspects of the trauma. The individual may not be able to recall with precision specific details of the torture events but will be able to recall the major themes of the torture experiences. For example, the victim may be able to recall being raped on several occasions but not be able to give the exact dates, locations, and details of the setting or perpetrators. Under such circumstances, the inability to recall precise details supports, rather than discounts, the credibility of a survivor's story. Major themes in the story also will be consistent upon re-interviewing.

The ICD-10 diagnosis of PTSD is very similar to that of DSM-IV. ICD-10 lists three categories of symptoms that must be present for at least one month. Duration of less than three months is considered acute, while longer persistence indicates a chronic disorder. The three categories of symptoms are:

- Intrusion of memories such as recurrent recollection of the events while awake, nightmares, reliving the experience of torture, flashbacks;
- Avoidance and denial of thoughts, feelings and activities associated with the trauma, feelings of detachment from others; and

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<sup>61</sup> World Health Organization, *The ICD-10 Classification of Mental and Behavioral Disorders and Diagnostic Guidelines*, Geneva, 1994.

<sup>62</sup> American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Washington, DC, 1994.

- Increased arousal such as sleep disturbance, irritability, difficulty in concentrating, hypervigilance and heightened startle responses.

According to DSM-IV, PTSD can be acute, chronic or delayed. The symptoms must be present for more than one month and the disturbance must cause significant distress or impairment in functioning. In order to make the diagnosis of PTSD, the individual must have been exposed to a traumatic event that involved life-threatening experiences for him/herself or others and produced intense fear, helplessness or horror. The event must be “re-experienced” persistently in one or more of the following ways:

- Intrusive distressing recollections of the event
- Recurrent distressing dreams of the event
- Acting or feeling as if the event were happening again (i.e., hallucinations, flashbacks, or illusions)
- Intense psychological distress at exposure to reminders of the event
- Physiological reactivity when exposed to cues that resemble or symbolize aspects of the event

The individual must persistently demonstrate avoidance of stimuli associated with the traumatic event and/or show general numbing of responsiveness as indicated by at least three of the following:

- Efforts to avoid thoughts, feelings or conversations associated with the trauma
- Efforts to avoid activities, places or people that remind him/her of the trauma
- Inability to recall an important aspect of the event
- Diminished interest in significant activities
- Detachment or estrangement from others
- Restricted affect
- Foreshortened sense of future

Also necessary to make the DSM-IV diagnosis of PTSD is the persistence of symptoms of increased arousal that were not present before the trauma as indicated by at least two of the following:

- Difficulty falling or staying asleep
- Irritability or angry outbursts
- Difficulty concentrating

- Hypervigilance
- Exaggerated startle response

Symptoms of PTSD can be chronic or fluctuate over extended periods of time. During some intervals, symptoms of hyperarousal and irritability dominate the clinical picture; at these times the survivor will usually also report increased intrusive memories, nightmares and flashbacks. At other times the survivor may appear relatively asymptomatic or emotionally constricted and withdrawn. One must keep in mind that not meeting diagnostic criteria of PTSD does not mean that torture was not inflicted. According to ICD-10, in a certain proportion of cases, PTSD may follow a chronic course over many years, with eventual transition to an enduring personality change.

### *Enduring Personality Change*

After catastrophic or prolonged extreme stress, disorders of adult personality may develop in persons with no previous personality disorder. The types of extreme stress that can change the personality include concentration camp experiences, disasters, prolonged captivity with an imminent possibility of being killed and exposure to life-threatening situations such as being a victim of terrorism, and torture. According to ICD-10, the diagnosis of an enduring change in personality should only be made when there is evidence of a definite, significant and persistent change in the individual's pattern of perceiving, relating or thinking about the environment and him/herself, associated with inflexible and maladaptive behaviors not present before the traumatic experience. The diagnosis excludes changes that are a manifestation of another mental disorder or a residual symptom of any antecedent mental disorder, as well as personality and behavioral changes due to brain disease, dysfunction or damage.

To make the ICD-10 diagnosis of "enduring personality change after catastrophic experience," the changes in personality must be present for at least two years following exposure to catastrophic stress. ICD-10 specifies that 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." This personality change is characterized by a hostile or distrustful attitude towards the world, social withdrawal, feelings of emptiness or hopelessness, estrangement and a chronic feeling of "being on edge," as if constantly threatened.

### *Substance Abuse*

Clinicians have observed that alcohol and drug abuse often develops secondarily in torture survivors as a way of suppressing traumatic memories, regulating unpleasant affects and managing anxiety. Although co-morbidity of PTSD with other disorders is common, systematic research has

seldom studied the abuse of substances by torture survivors. The literature on populations that suffer from PTSD may include torture survivors such as refugees, prisoners of war and veterans of armed conflicts and may provide some insight. Studies of these groups reveal that (a) substance abuse prevalence varies by ethnic or cultural group,<sup>63, 64</sup> (b) former prisoners of war with PTSD were at increased risk for substance abuse<sup>65, 66</sup> and (c) combat veterans have high rates of co-morbidity of PTSD and substance abuse.<sup>67, 68, 69, 70</sup> In summary, there is considerable evidence from other populations at risk for PTSD that substance abuse is a potential co-morbid diagnosis for torture survivors.

### *Other Diagnoses*

As evident from the catalogue of symptoms described in the section “Common Psychological Responses and Symptoms,” (see Chapter V), there are other diagnoses to be considered in addition to PTSD, major depressive disorder and enduring personality change. The other possible diagnoses include, but are not limited to:

- Generalized anxiety disorder: featuring excessive anxiety and worry about a variety of different events or activities, motor tension and increased autonomic activity
- Panic disorder: recurrent and unexpected attacks of intense fear or discomfort including at least four of the following symptoms: sweating, choking, trembling, rapid heart rate, dizziness, nausea, chills or hot flashes

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<sup>63</sup> Farias, P.J., “Emotional Distress and Its Socio-Political Correlates in Salvadoran Refugees: Analysis of a Clinical Sample,” *Culture, Medicine and Psychiatry*, 1991; 15:167-192.

<sup>64</sup> Dadfar, A., “The Afghans: Bearing the Scars of a Forgotten War,” Marsella, A.J., et al. (editors) *Amidst Peril and Pain: The Mental Health and Wellbeing of the World’s Refugees*, Washington, DC, American Psychological Association Press, 1994.

<sup>65</sup> Beebe, G.W., “Follow-up Studies of World War II and Korean War Prisoners, II: Morbidity, Disability, and Maladjustments,” *American Journal of Epidemiology*, 1975; 101, 400-422.

<sup>66</sup> Engdahl, B.E., Dikel, T., Eberly, R.E., & Blank, A. (in review), “The Comorbidity and Course of Psychiatric Disorders in a Community Sample of Former Prisoners of War.”

<sup>67</sup> Keane, T.M. & Wolfe, J., “Comorbidity in Post-Traumatic Stress Disorder: An Analysis of Community and Clinical Studies,” *Journal of Applied Social Psychology*, v. 20, no. 21 (Pt 1), 1990; 1776-1788.

<sup>68</sup> Kulka, R.A., Schlenger, W.E., Fairbank, J.A., Hough, R.L., Jordan, K., Marmar, C.R. & Weiss, D., *Trauma and the Vietnam War Generation: Report of Findings from the National Vietnam Veterans Readjustment Study*, New York: Brunner/Mazel, 1990.

<sup>69</sup> Jordan, K. Schlenger, W.E., Hough, R.L., Kulka, R.A., Weiss, D.S., Fairbank, J.A. & Marmar, C.R., “Lifetime and Current Prevalence of Specific Psychiatric Disorders among Vietnam Veterans and Controls,” *Archives of General Psychiatry*, v. 48, no. 3, 1991; 207-215.

<sup>70</sup> Shalev, A.Y., Bleich, A. & Ursano, R.J., “Post-Traumatic Stress Disorder: Somatic Comorbidity and Effort Tolerance,” *Journal of Psychosomatics*, v. 31, no. 2, 1990; 197-203.

- Acute stress disorder: this disorder features essentially the same symptoms as PTSD but is diagnosed within one month of exposure to the traumatic event
- Somatoform disorders: featuring physical symptoms that cannot be accounted for by a medical condition
- Bipolar disorder: featuring manic or hypomanic episodes with elevated, expansive or irritable mood, grandiosity, decreased need for sleep, flight of ideas, psychomotor agitation and associated psychotic phenomena
- Disorders due to a general medical condition: often in the form of brain impairment with resultant fluctuations or deficits in level of consciousness, orientation, attention, concentration, memory and executive functioning
- Phobias: such as social phobia and agoraphobia

## **The Psychological / Psychiatric Evaluation**

### **Interview Process**

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 (see also Chapter III, “Risk of Retraumatization of the Interviewee”). These emotional reactions are known as transference and countertransference. For example, mistrust, fear, shame, rage and guilt are among the typical reactions that torture survivors experience, particularly when asked to recount and remember details of their trauma history. Transference relates to feelings a survivor exhibits towards the clinician that are triggered by past experiences, but appear to be directed towards the clinician personally. In addition, the clinician’s emotional responses (e.g., horror or disbelief) to the torture survivor, known as countertransference, may affect the psychological evaluation. Transference and countertransference are mutually interdependent and interactive.

An interview or examination that involves recounting and remembering the details of a traumatic history will result in exposure to distressing and unwanted memories, thoughts and feelings, and can stimulate transference. Thus, even though a torture victim may consent to an evaluation with the hope of benefiting from it, the ensuing dialogue may be experienced as mirroring the trauma itself. This may result in the following phenomena:

The evaluator’s questions may be experienced as a forced exposure akin to an interrogation. The evaluator may be suspected of having voyeuristic and sadistic motivations, e.g., “Why does he/she make me reveal every last terrible detail of what happened to me?”; “Why would a

normal person choose to listen to stories like mine in order to make a living? He/she must have some strange kind of motivation.”

There may be prejudices towards the evaluator because he/she has not been arrested and tortured, therefore could not possibly understand how the victim feels.

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.

If the gender of the evaluator and of the torturer is the same, the interview situation may be perceived as resembling the torture situation more strongly 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 evaluator than she might experience with a female interviewer. Male rape victims may be ashamed to tell the details of their abuses to a female evaluator, but they may also experience fear speaking with a male evaluator if their abusers were male. It should be noted that in all but the most “traditionally fundamentalist” societies (where it is out of the question for a male to even interview – let alone examine – a woman), experience has shown that interviewees prioritize medical qualifications over gender due to the importance of being able to ask precise questions. Victims of rape have been known not to say anything to non-medical female clinicians and instead ask to talk to a physician, even if male, so that they may ask specific questions to a medical professional. Typical questions relate to possible sequelae such as pregnancy, reproductive function, the future of sexual relations between spouses, etc.

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 mistrust or doubt on the part of the examiner.

Under the aforementioned psychological pressures, survivors may either feel re-traumatized and overwhelmed with memories and affect or they may mobilize very strong defenses that result in profound withdrawal and affective flattening during examinations or interviews. For the purposes of documentation, it is particularly the withdrawal and flattening that presents difficulties because torture victims may be least able to effectively communicate their history and current suffering when it would be most beneficial for them to do so.

Countertransference reactions are often unconscious. When one is not aware of one’s countertransference, it becomes a problem. Having strong feelings when listening to individuals speak of their torture is to be expected. Although these feelings can interfere with the clinician’s effectiveness, when understood, they can also guide the clinician. Physicians and psychologists involved in the evaluation and treatment of torture victims

agree that attention to and understanding of typical countertransference reactions are crucial because countertransference can have significantly limiting effects on the clinician's ability to evaluate and document the physical and psychological consequences of torture. Effective documentation of torture and other forms of ill treatment requires an understanding of personal motivations for working in this area. There is consensus that professionals who continuously conduct this kind of examination should get the supervision and professional support from peers who are experienced in this field. Common countertransference reactions 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 over-identification that may lead to symptoms of depression or "vicarious traumatization" such as nightmares, anxiety and fearfulness;
- Omnipotence and grandiosity in the form of feeling like a savior, the great expert on trauma or the last hope for the survivor's recovery and well-being;
- Feelings of insecurity in one's professional skills in the face of the gravity of the reported history or suffering. This may manifest as a lack of confidence in one's 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 toward torturers and persecutors is expectable but may undermine the ability to maintain necessary objectivity when it is driven by unrecognized personal experiences and thus becomes chronic or excessive;
- Anger or repugnance against the individual may arise as a result of feeling exposed to unaccustomed levels of anxiety. They also may arise as a result of feeling used by the individual when the clinician experiences doubt about the truth of the alleged torture history and the individual stands to benefit from an evaluation that documents the consequences of the alleged history.

Significant differences in cultural value systems between the clinician and individual alleging torture may include a belief in myths about ethnic groups, condescending attitudes and underestimation of individuals' sophistication or capacity for insight. Conversely, clinicians who are mem-

bers of the same ethnic group as victims 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 may be important sources of information about the psychological state of the torture victim. Clinicians' effectiveness can be compromised when countertransference is acted upon rather than reflected upon. Clinicians engaged in the evaluation and treatment of torture victims are advised to examine countertransference and obtain supervision and consultation from a colleague when necessary.

### **Components of the Psychological/Psychiatric Evaluation**

This section of the manual provides an outline of the components of the psychological/psychiatric evaluation and serves as a guideline for preparing the written document. The major subheadings listed below should be included in the final report. Each subheading contains suggestions about information that should be obtained from the interviewee and from the mental status exam and included in the written evaluation. Where pertinent, there is additional information about why certain factors are important to include, what topics might be stressful for the interviewee to discuss, as well as advice on formulating a diagnosis. There are six helpful points in the Clinical Impression section to assist the clinician with evaluating the findings of his/her psychological examination.

#### *Introduction*

- Client's/patient's 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*

- History of torture (see Chapter III, "Taking the History" and Chapter IV, "Medical History")
- Persecution
- Refugee displacement
- Other relevant traumatic experiences

This part of the evaluation is often exhausting for the person being evaluated. Therefore, it may be necessary to proceed in several sessions. One

may consider starting with a general summary of the events before eliciting the details of torture experiences. The interviewer needs to know the legal issue at hand because that will determine the nature and amount of information necessary to achieve that legal standard.

### *Current Psychological Complaints*

The assessment of current psychological functioning constitutes the core of the evaluation. As severely brutalized prisoners of war and rape victims show a lifetime prevalence of PTSD of between 80% and 90%,<sup>71,72</sup> specific questions about the three DSM-IV categories of PTSD (re-experiencing of the traumatic event, avoidance or numbing of responsiveness including amnesia and increased arousal) need to be asked. Affective, cognitive, and behavioral symptoms should be described in detail and frequencies as well as examples (of nightmares, hallucinations, startle response) should be stated. An absence of symptoms can be due to the episodic or often delayed nature of PTSD or to denial of symptoms due to shame.

### *Post-Torture History*

This component of the psychological evaluation obtains information about current life circumstances. It is important to inquire about current sources of stress, such as separation or loss of loved ones, flight from one's home country and life in exile. The interviewer should also inquire about the individual's ability to be productive, earn a living, care for his/her family and access social supports.

### *Pre-Torture History*

- Developmental history: if relevant, describe childhood, adolescence, early adulthood
- Family history: family background, family illnesses, family composition
- Educational history
- Occupational history
- History of past trauma: childhood abuse, war trauma, domestic violence, etc.
- Cultural and religious background

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<sup>71</sup> Rothbaum, B.O., Foa, E.B., Riggs, D.S., et al., "A Prospective Examination of Post-Traumatic Stress Disorder Rape Victims," *Journal of Traumatic Stress*, 1992; 5, 455-475.

<sup>72</sup> Sutker, P.B., Winstead, D.K. & Galina, Z.H., "Cognitive Deficits and Psychopathology among Former Prisoners of War and Combat Veterans of the Korean Conflict," *American Journal of Psychiatry* 1991; 148, 62-72.

The summary of pre-trauma history is important to assess mental health status and level of psychosocial functioning of the 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/she was tortured.

In evaluating background information the interviewer should keep in mind that the duration and severity of responses to trauma are affected by multiple factors. These factors include, but are not limited to, the following:

- Circumstances of the torture
- Perception and interpretation of torture by the victim
- Social context before, during and after torture
- Community and peer resources, values and attitudes about traumatic experiences
- Political and cultural factors
- Severity and duration of the traumatic events
- Genetic and biological vulnerabilities
- Developmental phase and age of the victim
- Prior history of trauma
- Pre-existing personality

In many interview situations, due to time limitations and other problems, it may be difficult to obtain much of the above information. It is important, nonetheless, to obtain enough data about the individual's previous mental health and psychosocial functioning to form an impression of the degree to which torture has contributed to psychological problems.

#### *Medical History (see Chapter IV, "Medical History")*

The medical history summarizes pre-trauma health conditions, current health conditions, body pain, somatic complaints, use of medication and their side effects, relevant sexual history, past surgical procedures, and other medical data.

#### *Past Psychiatric History*

One should inquire as to 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 hospitalization. The inquiry also should include prior therapeutic use of psychotropic medications.

#### *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. These substances not only should include alcohol, cannabis, and opium, but regional substances of abuse, such as betel nut.

### *Mental Status Examination*

The mental status examination begins the moment the clinician meets the subject. The interviewer should make note of the person's appearance (such as signs of malnutrition and/or lack of cleanliness), changes in motor activity during the interview, use of language, presence of eye contact, the ability to relate to the interviewer and means the individual uses to establish communication. The following list summarizes the components of the exam. All aspects of the mental status examination should be included in the report of the psychological evaluation:

- General appearance
- Motor activity
- Speech
- Mood and affect
- Thought content
- Thought process
- Suicidal and homicidal ideation
- Cognitive exam: orientation, long term memory, intermediate recall, and immediate recall

### *Assessment of Social Function*

Trauma and torture can directly and indirectly affect a person's ability to function. Torture also can indirectly cause loss of functioning and disability if the psychological consequences of the experience impair the individual's ability to care for him/herself, earn a living, support a family, pursue education, etc. The clinician should assess the individual's current level of functioning by inquiring about daily activities, social role function (e.g., housewife, student, worker), social and recreational activities and perceptions of health status. One should ask the individual to assess his/her own health condition, to state the presence or absence of feelings of chronic fatigue and to report potential changes in overall functioning. For asylum seekers held in detention it may be very difficult to assess changes in overall function. The individual is held in artificial circumstances without a "normal" daily life and without opportunity to work or function in a "normal" setting.

### *Psychological Testing and the Use of Checklists and Questionnaires*

An individual who has survived torture may have trouble expressing his/her experiences and symptoms in words. 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 utilize trauma event and symptom checklists, there are numerous questionnaires available, although none are specific to torture victims.

Little published data exist on the use of psychological testing (projective and objective personality tests) in the assessment of torture survivors. Also, psychological tests of personality lack cross-cultural validity. These factors combine to severely limit the utility of psychological testing in the evaluation of torture victims. Neuropsychological testing, however, may be helpful in assessing cases of brain injury resulting from torture.

### *Clinical Impression*

In formulating the clinical impression for the purposes of reporting psychological evidence of torture, there are six important questions to ask:

- Are the psychological findings consistent with the alleged report of torture?
- Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?
- Given the fluctuating course of trauma-related mental disorders over time, what is the time frame in relation to the torture events? At what stage is the individual in the course of recovery?
- What are the coexisting stressors impinging on the individual (e.g., detention, ongoing persecution, forced migration, exile or loss of family and social role)? What impact do these issues have on the individual?
- What physical conditions contribute to the clinical picture? Pay special attention to any head injury sustained during torture and/or detention.
- Does the clinical picture suggest a false allegation of torture?

Clinicians should comment on the consistency of psychological findings and the extent to which these findings correlate with the alleged abuse. The emotional state and expression of the person during the interview, his/her symptoms, history of detention and torture, and personal history prior to torture should be described. Factors such as the onset of specific symptoms in relation to the trauma, the specificity of any particular psychological findings, and 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, and unemployment should be considered. 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. If available, these individuals can be referred for neurological and/or neuropsychological assessment.

If the survivor has symptom levels consistent with a DSM IV or ICD 10 psychiatric diagnosis, the diagnosis should be stated. More than one diagnosis may be present. Again, it must be stressed that even though a diagnosis of a trauma related mental disorder supports the claim of torture, not meeting criteria for a psychiatric diagnosis does not mean the person was not tortured. A survivor of torture may not have the level of symptoms required to fully meet diagnostic criteria for a DSM IV or ICD 10 diagnosis. In these cases, as with all others, the symptoms that the survivor has, and the torture story that he/she claims to have experienced, should be considered as a whole. The degree of consistency between the torture story and the symptoms that the individual reports should be evaluated and included in the report.

It is important to recognize that some people falsely allege torture for a range of reasons, and that others may exaggerate a relatively minor experience in order to make a stronger case for asylum. The clinician must always be aware of these possibilities and try to identify potential reasons for exaggeration or fabrication. The clinician should keep in mind, however, that such fabrication requires a detailed knowledge about trauma related symptoms that individuals rarely possess. Inconsistencies in testimony 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. Effective documentation of psychological evidence of torture requires clinicians to have the capacity to evaluate consistencies and inconsistencies in the report. If the interviewer suspects fabrication, additional interviews should be scheduled to help clarify inconsistencies in the report. Family or friends may be able to corroborate details of the history. If the clinician conducts additional examinations and still suspects fabrication, he/she should consult with colleagues on inconsistencies. The persistent suspicion of fabrication should be reported the applicant's attorney, who will determine whether to proceed with preparation of the affidavit.

### *Recommendations*

The recommendations resulting from the psychological evaluation depend on the original question posed at the time the evaluation was requested. Recommendations can include further assessment such as neuropsychological testing, medical or psychiatric treatment, as well as the need for asylum.

## Neuropsychological Assessment

Clinical neuropsychology is an applied science concerned with the behavioral expression of brain dysfunction. Neuropsychological assessment in particular is concerned with the measurement and classification of the behavioral disturbances associated with organic brain impairment. The discipline has long been recognized 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, there are very few neuropsychological studies of torture survivors available in the literature.<sup>73</sup> The following remarks therefore are limited to a discussion of general principles that may guide health providers in understanding the utility of, and indications for, neuropsychological assessment among subjects suspected of being tortured. Before discussing the issues of utility and indications, it is essential to recognize the limitations of neuropsychological assessment in this population.

### Limitations of Neuropsychological Assessment

There are a number of common factors complicating the assessment of torture survivors in general that are outlined in earlier in this Manual (see Chapter III). These factors apply to neuropsychological assessment in the same way as to a medical or psychological examination. Neuropsychological assessments may be limited by a number of additional factors including: 1) lack of research on torture survivors; 2) reliance on population-based norms; 3) cultural and linguistic differences and 4) retraumatization of those who have experienced torture.

1) Lack of research on torture survivors: As mentioned above, very few references exist at present in the literature concerning the neuropsychological assessment of torture victims. The pertinent body of literature concerns various types of head trauma and the neuropsychological assessment of PTSD in general. Therefore, the following discussion and subsequent interpretations of neuropsychological assessments are necessarily based on applying general principals established in subject populations other than torture victims.

2) Reliance on population-based norms: Neuropsychological assessment as it has been developed and practiced in the Anglo-American tradition relies heavily on an actuarial approach that typically involves comparing the results of a battery of standardized tests to population-based norms.

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<sup>73</sup> Jacobs, U. & Iacopino, V., "Torture and Its Consequences: A Challenge to Clinical Neuropsychology," *Professional Psychology: Research and Practice*, 2001 (in press).

Although there is consensus that norm-referenced interpretations of neuropsychological assessments can go hand in hand with an approach of qualitative analysis,<sup>74,75</sup> a reliance on the actuarial approach predominates. Moreover, a reliance on test scores tends to be greatest when the severity of the brain impairment is mild to moderate in severity, rather than severe, or when neuropsychological deficits are thought to be secondary to a psychiatric disorder. Given the limitations of such an actuarial approach with torture victims, the importance of qualitative, non-psychometric paradigms in the analysis of deficits cannot be overestimated. The general principles of cross-cultural neuropsychology are applicable and can be found in Nell, 2000, and Fletcher-Janzen, Strickland & Reynolds, 2000.<sup>75,76</sup>

3) Cultural and linguistic differences: the use of interpreters in assessment is a particularly difficult challenge that cannot be avoided when linguistically and culturally competent neuropsychologists are not available to conduct assessments, which is frequently the case for survivors of torture from developing countries. Interpreters require additional training for such purposes and can be most helpful when they are part of the same cross-cultural treatment team as the neuropsychologist. Alternatively, Nell's model of "devolving the transferable technology" of neuropsychological assessment by making neuropsychological skills available to culturally competent psychologists or other professionals may be pursued when such professionals are available and can be trained.<sup>76</sup>

4) Retraumatization: Neuropsychological assessments may retraumatize those who have experienced torture. Great care must be taken to minimize potential retraumatization of the subject in any form of diagnostic procedure (see Chapter V, "General Considerations"). To cite only one obvious example specific to neuropsychological testing, it could potentially be very damaging to administer the Halstead-Reitan Battery, in particular the Tactual Performance Test (TPT), in which the subject must be blindfolded. For most torture victims who have experienced blindfolding during detention and torture, and even for those who were not blindfolded, it would be traumatic to introduce the experience of helplessness inherent in this procedure. In fact, any form of neuropsychological testing in itself may be problematic, regardless of the particular instrument used. Being asked to give maximum effort on an unfamiliar task, being observed and timed with

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<sup>74</sup> Nell, V., *Cross-Cultural Neuropsychological Assessment: Theory and Practice*, Mahwah, NJ, Lawrence Erlbaum Associates, 2000.

<sup>75</sup> Fletcher-Janzen, E., Strickland, T. L. & Reynolds, C. R. (editors), *Handbook of Cross-Cultural Neuropsychology*. New York, Kluwer Academic/Plenum Publishers, 2000.

<sup>76</sup> Nell, V., *Cross-Cultural Neuropsychological Assessment: Theory and Practice*, Mahwah, NJ, Lawrence Erlbaum Associates, 2000.

a stop watch, and in general being asked to perform, rather than having a dialogue, may prove to be too stressful or reminiscent of a torture experience. This does not mean that such obstacles cannot be overcome or that retraumatization should be expected to occur in most cases. However, the examiner must be familiar with these potential problems in order to take extra time and effort to establish rapport and an atmosphere of safety in evaluating individuals who have suffered extreme traumatization.

### Indications for Neuropsychological Assessment

The diagnostic use of neuropsychological evaluation procedures are particularly indicated if: (a) the purpose of the evaluation is forensic in nature, e.g., the individual being examined is in detention and there is suspicion of brain injury, (b) the purpose of the evaluation is forensic in nature and there is a lack of gross neurological disturbance, (c) reported symptoms are predominantly cognitive in nature, or (d) a differential diagnosis between brain impairment and PTSD has to be made. However, regardless of the question of differential diagnosis, neuropsychological assessment may constitute the first step for neuropsychological rehabilitation by providing a comprehensive description of behavioral problems and their etiologies.

#### *Brain Injury*

- Causes: Brain injury and resulting brain damage may result from various types of head trauma and metabolic disturbances that can be inflicted during periods of persecution, detention and torture. This may include gunshot wounds, effects of poisoning and malnutrition as a result of starvation or forced ingestion of harmful substances, effects of hypoxia or anoxia resulting from asphyxiation and near drowning and most commonly from blows to the head suffered during beatings. Blows to the head are frequently encountered during periods of detention and torture. In two samples of torture survivors, blows to the head were the second most frequently cited form of bodily abuse, second only to general beating to the body. Rasmussen reports beatings to the body in 97% of cases and severe beatings to the head in 58% of cases.<sup>77</sup> Traue et al. report beatings to the body at 58% and beatings to the head at 45%.<sup>78</sup> Thus the potential for resulting brain damage must be considered high among torture victims.

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<sup>77</sup> Rasmussen, O.V., "Medical Aspects of Torture," *Danish Medical Bulletin*, 1990; 1, 1-88.

<sup>78</sup> Traue, H.C., Schwarz-Langer, G. & Gurrus, N.F., "Extremtraumatisierung durch Folter: Die Psychotherapeutische Arbeit der Behandlungszentren fuer Folteropfer," *Verhaltenstherapie und Verhaltensmedizin*, 1997; 1, 41-62.

- **Assessment:** Closed head injuries resulting in mild to moderate levels of long-term impairment are perhaps the most commonly assessed cause of neuropsychological abnormality. Signs of injury may include scars on the head, but brain lesions may not be detected by diagnostic imaging of the brain. Mild to moderate levels of brain damage might be overlooked or underestimated by treating mental health professionals because symptoms of depression and posttraumatic stress are likely to figure prominently in the clinical picture, resulting in less attention being paid to the potential effect of head trauma. Commonly, the subjective complaints of survivors include difficulties with attention, concentration and short term memory, which can be either the result of brain impairment or PTSD. Since the aforementioned complaints are so common in survivors suffering from PTSD, the question of whether they are actually due to head injury may not even be asked.
- **Differential diagnosis:** The diagnostician must rely, in an initial phase of examination, on reported history of head trauma and the course of symptomatology. As is usually the case with brain-injured subjects, information from third parties, particularly relatives, might prove helpful. It must be remembered that brain-injured subjects often have great difficulty articulating or even appreciating their limitations because they are, so to speak, “inside” the problem. In gathering first impressions regarding the difference between organic brain impairment and PTSD, an assessment concerning the chronicity of symptoms is a helpful starting point. If symptoms of poor attention, concentration and memory are observed to fluctuate over time and to co-vary with levels of anxiety and depression, this is more likely due to the phasic nature of PTSD. On the other hand, if impairment seems to appear chronic and lack fluctuation, and if complaints and observations to that effect are offered by family members, the possibility of brain impairment should be entertained, even in the initial absence of a clear history of head trauma.
- **Neurological evaluation and referral:** Once there is a suspicion of organic brain impairment, the first step for the mental health professional is to consider a referral to a physician for further neurological examination. Depending on initial findings, the physician may then consult a neurologist and/or order diagnostic tests. An extensive medical work-up, specific neurological consultation and neuropsychological evaluation are among the possibilities to be considered.
- **Test selection:** The selection of neuropsychological tests and procedures is subject to the limitations specified above and therefore can not follow a standard battery format, but rather must be case-specific and sensitive to individual characteristics. Neuropsychological assessment in general should not be conducted with an over-reliance on “testing” and this is

particularly true in a cross-cultural context, where norms are unavailable or insufficient.<sup>79, 80</sup> Thorough history-taking and observation of behavior, when informed by knowledge of brain-behavior relations, are the most powerful clinical tools and may be sufficient for arriving at diagnostic conclusions in a significant number of cases. The flexibility required in the selection of tests and procedures demands sufficient experience, knowledge and caution on the part of the examiner.<sup>81</sup>

### *Posttraumatic Stress Disorder (PTSD)*

- PTSD and Neuropsychological Impairment: The considerations offered above should make it clear that great caution is needed when attempting neuropsychological assessment of brain impairment in suspected torture victims. This must be even more strongly the case in attempting to document PTSD in suspected survivors through neuropsychological assessment. Even in the case of assessing PTSD subjects for whom population-based norms are available, there are considerable difficulties to consider.<sup>82</sup> PTSD is a psychiatric disorder and traditionally has not been the focus of neuropsychological assessment. Furthermore, PTSD does not conform to the classical paradigm of an analysis of identifiable brain lesions that can be confirmed by medical techniques. With an increased emphasis on and understanding of the biological mechanisms involved in psychiatric disorders generally, neuropsychological paradigms have recently been invoked more frequently than in the past. However, as Knight points out, "...comparatively little has been written to date on PTSD from a neuropsychological perspective."<sup>82</sup>

There is great variability among the samples used for the study of neuropsychological measures in posttraumatic stress. This may account for the variability of the cognitive problems reported from these studies. As Knight points out, "Clinical observations suggest that PTSD symptoms show the most overlap with the neurocognitive domains of attention, memory and executive functioning." This is consistent with complaints heard frequently from survivors of torture. Subjects com-

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<sup>79</sup> Jacobs, D.M., Sano, M, Albert, S., Schofield, P. et al., "Cross-Cultural Neuropsychological Assessment: A Comparison of Randomly Selected, Demographically Matched Cohorts of English- and Spanish-speaking Older Adults," *Journal of Clinical and Experimental Neuropsychology*, 1997; 19 (3), 331-339.

<sup>80</sup> Spreen, O. & Strauss, E., *A Compendium of Neuropsychological Tests*, NY, Oxford University Press, 1998.

<sup>81</sup> Comprehensive lists of neuropsychological procedures and tests and their proper application can be found in standard references such as: Spreen, O. & Strauss, E., *A Compendium of Neuropsychological Tests*, NY, Oxford University Press, 1998.

<sup>82</sup> Knight, J.A., "Neuropsychological Assessment in Post-traumatic Stress Disorder," in Wilson, J.P. & Keane, T.M. (editors) *Assessing Psychological Trauma and PTSD*, NY, Guilford, 1997.

plain of difficulties in concentrating and of feeling unable to retain information or engage in planned, goal-directed activity.

- Distinguishing PTSD from other disorders: Neuropsychological assessment methods appear able to identify the presence of neurocognitive deficits in PTSD, even though the specificity of these deficits is more difficult to establish. Some studies have documented the presence of deficits in PTSD subjects when compared to normal controls, but failed to discriminate these subjects from matched psychiatric controls.<sup>83, 84</sup> In other words, it is likely that neurocognitive deficits on test performances will be evident in cases of PTSD but insufficient for diagnosing PTSD. As in many other types of assessment, interpretation of test results must be integrated into a larger context of interview information and possibly personality testing. In that sense, specific neuropsychological assessment methods can make a contribution to the documentation of PTSD in the same manner that they may for other psychiatric disorders associated with known neurocognitive deficits.

## Conclusion

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 also may be used to evaluate specific symptoms, such as problems with memory, that occur in PTSD and related disorders.

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<sup>83</sup> Dalton, J.E., Pederson, S.L., & Ryan, J.J., "Effects of Posttraumatic Stress Disorder on Neuropsychological Test Performance," *International Journal of Clinical Neuropsychology*, 1989; 11 (3), 121-124.

<sup>84</sup> Gil, T. et al., "Cognitive Functioning in Posttraumatic Stress Disorder," *Journal of Traumatic Stress*, 1990; 3 (1), 29-45.



# VI. CHILDREN AND TORTURE

## Introduction

Torture can affect a child directly or indirectly. The impact can be due to the child's 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 indirect, 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 summarized.

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 behaviorally.<sup>85</sup> 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.

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<sup>85</sup> Schlar, C., "Evaluation and Documentation of Psychological Evidence of Torture" (unpublished paper), 1999.

## 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.<sup>86</sup> For children under the age of three who have experienced or witnessed torture, the protective and reassuring role of their caregivers is crucial.<sup>87</sup> 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.<sup>88</sup> 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 behavior.<sup>89</sup> Alternatively, the effects of torture on adolescents may be similar to those seen in younger children.

## Clinical Considerations

Symptoms of Posttraumatic Stress Disorder may appear in children. The symptoms can be similar to those observed in adults,<sup>90, 91, 92, 93</sup> but the clinician must rely more heavily on observations of the child's behavior 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

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<sup>86</sup> von Overbeck Ottino, S., *Pratique Psychothérapeutique avec les Familles Migrantes; Un Cas d'Enfant Traumatisé par la Guerre* (in press), 1999.

<sup>87</sup> Grappe, M., "La Guerre en ex-Yougoslavie: Un Regard Sur les Enfants Réfugiés," in M.R. Moro et S. Lebovici (editors), *Psychiatrie Humanitaire en ex-Yougoslavie et en Arménie; Face au Traumatisme*, PUF, Paris, 1995.

<sup>88</sup> Piaget, J., *La Naissance de l'Intelligence Chez l'Enfant*, Delachaux et Niestlé, Neuchâtel, 1936.

<sup>89</sup> Grappe, M., "La Guerre en ex-Yougoslavie: Un Regard sur les Enfants Réfugiés," in M.R. Moro et S. Lebovici (editors), *Psychiatrie Humanitaire en ex-Yougoslavie et en Arménie; Face au Traumatisme*, PUF, Paris, 1995.

of bowel movements, social withdrawal, restricted affect, attitude changes toward self and others and feelings that there is no future. He/she 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 behavior 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 behavior 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.

### **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 behaviors 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, he/she may develop dysfunctional beliefs, such as that he/she is responsible for the bad events or that he/she 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.

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<sup>90</sup> Terr, L. C., "Childhood Traumas; An Outline and Overview," *American Journal of Psychiatry*, 1991; 148, 10-20.

<sup>91</sup> *Zero to Three*, National Center for Infants, Toddlers and Families, 1994.

<sup>92</sup> Sirni, F., "On Torture un Enfant, ou les Avatars de l'Ethnocentrisme Psychologique," *Enfances*, 1995; 4, 205-215.

<sup>93</sup> Bailly, L., *Les Catastrophes et Leurs Conséquences Psychotraumatiques Chez l'Enfant*, ESF Éditeur, Paris, 1996.



# VII. WRITTEN REPORTS AND ORAL TESTIMONY

## 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 applicant's allegations of abuse. The health professional provides expert opinions on the degree to which the his/her findings correlate with the applicant's allegation of abuse. Clinical evaluations are often critical in enabling adjudicators to make accurate and just decisions for asylum applicants. In addition, each written report and oral testimony represents an opportunity for clinicians to educate adjudicators on the physical, psychological and historical evidence of torture.<sup>94</sup>

Asylum 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 Chapter III, "The Purpose of Inquiry," the ethical obligation of beneficence demands uncompromising accuracy and impartiality in order to establish and maintain professional credibility. Clinicians who conduct evaluations of asylum applicants 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 patient 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.

The clinician should review the declaration (testimony) and the asylum application that the asylum applicant has presented to the immigration office 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 applicant and/or the applicant's attorney to a point of clarity. Adjudicators often interpret inconsistent testimony as a lack of

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<sup>94</sup> For example, when reporting the absence of physical findings on examination of an applicant who alleges electric shock torture several years ago the clinician should inform the adjudicator that, under such circumstances, the absence of findings (depending the level and duration of the current and area of contact) is what is typically observed, and this element of consistence supports, rather than refutes, the allegation of electric shock torture.

credibility on behalf the applicant, when, in fact, such inconsistencies are often related to the presence of psychological, cultural, translation or other factors.

Effective written reports and oral testimony not only require knowledge of torture and its after-effects; they 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 can not 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 that was conducted.

Physical and psychological evaluations of asylum applicants 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 applicant'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.

## **Content of Written Reports**

When an asylum seeker bears physical or emotional scars from his/her mistreatment, affidavits from a medical or mental health professional should be introduced into evidence. 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 Posttraumatic Stress Disorder (PTSD). In addition, the professional's participation in training and seminars relating to torture survivors sponsored by Physicians for Human Rights or other groups 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 Physicians for Human Rights or another human rights organization, these facts should be included. A copy of the medical professional's resume or *curriculum vitae* should be attached to the affidavit.

The affidavit should document in detail any physical scars or other physical problems (e.g., a fractured leg) that the asylum seeker states to be the result of torture or physical abuse suffered at the hands of his/her per-

secutor. In identifying these physical symptoms, the medical professional should use lay terms as well as technical medical terms so that the asylum adjudicator will understand the results of the physical examination. Copies of x-rays, photographs or other reports also can be attached to the affidavit where appropriate and available.

In some cases, the medical professional may be able to conclude that the specific physical signs and/or symptoms are consistent with the form of torture or abuse reportedly suffered by the asylum seeker. For example, the medical professional may be able to describe a small scar on the asylum seeker's arm and conclude that the scar is consistent with cigarette burns. When such a conclusion can be drawn, this information should be included.

If the medical professional concludes that the asylum seeker is suffering from PTSD, depression, or other psychological effects of the torture, the affidavit should list the symptoms reported by the asylum seeker, the professional's conclusion (whether PTSD or other), and the reasons for that conclusion.

Some INS trial attorneys and immigration judges have objected to affidavits in which medical professionals recite information provided by the asylum seeker 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 asylum seeker. The asylum seeker'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 asylum seeker "states" or "reports" that a specific incident occurred. Such an approach is the safest, as even if the professional believes the asylum applicant, the professional is only reporting hearsay information. Failure to use such language has sometimes been used to undermine the credibility of medical affidavits.

The components of written reports are elaborated throughout this Manual. 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**

### **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): Y/N

Provide Details of Any Restrictions:

### **II. Clinician's Qualifications (For Judicial Testimonies)**

Medical Education and Clinical Training

Psychological / Psychiatric Training

Experience in Documenting Evidence of Torture and Ill Treatment

Regional Human Rights Expertise Relevant to the Investigation

Relevant Publications, Presentations and Training Courses

Provide Curriculum Vitae

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 of Torture Survivor:**

General Information: (*age, occupation, education, family composition, etc.*)  
Past Medical History  
Review of Prior Medical Evaluations of Torture and Ill Treatment  
Psychosocial History Pre-Arrest

#### **V. Allegations of Torture and Ill Treatment:**

Summary of Detention(s) and Abuse  
Circumstances of Arrest and Detention  
Initial and Subsequent Places of Detention (*chronology, transportation, and detention conditions*)  
Narrative Account of Ill Treatment of Torture (*in each place of detention*)  
Review of Torture Methods  
Physical Symptoms and Disabilities: Describe the development of acute and chronic symptoms and disabilities and the subsequent healing processes

#### **VI. Physical Examination**

General Appearance  
Skin  
Face/Head  
Eyes/Ears/Nose/Throat  
Oral Cavity/Teeth  
Chest/Abdomen (*including vital signs*)  
Genitourinary System  
Musculoskeletal System  
Nervous System (*Central and Peripheral*)

#### **VII. Psychological History / Examination:**

Methods of Assessment  
Current Psychological Complaints  
Post-Torture History  
Pre-Torture History  
Past Psychological / Psychiatric History  
Substance Use and Abuse History  
Mental Status Examination  
Assessment of Social Functioning  
Psychological Testing (see Chapter V, “The Psychological/Psychiatric Evaluation”)  
Neuropsychological Testing (see Chapter V, “Neuropsychological Assessment” for limitations)

## **VIII. Photographs**

## **IX. Diagnostic Test Results** (see Appendix I for indications and limitations)

## **X. Consultations**

## **XI. Interpretation of Findings**

### **1. Physical Evidence:**

Correlate the degree of consistency between the history of acute and chronic physical symptoms and disabilities with allegations of abuse.

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 torture or ill treatment was inflicted.)

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:**

Correlate the degree of consistency between the psychological findings and the alleged report of torture.

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.

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 at what point is the individual in the course of recovery?).

Identify any coexisting stressors impinging on the individual (e.g., ongoing persecution, forced migration, exile, loss of family and social role) and the impact these may have on the individual.

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.

## **XII. Conclusions and Recommendations:**

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.

Reiterate the symptoms and/or disabilities that the individual continues to suffer as a result of the alleged abuse.

Provide any recommendations for further evaluation and/or care for the individual.

### **XIII. 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).”

### **XIV. 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:...”

### **XV. Clinician’s Signature, Date, Place**

### **XVI. Relevant Appendices**

Clinician’s Curriculum Vitae, Anatomical Drawings for Identification of Torture and Ill Treatment (see Appendix II), Photographs, Consultations, and Diagnostic Test Results, among others.

## **Sample Medical and Psychological Affidavits**

The concrete product of the psychological or medical evaluation is the written report submitted to the INS officer or the court in support of the asylum seeker's application for asylum. Each element of the assessment process contributes directly to the preparation of this report.

The samples offered here represent a number of styles of writing as well as several different areas of expertise. Health professionals and social workers who provide evaluations for asylum seekers vary widely in training and levels of experience, and may not have extensive credentials to offer in their evaluations. This collection of samples is offered to provide guidance, not standard-setting.

## Sample Medical Affidavit

### Affidavit of Vincent James Iacopino MD, PhD in Support of Mr. Xxx Xxxx

#### Medical Evaluation

I, VINCENT JAMES IACOPINO, M.D., Ph.D., hereby declare as follows: I am a specialist in internal medicine and have extensive experience in the diagnosis and treatment of people who have survived torture and other forms of physical and psychological abuse.

I received a Bachelor of Science Degree from Villanova University in 1979. In 1980, I received a Master of Science Degree in Physiology from Georgetown University. Thereafter, I received a Ph.D. from Georgetown University, and my M.D. from the Georgetown University School of Medicine in 1985.

I did my internship and residency in internal medicine at the University of Minnesota Hospitals and Clinics and from July 1985 to June 1986 and April 1987 to April 1989.

I was the Chief Resident at the VA Medical Center in Minneapolis, Minnesota, from June 1989 to June 1990.

From July 1991 to July 1993, I was a Clinical Scholar with the Robert Wood Johnson Clinical Scholars Program at Stanford University and the University of California, San Francisco, and Attending Physician at the VA Medical Center in Palo Alto.

My honors and awards have included: a Certificate of Commendation for Volunteer Efforts to Aid Refugees, State of Minnesota, Governor's Office, 1989; an Upjohn Achievement Award for Outstanding Research and Scholarship, 1985; and a Joseph Collins Foundation scholarship for Academic Achievement and Proficiency in the Arts and Letters, 1984, 1985.

I am currently licensed by the State of California as an M.D. and Board Certified in internal medicine by the American Board of Internal Medicine.

My present positions include: Senior Medical Consultant for Physicians for Human Rights (PHR), Boston, Massachusetts, an organization that brings the scientific knowledge and skills of the medical sciences to the investigation and prevention of violations of international human rights and humanitarian law, and Instructor in "Health and Human Rights," a class at the University of California, Berkeley, School of Public Health. During the past eight years working with PHR, I participated in the investigation and documentation of human rights violations in many countries including: Albania and Macedonia (4/99), Afghanistan (5/98), South Africa

(3/97 and 7/97), Turkey (6/95 and 6/97) Kashmir India (10/92), Punjab India (10/92) and Thailand (5/92). In the course of this work, I evaluated medical evidence of torture for several hundred individuals.

Between 1991 and July 1997, I was Medical Director of Survivors International, San Francisco, California, an organization that provides medical and psychological care to survivors of torture from around the world. Through this work, I have examined and participated in the care of more than 100 survivors of torture. Presently, I am a member of the Board of Directors of Survivors International.

I have qualified as a medical expert in US Immigration Courts regarding assessment of physical and psychological consequences of torture on more than 100 occasions. Also, I have qualified in US Immigration Courts on numerous occasions to testify on human rights conditions in countries where I have conducted human rights investigations.

During the past three years, I have been the International Coordinator of a project to develop the *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (The "Istanbul Protocol"). More than 75 forensic doctors, physicians, psychologists, human rights monitors, and lawyers representing 40 organizations and institutions from 15 countries contributed to the 100-page Manual. On August 9, 1999, the Manual was formally submitted to the High Commissioner for Human Rights for publication and distribution.

I have qualified as a medical expert in US, Canadian and British Immigration Courts regarding assessment of physical and psychological consequences of torture on many occasions.

I currently serve on the Editorial Board of the *Western Journal of Medicine* and the *Journal of Immigrant Health*.

In addition to basic science and clinical publications, I am author of twenty-nine human rights publications listed on the attached curriculum vitae [omitted].

I have conducted more than 70 human rights presentations in the past ten years, many of which have focused specifically on the medical and psychological consequences of torture.

## **Background**

On November 10, 1998, I conducted a detailed, 2-hour interview of Mr. \_\_. Dr. \_\_, M.D. was present as an observer. The interview and examination were completed following a second, 2-hour interview and examination on August 13, 1999. Mr. \_\_ is a 43 year-old married man originally from \_\_, Bosnia. He completed 12 years of education and became a \_\_. He stated that he was not politically active and did not serve in the military. He has two children aged 20 and 17. He arrived in the United States on July 14, 1995.

## Medical History Prior to Arrest

*Mr. \_\_\_'s medical history is not significant for any major illness, trauma or surgery prior to his arrest and torture. He has about a 22-pack-year smoking history.*

## Torture Experiences

On May 27, 1992, Mr. \_\_\_ was detained by Bosnian Serb Police. He relates that the police came to his house and told him that he needed to go to the police station and provide some information. Once he arrived at the police station in \_\_\_, the police began beating him in the waiting room. He was beaten with hard rubber truncheons, baseball bats and metal pipes to his all parts of his body, including his back, head, chest, abdomen and extremities. He fell to the ground and was kicked. For the first 4 days, he was kept alone in an admission cell, then was moved to a group cell for the next two months. During this period of detention, \_\_\_ was beaten several hours each day as described above. Subsequently, in mid-July, he was moved to the \_\_\_ Territorial Defense (TO warehouse) where he remained until November 1992. During this time, the beatings were less frequent (1-2 times/week) and there were more men (approximately 180) at the warehouse facility. During beatings, police made remarks about their intention to "kill all Bosnian Muslims" and that there was "no need for Muslims to exist." On 3 or 4 occasions the beatings resulted in loss of consciousness; it is not clear whether this was associated with specific head trauma. Two of the perpetrators that participated in Mr. \_\_\_'s torture were \_\_\_ (his brother-in-law worked in \_\_\_'s place of work) and \_\_\_ (also known to Mr. \_\_\_). Some of the specific accounts of torture related by Mr. \_\_\_ are as follows:

- Left Facial Trauma: \_\_\_ was kicked in the face by \_\_\_. This caused intense pain and swelling, so much so that \_\_\_ was unable to open his mouth to eat for about 10 days.
- Once, \_\_\_'s right index finger was struck, on end, by \_\_\_ with the butt of a gun which resulted in the dislocation of the finger. His cellmates later helped to reduce the dislocation.
- Genital Trauma: Two police accompanied \_\_\_ to the toilet. When \_\_\_ spread his legs to urinate, he was kicked in the testicles. One of police said, "You don't need this anymore."
- Mock Executions: With about 30 detainees in a room, Serb police would place a gun on a table and spin it. Then they would fire at the person to whom the gun was pointing. \_\_\_ witnessed two executions in this way. Once, \_\_\_ shot near \_\_\_ and said, "You are lucky this time, but not next time."

- **Witnessing Torture and Executions:** \_\_\_ and other detainees were often forced to watch others being beaten and tortured. In addition, \_\_\_ heard the sounds of detainees screaming throughout the period of detention. \_\_\_ also saw the police beat a man and then shoot him after they released him.
- **Sexual Assault of Men:** The police frequently (2-3 times weekly) assembled all the detainees (20-30 in the police station and about 180 at the TO warehouse) and forced the men to perform sex acts, such as oral sex, while forcing the other detainees to watch. \_\_\_ recalls \_\_\_ laughing during these acts.
- **Sexual Assault of Women:** During cleaning duty, \_\_\_ saw 2 women raped by 6-7 police at the police station. \_\_\_ was there slapping and swearing at the women.
- **Asphyxiation:** Several times when Mr. \_\_\_ was punched in the abdomen, the perpetrators covered \_\_\_'s nose and mouth to prevent him from breathing.
- **Dental Trauma:** Police used pliers to forcibly extract one of \_\_\_'s right upper molars. The tooth was broken in the process. \_\_\_ reports that this was very painful.
- **Suspension:** On one occasion, \_\_\_'s hands were tied to the bars of a window while he was beaten. He collapsed and consequently was partially suspended by his wrists for approximately 1 hour. He noted mild abrasions on his wrists that lasted several days. On another occasion, he was partially suspended upside-down by one foot. During this time, the sole of his foot was exposed and beaten. After this, he was forced to run.
- **Humiliations:** While he was initially detained at the police station, \_\_\_ was forced to lick blood off the walls.
- **Cell Conditions:** At the police station in \_\_\_, there were about 20 men in a group cell about 15 feet x 15 feet in size. It was so crowded that the detainees slept sitting up. Those who were more injured were given priority for laying down on the concrete floor. \_\_\_ was infected with head lice and exposed to rats. Toilet facilities were restricted to one visit per day. The detainees were given about one liter of water daily for drinking and were fed bread, jam, pork grease and tea. Mr. \_\_\_ lost between 50 and 75lbs during the first 6-7 months of detention.

### **Acute Physical Symptoms Following Torture:**

- **Dislocation of Right Index Finger:** \_\_\_ accurately described lateral dislocation of the 2nd right digit at the metacarpophalangeal joint (where the

finger meets the hand). This was associated with swelling and echymosis (bruising) that lasted 2-3 weeks.

- **Chest Trauma:** After being struck with a baseball to the chest, \_\_ suffered severe pain and swelling over his chest wall. The swelling lasted several weeks and extensive bruising persisted for approximately 2 months. Initially, during the time he experienced severe pain, he also noted shortness of breath. There was no symptom of hemoptysis (coughing up blood).
- **Left Facial Trauma:** For about 10 days after being kicked in the face during one detention period, \_\_ could only drink fluids from a straw. Later, he ate bread softened in tea. He experienced pain with eating for 2-3 months.
- **Dental Injuries:** After being kicked in the face, one bicuspid on the bottom right and 2 left upper molars were loosened by the trauma and later fell out. Forced extraction with pliers of the right upper molar resulted in a painful broken crown.
- **Genitourinary Symptoms:** After being kicked in the testicles, \_\_ experienced severe pain and swelling, as well as blood in his urine. These symptoms lasted more than one month.

Note: Mr. \_\_ did not receive any medical care for these problems during detention.

### **Chronic Physical Symptoms and Disabilities:**

- **Chronic Pain:** Mr. \_\_ periodically experiences pain in the anterior chest wall bilaterally, right index finger and left side of his face, especially when the weather is cold or rainy.
- **Headaches:** Mr. \_\_ suffers from headaches located at the back of his head; these occur with stress and improve with the use of aspirin or Tylenol.
- **Kidney Problem:** Symptoms of nocturia (urinating at night) and dribbling were noted over the past several years. These symptoms are most likely due to an enlarged prostate, unrelated to his torture experiences. He was advised to seek medical attention.

In November 1992, Mr. \_\_ was transferred to Batkovic concentration camp, a work camp where he was forced to dig trenches, do agriculture work, etc. He remained there until he was transferred to a military base where he was “court-marshaled.” In October 1994, he was released in a prisoner exchange.

### **Physical Examination** (*Drawings not reproduced here*)

Mr. \_\_\_ was moderately overweight and healthy in appearance. His vital signs were normal. Examination was within normal limits with the following exceptions:

- Teeth (SEE ATTACHED DRAWING): Two left upper molars (#s 14 and 15) and one lower bicuspid (#20) were missing and reportedly fell out after Mr. \_\_\_ was kicked in the face. A broken crown was noted in one of the right upper molars (#2). The appearance was consistent with the alleged trauma of forced removal with pliers. Other missing teeth were noted as well: #s 3, 4, 19, 30 and 31, reportedly due to gum disease and tooth decay.
- A 3cm x 1cm firm raised (0.5cm) mass was palpated on the posterior occiput (back of the head). This is highly consistent with callous formation (bone deposition) from a healed fracture of the skull or calcification of a soft tissue injury. SEE ATTACHED DRAWING.
- Hyperpigmented scars were noted on the anterior shins bilaterally and were attributed to old football injuries. There was a 1.5cm laceration-type scar noted on the right index finger that was also reported to be unrelated to the torture experiences. SEE ATTACHED DRAWINGS.

### **Diagnostic Imaging** (*Reports not reproduced here*)

PA and Lateral Chest (SEE ATTACHED REPORT, University of \_\_\_, Dept. of Radiology September 17, 1999; PA and Lateral Chest): “The spine shows multiple compressions throughout nearly all the vertebral bodies, and ribs are deformed from the healing of previous fractures.”

Facial Bone X-Rays (SEE ATTACHED REPORT, University of \_\_\_, Dept. of Radiology 9/17/99; Facial Bone Films): No sign of fracture noted with this mode of diagnostic imaging.

### **Impression**

To date, I have conducted several hundred interviews with survivors of torture in the San Francisco Bay Area and on human rights investigations in India, Turkey, Albania and Macedonia. In addition, I have provided medical treatment and/or conducted asylum evaluations for approximately 10 Bosnian refugees in the past 5 years. On numerous occasions, I have qualified as an expert on the medical consequences of torture.

My assessment is that Mr. \_\_\_ demonstrates historical and physical evidence of the abuse he alleges.

**Historical Evidence:** The historical information presented in Mr. \_\_\_’s testimony is entirely consistent with what I would expect given the meth-

ods of torture alleged. Mr. \_\_\_'s description of the acute wounds and injuries that he experienced (i.e., bruises following beatings, trauma to the left face, rib fractures, dislocation of the right index finger, trauma to the genitals, and wrist abrasions associated with suspension), and the subsequent healing processes accurately reflect what I would expect given the methods of torture alleged. For example, the pain, swelling, shortness of breath and bruising following blunt trauma to the chest reflect a highly accurate description of the rib fractures that have been confirmed by x-ray. Regarding the constellation of symptoms reported in association with blunt trauma to the left face, these symptoms suggest a fracture of the maxilla (upper jaw). Plain x-rays of the face can show evidence of such fractures, but often a CAT (computerized axial tomography) scan is needed to demonstrate this. A CAT scan was not obtained in this case due to its high cost. Again, in the case of the right finger dislocation and trauma to the genitals, Mr. \_\_\_'s descriptions of acute and chronic symptoms are entirely consistent with the torture alleged. It is worth noting that without medical knowledge of human anatomy and pathophysiology, most individuals would not be able to fabricate such accurate historical information. Furthermore, the story that was related is consistent with other torture survivors that I have examined. For example, it is common for perpetrators to kick a male victim's genitals and, at the same time, tell the victim that he will no longer be able to procreate or function normally.

**Physical Evidence:** Mr. \_\_\_ has several physical findings that are highly consistent with his allegations of abuse. First, he has radiographic evidence of multiple, old rib fractures (and vertebral compression fractures) that strongly corroborate Mr. \_\_\_'s allegations of repeated blunt trauma to the chest, often with hard objects such as metal pipes and baseball bats. Second, examination of his teeth demonstrated several missing teeth and a broken crown consistent with his allegation of a forced tooth extraction and teeth falling out after he was kicked in the face. Third, he had a 3cm x 1cm raised mass on the back of his head that is consistent with previous blunt trauma. This injury is most likely due to a healed skull fracture or calcification of a soft tissue injury. That he was unaware of this injury until my examination may be due to its location (not visible to him) and/or loss of consciousness at the time of the injury.

Based on my knowledge of methods of torture and their physical effects, and an understanding of specific regional practices of torture in Bosnia, is my judgment that Mr. \_\_\_'s allegations of torture are highly consistent with and supported by the historical and physical evidence presented above. Mr. \_\_\_ continues to suffer physical sequelae of his abuse.

I declare under penalty of perjury, pursuant to the laws of the United States, that the foregoing is true and correct and that this affidavit was executed on 9/30/99 at Henderson, Nevada.

I received compensation in the amount of \$\_\_ (including airfare to \_\_)  
for this medical evaluation.

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Vincent Iacopino, M.D., Ph.D.

Date

## Sample Psychological Affidavit

### 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 ?? hours), 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

I am a medical doctor licensed in the Commonwealth of Massachusetts since 1991. I am a psychiatrist certified by the American Board of Psychiatry and Neurology since 1986. I completed a fellowship in International Psychiatry and Epidemiology with the Harvard Program in Refugee Trauma in 1991-1992. I have been working in the field of refugee mental health and clinical treatment of victims of torture since 1989. I have been the medical director of two clinical programs for torture survivors in the Boston area, the Indochinese Psychiatry Clinic (1993-1999), and the International Survivors Center (2000-current.) I have personally examined several hundred survivors of torture and human rights abuses, written multiple reports, and treated and/or supervised the treatment of hundreds of torture survivors. I have lectured and taught nationally and internationally on this topic and have published multiple articles and monographs relating to the psychological consequences of torture and refugee mental health. I am one of the lead editors of the United Nations document, *Manual on Effective Documentation of Torture and Other Cruel and Degrading Punishment*, also known as the "Istanbul Protocol". I am also one of the editors of the Physicians for Human Rights manual on assisting asylum seekers, *Examining Asylum Seekers: A Health Professional's Guide to Medical and Psychological Evaluations of Torture* (now in press).

Attached is my *curriculum vitae* [omitted]

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 programs 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 scarce, 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 program 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 his 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 his inability to spell a five-letter word backwards.

## **Clinical Impression**

Mr. \_\_\_'s psychological complaints and the findings of this evaluation are consistent with his description of torture and the extreme brutality he has witnessed and experienced. He has multiple symptoms of Posttraumatic Stress Disorder such as irritability, hyperarousal, sleep disturbance, nightmares, and multiple behaviors consistent with avoidance. All of these symptoms are typical and expected symptoms of Posttraumatic Stress Disorder. His level of depression and loss are significant but also predictable given the loss of family and home. The posttraumatic stress symptoms and his depression are typical and expectable reactions to extreme stress and trauma. His symptoms were more prominent when he first arrived in the United States but have diminished in severity since that time. It is not uncommon for trauma-related symptoms to decrease once an individual has achieved some degree of safety and security. The exacerbation of some symptoms around the 4th of July celebrations when this gentleman was exposed to fire works is emblematic of Posttraumatic Stress Disorder. The sounds and explosions triggered Mr. \_\_\_'s heightened startle response and worsened his nightmares and anxiety. This type of fluctuating course of symptomatology is typical of Posttraumatic Stress Disorder. Individuals can become symptomatic after asymptomatic periods when they experience various types of environmental stresses.

In addition to the direct personal torture and atrocities that Mr. \_\_\_ witnessed and experienced, he and his family have also suffered from refugee displacement and the losses and deprivations that this experience entails. Also, he is now separated from his family. It is likely that these factors contribute to his psychological distress. On the other hand, refugee displacement alone is not likely to have produced the constellation and severity of symptoms that Mr. \_\_\_ demonstrates. He describes a profound sense of being changed or damaged by the violence that he has seen and experienced. He communicates the sense that he will never be the same, that his own life is no longer worth living and that death would be a welcome relief. The only meaning he finds to life at this time is the hope that he can possibly provide a better future for his children. He demonstrates great emotion when speaking of this. Mr. \_\_\_ communicates a genuine sense of loss and alienation that is found among those individuals who have been severely tortured and deprived over an extended period. Also, the difficulty Mr. \_\_\_ describes in providing precise dates of events is not unexpected for an individual suffering from Posttraumatic Stress Disorder especially when this disorder is accompanied by symptoms of depression. Posttraumatic Stress Disorder and depression can affect concentration and recall.

## **Recommendations**

1. From a psychiatric point of view, Mr. \_\_\_ will certainly benefit from the safety and security that asylum would provide. Of equal importance to

Mr. \_\_\_ is the opportunity to bring his family to the United States were he granted asylum. Given the consistency of his report with the findings of this evaluation, I find Mr. \_\_\_ to be entirely credible. He does not appear to be disabled by his mental and emotional symptoms. Work/gainful employment will help restore his sense of hope for the future.

2. Mr. \_\_\_ should have a physical exam and follow-up for his respiratory problem.

3. Mental health treatment such as supportive counseling should be offered but not pressed upon him as he finds it very difficult to repeatedly describe his traumatic experiences, and indeed doing so may make him feel worse. Medications for sleep disturbance and relief from symptoms of Posttraumatic Stress Disorder could be considered in the future if his symptoms interfere with his ability to function.

Kathleen Marie Allden, M.D.

Subscribed to and sworn to before me, a notary public, on this \_\_\_\_ day of November, 2000.

Notary Public

## Sample Psychological Affidavit

May 8, 2001

John Doe  
Attorney at Law  
AAA BBBB Street  
San Francisco, CA 94CCC

Re: Forensic Psychological Evaluation of Mr. \_\_\_ \_\_\_

Dear Mr. Doe:

At your request, I have prepared this report of my independent psychological evaluation of Mr. \_\_\_. It is my understanding that Mr. \_\_\_ is currently applying for political asylum in the United States based on political persecution and torture as outlined in the declaration you made available for my review.

### Qualifications

My qualifications to render a psychological opinion in this matter can be found in the enclosed curriculum vitae [omitted]. In summary, I received my undergraduate degree (Vor-Diplom) from the University of Tuebingen, Germany. I spent a total of 8 semesters studying psychology there, and completed all coursework towards a Master's Degree equivalent before obtaining 2-year scholarship to study at Antioch University, San Francisco. There I obtained an M.A. in Clinical Psychology in 1989. I received my Ph.D. in Clinical Psychology from the Wright Institute, Berkeley, CA, in 1995. I am a licensed clinical psychologist in California. I am the Clinical Director of Survivors International, San Francisco. I am a Qualified Medical Evaluator for the Industrial Medical Council of the California Worker's Compensation system. I currently have a private practice in Albany, CA, and I am also a professor at the Wright Institute, Berkeley. I have performed or supervised over 100 forensic evaluations, which include ca. 50 independent psychological evaluations regarding immigration issues. I have been qualified as an expert witness in Immigration Court on roughly 15 occasions. I have presented on the topic of forensic psychological evaluation of trauma in the context of Immigration Court to attorneys and law students and have lectured and published on this topic to health professionals nationally and internationally.<sup>95</sup>

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<sup>95</sup> Jacobs, U. & Iacopino, V. "Torture and Its Consequences: A Challenge to Clinical Neuropsychology," *Professional Psychology: Research and Practice*, 2001; October Issue, In Press.

## 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 \_\_ 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 in 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 organization'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' organization 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 organization and apparently stands for \_\_\_ \_\_\_, an organization 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).

### *Behavioral 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 Behavior: 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 behavior. 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.

#### *Diagnostic Findings and Impression:*

Mr. \_\_\_'s current symptoms and mental status, as reported above, are consistent with a history of persecution and trauma and constitute a diagnosis of Posttraumatic Stress Disorder (PTSD) according to the Diagnostic and Statistical Manual of the American Psychiatric Association, 4th edition (DSM-IV). There are also elements of recurring Panic Disorder, although the primary symptomatology at this time is of the posttraumatic type. It should be noted that Panic Disorder is not infrequently found in survivors of torture and war trauma, and that this type of mixed symptomatology is very consistent with the documented trauma history.

The particular constellation of symptoms documented through this interview and psychological testing cannot be well accounted for by psychological maladjustment prior to the history of political persecution. The pre-trauma history suggests that Mr. \_\_\_ was a psychologically well-adjusted, healthy man who was able to make quite a good recovery from

the anxiety symptoms that resulted from severe war trauma, even without major mental health intervention. In addition, the particular posttraumatic stress symptomatology documented here is not found in individuals with Mr. \_\_\_'s premorbid personality adjustment or solely on the grounds of the stresses related to exile. For these reasons, there is strong evidence that the current psychological condition of Mr. \_\_\_ was caused predominantly by the events of political persecution and torture as documented.

Malingering or deception for the purpose of obtaining political asylum are very unlikely in this case for several reasons:

Mr. \_\_\_ reported a history of persecution that was sufficiently detailed and narrated in a non-defensive manner except where specifically noted. These moments of reluctance to describe details of the history were in turn connected with considerable affect and related to particularly traumatic events or cultural taboos.

Mr. \_\_\_ reported a history of developing and enduring symptomatology that was very consistent with the history of war trauma and subsequent persecution and torture. The course of symptom exacerbation described is one that would be expected under the circumstances, but could hardly be fabricated by a layperson. In addition, Mr. \_\_\_ made no effort to hide the pre-existing panic symptomatology. Further, the description of the medical advice he received appears credible, and the description of the resolution of the initial symptoms is consistent with the natural history of such conditions.

Mr. \_\_\_ obtained validity profiles on the psychological questionnaires that were consistent with profiles obtained by patients with confirmed diagnoses of Posttraumatic Stress Disorder and inconsistent with profiles of malingering and deception.

The narrative of Mr. \_\_\_ was accompanied by appropriate emotional expression of distress that appeared partly involuntary, against his own efforts to contain his emotions and act as a traditional male of his cultural background.

The detailed history obtained during this examination was highly consistent with the history documented in the asylum declaration, with the notable exception of one major event of persecution that he reluctantly disclosed only after several hours of interviewing.

## **Diagnosis**

Axis I: 309.81 Posttraumatic Stress Disorder, chronic

Axis II: 71.09 No diagnosis

Axis III: Noncontributory

Axis IV: Displacement from family and country of origin

Axis V: GAF = 60 (current)

## Recommendations

Mr. \_\_\_ is currently experiencing significant symptoms as a result of political persecution and displacement from his family and culture. I referred him for an evaluation by a psychiatrist and explained to him that his symptoms should be treated by a clinician through the Survivors International network. He was very reluctant to accept this at first, but agreed to follow up with the referral after I explained that it would not be necessary for him to disclose any more of his history than he wishes. He was very concerned that he would feel worse than he already does if he were forced to tell the same stories again. Should Mr. \_\_\_ be denied political asylum, I am quite convinced that he would go to any number of other countries but not return to \_\_\_. If he were to return there, he would certainly suffer an exacerbation of his current condition, regardless of the current political situation. I sincerely hope that these findings will be taken into consideration by the court when making a decision about Mr. \_\_\_'s application for political asylum.

Respectfully submitted,

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Uwe Jacobs, Ph.D.  
PSY 15165

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Date

## Sample Medical and Psychological Affidavit

Executive office for Immigration Review  
United States Department of Justice  
Office of the Immigration Judge  
San Francisco, California

In the matter of Mr. \_\_\_\_ (A# \_\_\_\_-\_\_\_\_-\_\_\_\_)

DECLARATION OF VINCENT JAMES IACOPINO  
IN SUPPORT OF MR. \_\_\_\_  
APPLICATION FOR ASYLUM

I, VINCENT JAMES IACOPINO, M.D., Ph.D., hereby declare as follows:  
1-18. [Clinician's qualifications] (See Affidavit 1)

### Background

19. On \_\_\_\_, I conducted a detailed, 4 hour interview and examination of Mr. \_\_\_\_\_. Mr. \_\_\_\_ is a 28 year old man from \_\_\_\_ Village, in the Jalandhar district of Punjab, India. He is a college graduate and received an MA in economics in 1991. Mr. \_\_\_\_ stated that he joined the AISSF (All India Sikh Student Federation) in 1987. His activities with the federation consisted of participating in rallies, raising funds and distributing materials and posters. \_\_\_\_'s father was a tax assessor and the family owned a farm as well.

### Medical History Prior to Arrest

20. Mr. \_\_\_\_ had no significant history of serious illness or surgery. He had no significant history of trauma prior to his arrests.

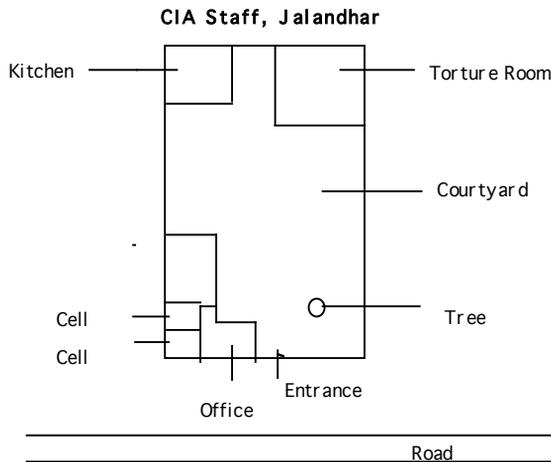
### Summary of Arrests and Torture

21.

DATE	PLACE	PERIOD DETAINED	ABUSE
5/30/88	CIA Staff, Jalandhar	2 weeks	tortured
8/15/90	Goraya Police Station	1 day	no torture
11/23/90	Goraya Police Station	3 days	no torture
June, 1991	Goraya Police Station	8-9 days	tortured
12/6/91	CRPF camp near Jalandhar	1 day	tortured

## Arrest #1 and Torture

22. On \_\_\_\_, after returning from the fields, \_\_\_\_ lay asleep in his home. He was awakened by approximately 25 Punjabi Police and Central Reserve Police Force (CRPF) soldiers. A gun was pointed at his chest; “Get up. Come lets go,” he heard them say. His *pama* (turban) was removed and used to bind his hands behind his back. His mother, who witnessed the a rest, asked why they were arresting \_\_\_\_. The reply: “Read the papers tomorrow. There will be the news of his encounter.” He was taken to the Central Investigations Agency (CIA) Staff, Jalandhar. The following is a representation of Mr. \_\_\_\_’s illustration of the compound.



23. He was taken to the torture room immediately on arrival. Before describing his torture experience, I asked Mr. \_\_\_\_ to describe any objects or devices in the room that may or may not have been used to torture him. He noted bamboo rods, approximately five feet in length and several inches in diameter, a wooden log measuring about four to five feet in length and about eighteen inches in diameter, iron rods, a small (one foot square in size) hand-cranked generator (referred to locally as a Dynamo) with two wires leading from it with alligator clips on the ends. He also noted a pulley hanging from a ceiling hook and a leather belt, about three feet long with a wooden handle. The Senior Superintendent of Police (SSP) ordered \_\_\_\_’s torture and was present during it.

24. First, Mr. \_\_\_\_’s hands were untied and he was ordered to remove his clothes; he did so, retaining only his underwear. One of his captors said,

“We’re going to tear it off. It’s better you remove it.” So he did. They asked him the whereabouts of \_\_\_\_, an AISSF leader who was from the same village as \_\_\_\_. \_\_\_\_ replied, “I don’t know.” They said, “We know you participated in rallies. You instigate people to revolt against the government. We’ll give you *Khalistan*.”<sup>96</sup> They also accused Mr. \_\_\_\_ of “collaborating with militants.” The parna was again fastened to his hands, behind his back. He was then suspended by a rope that was attached from the *pama* to a pulley suspended from a hook attached to the ceiling. As two men lifted \_\_\_\_, another pulled the rope until he was fully suspended. The rope was then attached to a pillar. Mr. \_\_\_\_ experienced intense pain in his shoulders. To amplify his pain one of the policemen pulled downward on his legs. After about ten minutes he passed out. He awoke on the floor after water was thrown in his face. He was asked, “Do you want a drink?” To which he replied, “Yes,” but none was given.

25. Next, he was made to sit on the floor with his legs outstretched and his hands still bound behind his back. One man stood behind \_\_\_\_. As the man forced his knee into \_\_\_\_’s back and pulled his head backward by his hair, a heavy wooden roller was placed on \_\_\_\_’s thighs. Using their hands, two men rolled the heavy object back and forth over Mr. \_\_\_\_’s thighs as another stood on the roller to increase its weight. This form of torture continued for approximately four minutes. After this, and while still sitting on the floor, two men grasped each of Mr. \_\_\_\_’s legs and stretched them with great force toward a 180-degree angle. When his legs were stretched apart, \_\_\_\_ was asked, “Are you married?” “No,” he said. “Well don’t,” one said. They kicked \_\_\_\_ in the groin and told him, “We’ll make you incapable of sleeping with a woman.” Three to four cycles of these three torture methods (suspension, roller and leg stretching) were then repeated for approximately four hours. During a two-week period of detention, Mr. \_\_\_\_ was tortured in a similar fashion on several occasions. While he was detained, Mr. \_\_\_\_ could hear the screams of others being tortured.

26. Mr. \_\_\_\_ was then brought before the Court in Phillaur on charges of sheltering militants. He showed me a copy of the First Information Report, dated \_\_\_\_, indicating that the document had been post-dated (the FIR in India is supposed to be filed within 24 hours of a detainee’s arrest). He was then remanded to Goraya Police Station for approximately five days, after which he was sent to Jalandhar Central Jail where he remained for about two and a half months until he was released on bail. While in jail he met \_\_\_\_ who also had been tortured.

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<sup>96</sup> “Khalistan” is the idea of a separate Sikh state.

## Physical Condition Following Torture #1

27.

a) \_\_\_ experienced severe pain and swelling in the anterior (front) and medial (inner) regions of his thighs. He observed dark black and blue discoloration over these areas for several months. He could not walk without severe pain for several months and still experiences pain in the anterior thighs when he runs or works. After the swelling resolved, he later noted hollowed-out depressions in his thighs.

b) He had severe pain in the anterior aspect of his shoulder, but this eventually resolved.

c) The abrasions that he noted on his wrists lasted a few weeks and disappeared.

\_\_\_ returned home. His parents suggested he focus on his studies and not indulge in any activity that may provoke the police. They did not speak of his torture experience. \_\_\_ subsequently diminished his activities with the AISSF.

## Arrest #2

28. On \_\_\_, Indian Independence Day, there was a call for Sikh men to wear black turbans and for the women to wear black scarves. \_\_\_ observed this protest and while picking up groceries in Goraya, he was arrested by the Goraya Police. At the station, he and many others had their names and addresses, fingerprints and photographs taken. Mr. \_\_\_ was released later that night.

## Arrest #3

29. On \_\_\_ at about 7:30 pm, while \_\_\_ was at home, about fifteen to twenty Punjabi Police and CRPF arrested him. His hands were bound with his *pama* and he was taken to Goraya Police Station. He was not tortured, but he was detained there for three days before being transferred to New Jail, Ludhiana, on charges of sedition. After ten days the charges were dropped. Mr. \_\_\_ believes this arrest was an attempt to thwart his participation in a call by several organizations, including the AISSF, to protest police and Indian government actions in Punjab on \_\_\_.

## Arrest #4 and Torture

30. In early \_\_\_, after distributing AISSF posters, \_\_\_ was stopped at a check-point and arrested after some of the posters were discovered in his scooter. His turban was used to bind his hands and he was then taken to Goraya Police Station. On arriving, he was forced to disrobe. They told

him, "You want *Khalistan*? We'll give you *Khalistan*." Using one of Mr. \_\_\_'s shoes, an official struck him in the face. Among the officials present were Station House Officer, \_\_\_ and a man named \_\_\_. They threatened to kill him. They tortured him as before, repeating cycles of suspension, roller and leg stretching. During the eight or nine days that he was detained, he was tortured in this way three times. The village council, or *panchayat*, intervened on his behalf and promised to be responsible for him. Before leaving, \_\_\_ was made to sign papers indicating that he would no longer participate in Federation activities. He was given a "final warning" from the SHO: "The next time we will finish you." Fearing he would be killed if arrested again, \_\_\_ ceased his activities with the Federation.

#### **Physical Condition Following Torture #4**

31. Mr. \_\_\_'s physical condition at this time was much as it had been following the first arrest and torture described above. He saw a medical doctor for two and a half months who treated his wounds and symptoms.

#### **Arrest #5 and Torture**

32. On \_\_\_, Mr. \_\_\_ was arrested again. Apparently, there was a rally one or two days before in which violence broke out. Although \_\_\_ did not attend the rally, 20 to 25 CRPF soldiers arrested him at his house on \_\_\_. He was taken to a CRPF camp outside of Jalandhar and accused of participating in the rally and withholding information about militants. He denied either knowing or assisting militants. He was tied to a chair with rope and smacked in the face with his shoe. He was released momentarily to be disrobed, then again bound to the chair. Wires with alligator clips on the ends were clipped to his penis and scrotum. A Dynamo was used to generate an electric current for periods of five to ten seconds intermittently over approximately five minutes. At one point, white fluid discharged from his penis. One man said, "Do you see this? Now you are useless." In a semi-conscious state he heard someone say, "His job is done." He was then taken to another room. There he was beaten with bamboo rods while he was standing. He fell to the ground and attempted to protect himself. After five to seven minutes of beating, someone held his neck as another forced a rod into his rectum. They demanded he sign papers, one with writing on it and the other which was blank. "You have made our job a lot easier," he was told.

33. At about midnight ten to twelve police transported him to the bridge of a canal in an isolated area. "Take him and finish him," he heard one of them say. \_\_\_ pleaded for his life, "I am not at fault. You are going to kill me for no reason." To which, they replied, "Either you become an informer or we'll kill you." \_\_\_ agreed. He was given two weeks to assist them and was expected to inform them of any Federation meeting that was

to take place. They returned to the police station where he remained unharmed for several more days. Thereafter, his parents secured his release with a 200,000 rupee bribe. \_\_\_ told his parents that his “conscience would not permit him to inform on Federation members.” He went into hiding and subsequently fled India. On arrival to the United States, Mr. \_\_\_ was detained for two months before he was released on bond.

### **Physical Condition Following Torture #5**

34. Mr. \_\_\_’s observations of his wounds, his physical symptoms and their associated disabilities were similar to the other times that he was tortured. Where he had received electric shocks, he had small patches of redness that resolved over a few weeks.

### **Psychological Symptoms**

35. Since Mr. \_\_\_ was first tortured in 1988 he has experienced psychological symptoms consistent with Posttraumatic Stress Disorder (PTSD). These symptoms began in India after he was tortured, and some have diminished since he has been in the United States. He has experienced the following symptoms:

a) Nightmares: These occurred nightly when he was in India. In his dreams, Gertej often would be shot dead while running from the police. Since being in the United States, the frequency of his nightmares has decreased somewhat and the themes of the dreams now focus more on his fear of returning to India.

b) Intrusive Recollections: While in India, most of his waking hours were flooded with thoughts of his persecution and the intense fear of being tortured again and killed. Every day he is reminded of his torture experiences when he changes his clothes and sees the large hollowed-out deformities in his thighs that resulted from the “roller” method of torture. For hours he will focus intensely on what was done to him and what may happen again if he were to return to India. Recently, Mr. \_\_\_’s mother and father were arrested by police. This has heightened his concern for his family’s safety and amplified recollections of his abuse.

c) Reliving Experiences: Certain observations have the effect of stimulating intense anxiety and are associated with a “shiver,” sweating and shortness of breath. For example, when \_\_\_ sees vehicles in this country (Suzuki Jeep and Geo Metro) that resemble those used by police in India (Gypsy and Maruti automobiles) he relives the anxiety and fear that he experienced in India.

d) Avoidance Thoughts: \_\_\_ sometimes listens to music to escape the

intrusive recollections that plague him. This often helps. One of the reasons he moved from Seattle to Yuba City is that in Seattle he was surrounded by people who talked about the conflict in Punjab.

e) Hypervigilance: While in India, the sound of cars passing his house in the night triggered intense startle reactions.

f) Isolation: Before being tortured, \_\_\_ enjoyed playing sports and being with friends. However, after the torture, he lost interest in these pleasures and now seeks solitude.

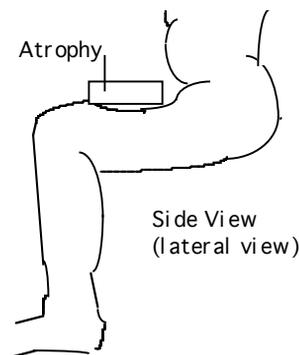
g) Concentration: \_\_\_ has noted that his mind often wanders and he loses track of what he is doing. For example, on the way from Seattle to today's interview in San Francisco, he made a wrong turn and did not realize it until he was nearly in Sacramento. He avoids using the stove because he has had difficulty remembering to turn it off. Also, he sometimes completely forgets the cab routes that he has come to know.

h) Memory: In describing how he was tortured by electric shocks, he forgot about the 5 to 7 minute period that he was beaten with bamboo rods, just after the electric shocks, until sometime later when I asked him specifically if he was beaten. When we discussed his problems with memory he said, "When I talk about the electric shock, I forget about the beating and when I talk about the beating, I forget about the electric shock."

i) Difficulty Sleeping: He had marked difficulty falling asleep while in India, but this improved once he arrived in the United States.

### **Pertinent Physical Examination Findings**

36. Mr. \_\_\_ was slightly cachectic (gaunt) in appearance. His vital signs were normal. Examination of all organ systems was within normal limits, with exception of the skin and musculoskeletal examinations. His findings are as follows:



a) On the anterior (front) aspects of the thighs there is marked atrophy of the quadriceps muscle. The normal contour of the thigh has been deformed bilaterally (on both sides), leaving concave depressions measuring four inches by two inches and about 3/4 inch deep.

b) There are several linear, pink scars arranged in a longitudinal (vertical) orientation in the area of the left shoulder. The appearance is very similar to stretch marks, however their orientation does not correspond to the usual lines of orientation, i.e. parallel to the underlying muscle tissue.

c) No scars were present on the penis or scrotum, medial (inner) aspect of the thighs, or on the wrists.

### **Impression**

37. My assessment is that Mr. \_\_\_ demonstrates clear and highly specific historical, physical and psychological evidence of torture.

38. Historical Evidence:

To date, I have conducted more than 30 interviews with Sikh survivors of torture in the San Francisco Bay Area. In addition, in October, 1992, I visited Punjab, India on a human rights documentation mission with Physicians for Human Rights/Asia Watch where I conducted interviews with dozens of survivors of torture. Historical information in Mr. \_\_\_'s testimony is highly supported by the other testimonies I have gathered. For example:

a) It is very common when a Sikh is arrested for police and Indian security forces to remove his turban, a symbol of Sikh (male) identity, and to use it to restrain his hands.

b) The detailed description of torture devices that Mr. \_\_\_ provided is representative of what I have heard in dozens of testimonies from Sikh survivors of torture (e.g. dimensions and material composition of the bamboo rods, leather belts and the roller). His description of the hand-cranked Dynamo with two wires and alligator clips is the same as testimony of others who were tortured in the same fashion. In fact, the particular method of suspension that Mr. \_\_\_ describes is precisely what other survivors of torture have told me who were tortured in CIA Staff Jalandhar: that there was a pulley attached to a hook in the ceiling and that after they were lifted off the ground by several men, another man tightened the rope and fastened it to a support column. Similarly, others have also alleged that their legs were pulled downward to increase the pain in the shoulders while being suspended. Mr. \_\_\_'s allegation that he was kicked in the groin when his legs were stretched apart, and that he was told he would no longer have normal sexual function after being kicked and shocked with electricity, are entirely consistent with dozens of testimonies of survivors of torture.

c) The practice of disrobing detainees prior to interrogation or torture that was described is also representative of many other testimonies.

d) The body positions and modes of restraint that Mr. \_\_\_ described in his testimony are also highly consistent with dozens of other testimonies. An example of this is the position used for the roller method of torture: hands tied behind the back with someone stepping on the hands while forcing the back forward with a knee and simultaneously pulling the head backward by the hair.

e) Mr. \_\_\_'s description of the acute wounds that he experienced (i.e. bruising of the adductor [inner thigh] muscles, burn marks on his penis and scrotum and wrist abrasions) following torture and the subsequent healing process also accurately depicts what I would expect given the methods of torture alleged.

f) The practice of back-dating the First Information Reports prior to bringing a detainee to court, as indicated by Mr. \_\_\_'s testimony and the document he showed me, is again highly consistent with regional law enforcement practices that I documented while in Punjab. Similarly, the practice of rounding up Sikhs prior to potential protests, significant anniversaries, such as Operation Blue Star, or after an incident occurs, is also a very common practice by police and Indian security forces that the PHR/Asia Watch team documented in October 1992.

The significance of the aforementioned historical evidence is that it is highly suggestive of one who has experienced torture first hand.

### 39. Physical Evidence

Although torture may leave no physical evidence of abuse, Mr. \_\_\_ demonstrates striking and very specific evidence of the torture he alleges.

a) The areas of marked atrophy (loss of tissue, associated with volume loss of, in this case, the quadriceps muscle) on Mr. \_\_\_'s thighs are highly specific and consistent with the roller method of torture that he alleges. I have observed this finding in Sikh survivors of torture on other occasions, especially when use of the roller has been extensive.

b) The small vertical scars present over the left shoulder have a very similar appearance to "stretch marks." However, their unusual vertical orientation is suggestive of a possible traumatic cause, such as that resulting from the method of suspension alleged, rather than a normal physiological process.

c) The beatings and electric shocks that Mr. \_\_\_ described typically do not leave direct physical evidence and therefore the absence of associated findings on physical examination that may support such allegations is expected.

40. Psychological Evidence

Mr. \_\_\_ also demonstrates diagnostic criteria for Posttraumatic Stress Disorder (PTSD). His symptoms began in India and have persisted significantly since being in the United States. The content of Mr. \_\_\_'s symptoms refer specifically to his torture experience. Mr. \_\_\_'s difficulties with memory, concentration, and his somewhat withdrawn affect are related to his traumatic experiences of torture. His ability to present historical information is sometimes mitigated by these psychological sequelae of torture, which inherently support, rather than undermine, his allegations of torture.

41. Based on my knowledge of methods of torture and their physical and psychological effects, and an understanding of specific regional practices of torture in Punjab, India, it is my judgment that Mr. \_\_\_'s allegations of torture are highly consistent with and supported by the historical, physical and psychological evidence presented above. \_\_\_ continues to suffer physical and psychological sequelae of his abuse. I have referred him for psychological counseling.

42. I declare under penalty of perjury, pursuant to the laws of the United States, that the foregoing is true and correct and that this affidavit was executed on \_\_\_ at Sunnyvale, California.

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VINCENT IACOPINO, M.D., Ph.D.

## Sample Medical and Psychological Affidavit

### Executive Office for Immigration Review United States Department of Justice

#### In the Matter of the Application for Political Asylum of \_\_\_

Affidavit of Allen S. Keller, M.D.

I Allen S. Keller, M.D., being duly sworn, state:

1. I am an American physician licensed to practice medicine in the State of New York. I am a graduate of NYU School of Medicine and completed my residency in Primary Care Internal Medicine at NYU/Bellevue Medical Center. This residency provided intensive training in doctor-patient communications and performing detailed psycho-social evaluations, including evaluating and treating common psychiatric disorders such as anxiety and depression. I am board-certified in internal medicine and am an Assistant Professor of Clinical Medicine at NYU School of Medicine. I am an Attending Physician in the Department of Medicine at Bellevue Hospital in New York City.

2. I have received specialized post-graduate training through Physicians for Human Rights in the use of medical skills for the documentation and treatment of torture victims. I have been conducting medical evaluations of survivors of torture since 1990. In 1993, I worked in Cambodia where I developed a program to train Cambodian health professionals in the evaluation and treatment of survivors of torture. In November and December of 1996, I led a fact-finding mission to Dharamsala, India on behalf of Physicians For Human Rights to examine Tibetan refugee survivors of torture and to evaluate and document the continued use of torture of Tibetans by Chinese officials.

3. I have also trained several health professionals in this country in the evaluation of torture survivors. I have participated in training staff of the Immigration and Naturalization Service concerning the physical, psychological and social consequences of torture. I am on the International Advisory Board of Physicians For Human Rights. Most recently, I have developed a program at Bellevue Hospital and NYU Medical Center in New York City to provide medical, psychological, and rehabilitative ser-

vices to survivors of torture. Currently, I am the director of this program – The Bellevue/NYU Program For Survivors of Torture. I have been previously qualified in Federal Immigration Court as an expert witness in evaluating and treating survivors of torture.

4. On \_\_\_\_, I conducted a detailed clinical interview and physical examination of Mr. \_\_\_\_ in order to evaluate the effects of the maltreatment he reports occurred in Tibet prior to his entry into the United States. The evaluation was conducted at Bellevue Hospital and took approximately three hours. The evaluation was conducted with the assistance of a Tibetan speaking interpreter. I have subsequently seen Mr. \_\_\_\_ for several follow up visits, most recently on \_\_\_\_.

5. Mr. \_\_\_\_ reports that he had no medical or psychological problems prior to the abuse he suffered in Tibet.

6. Mr. \_\_\_\_ is male in his late 20's from Sichuan Province, the People's Republic of China, where he was a monk. He reports that in the Spring of 1994, he was detained by Chinese authorities for approximately two weeks. At the time he was on his way to a "Holy Celebration" in Lhasa, the capital of Tibet. Mr. \_\_\_\_ reports that he was neither formally charged nor told why he was being detained. During the course of his detention, Mr. \_\_\_\_ says that he was repeatedly interrogated about his political and religious activities and subjected to torture. He reports that he was repeatedly beaten and was punched and kicked all over his body, including on his back and face. He also reports being thrown down onto the floor and shocked repeatedly with an electric cattle prod, including on the sides of his face and on his abdomen. Mr. \_\_\_\_ reports that these episodes of interrogation and torture occurred throughout his detention, but were particularly severe at the beginning of his detention.

7. Mr. \_\_\_\_ reports that he was kept in a cell with no bed and had to sleep on the floor. There was no natural light in the cell. A ceiling light remained on at all times. The cell had no toilet. He reports that he was fed two small meals a day, but was not permitted to bathe or brush his teeth.

8. Mr. \_\_\_\_ reports that following these beatings and torture, he felt sore all over his body. He reports noting dried blood on his face and around his ears. Mr. \_\_\_\_ reports that he subsequently noted a white/watery discharge from his left ear, and decreased hearing in that ear.

9. Since his abuse, Mr. \_\_\_\_ reports that he continues to suffer from a number of physical symptoms. He reports that he continues to suffer from

musculoskeletal pain, particularly back pain. He also reports having difficulty hearing well in his left ear since his trauma.

10. Mr. \_\_\_ also describes suffering from a number of psychological symptoms since his abuse. He reports frequently thinking about the events of his abuse. He reports frequently having difficulty sleeping. He reports experiencing nightmares about his abuse and about family members being in danger. He reports being startled easily and describes feelings of sadness and weakness.

11. On physical examination, there are several scars on his face that Mr. \_\_\_ reports occurred during his childhood and are unrelated to his abuse. No other scars on his skin are noted. This is consistent with the events that Mr. \_\_\_ describes, which would not necessarily leave physical scars on his skin. Examination of his ears reveals a large, old perforation of the left tympanic membrane (ear drum). This is consistent with the events Mr. \_\_\_ describes. He reports pain on palpation over his back, particularly the lower back. This is consistent with the beatings Mr. \_\_\_ describes.

12. It is my assessment that Mr. \_\_\_ has been a victim of torture. Torture, according to the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 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.”

13. Mr. \_\_\_ provides great detail and consistency regarding the events of his alleged abuse. The historical, physical and psychological findings support his allegations of abuse. It is my assessment that Mr. \_\_\_’s hearing loss in his left ear is a result of the beatings he suffered. It is also my assessment that as a result of his abuse, Mr. \_\_\_ is suffering from psychological symptoms of depression and Posttraumatic Stress Disorder, including recurrent memories of his abuse, feelings of sadness and difficulty sleeping.

14. The detail and consistency with which Mr. \_\_\_ describes his mistreatment, as well as the findings on physical and psychological examination, persuade me that he is very credible and is telling the truth. It is also my impression that Mr. \_\_\_ continues to suffer from the physical and psychological effects of his abuse. In the future, Mr. \_\_\_ will continue to be fol-

lowed in the Bellevue/NYU Program for Survivors of Torture and receive medical and psychological care. It is my impression that he has benefited from these services and will continue to do so.

15. It is my assessment that to force Mr. \_\_\_ to leave the United States and return to China would pose a serious threat to his physical and mental health.

I declare under penalty of perjury that the foregoing is true and correct.

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Allen S. Keller, M.D.

Sworn to before me on this \_\_\_\_\_ day of October, 1998.

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Notary Public

## Sample Neuropsychological Consultation

Name: \_\_\_\_\_

DOB: Unknown, stated age range from 54 to 60+

Country of Origin: India

Sex: Male

Handedness: Right

Primary Language: Punjabi

Education: 4th grade

Occupation: Unemployed, former farmer

Procedures: Clinical Interview, Review of Records, Lateral Dominance Exam, Sensory-Perceptual Exam, Finger Tapping, Grooved Pegboard, Full Object-Memory Evaluation, Picture Completion and Block Design (WAIS-III), Draw-A-Clock

### Identifying Information and Reason for Referral:

Mr. \_\_\_ is a Sikh man in his late 50s or early 60s from Punjab, India, who is currently seeking political asylum in the United States based on a history of political persecution and torture. He was examined by \_\_\_, M.D., at Survivors International, San Francisco in February 1999 in the context of his asylum claim. Subsequent to giving Mr. \_\_\_ a medical examination, Dr. \_\_\_ referred Mr. \_\_\_ to me for neuropsychological examination to evaluate the suspected presence and scope of brain impairment as a result of head trauma. I examined Mr. \_\_\_ on 4/17/99 for 2 1/2 hours at the offices of Survivors International in the presence of his niece, Ms. \_\_\_, who provided collateral information and functioned as the interpreter. The use of an independent interpreter would ordinarily be preferable but had to be rejected in this case due to Mr. \_\_\_'s inability to tolerate this.

This is a supplemental neuropsychological study to complement Dr. \_\_\_'s comprehensive medical report. It is therefore limited in its scope and should be viewed as such. When submitted as evidence for the purpose of Mr. \_\_\_'s asylum hearing, the report should be appropriately marked in this manner. My qualifications for performing this evaluation are summarized in the enclosed curriculum vitae.

### Record Review:

Dr. \_\_\_'s report indicates that Mr. \_\_\_ suffered severe head trauma with loss of consciousness for several days in the fall of 1996, when he was attacked by several men whom he believed to be associated with the police. The police had imprisoned and tortured Mr. \_\_\_'s brother at around the same time. Apparently, the torture of the brother was so severe that he died from its consequences within several months of his release.

Dr. \_\_\_ documents the presence of a 3.5 cm scar on the right fronto-temporal side of the head that is consistent with a blow to the head from a

blunt instrument. In addition, all teeth on the right side appear to have been knocked out during the attack. Mr. \_\_\_ has reported some loss of vision and hearing on the right side and has complained of memory problems. He is reported to be extremely fearful and paranoid to the point of refusing to leave the house and being quite unwilling to be examined for fear of a connection between health professionals and the Punjab police. He is reported to be extremely forgetful and unable to follow even simple instructions. He frequently gets disoriented and his niece must watch him carefully so he does not get lost.

Dr. \_\_\_ reports that Mr. \_\_\_ had to be convinced to continue with the examination several times because he was obviously afraid of her and did not want to proceed. He was able to follow simple commands with difficulty, was unable to state his age and wept when he recounted the history of his beating. Dr. \_\_\_ concluded that Mr. \_\_\_ exhibited and reported symptoms of Posttraumatic Stress Disorder as well as signs of organic brain damage. There is no report of any seizure activity subsequent to injury.

### **Additional Relevant History:**

During the course of my evaluation of Mr. \_\_\_ and interview of Ms. \_\_\_, the following additional information was obtained:

Subsequent to Mr. \_\_\_'s coma, which lasted for several days, he was delirious and continuously talked of running away for several days, according to a woman who was in the hospital with him and who told him this later. A male friend told him that he did not remember how to use a toilet, that he soiled himself and that the friend had to clean him. Mr. \_\_\_ has no memory of these events. He adds that the doctors at the hospital had initially given him a poor prognosis and thought he would not survive. He said on two occasions that there was "bad blood coming down through his nose" due to the injury, but it remains unclear whether this was blood, cerebrospinal fluid, or both.

Regarding Mr. \_\_\_'s current situation, Ms. \_\_\_ reports that he constantly talks about being a burden and says that people who live like he does should just die. He also worries constantly about his two nephews in India – the sons of his deceased brother – and cannot seem to get comfort from the fact that Ms. \_\_\_ gets nearly a telephone call per week assuring them that the nephews are doing fine. She tries continually to reassure him that the American police will not harm him. She tells of an example of this from the morning of the examination, when she and Mr. \_\_\_ saw three policemen and she pointed out to him that they were not causing any harm.

### **Recent Medical History:**

Mr. \_\_\_ has been treated by a psychiatrist at the \_\_\_ Clinic in (city A). Initially, he was prescribed Zyprexa and Prozac. Currently, he is only taking

Prozac. Ms. \_\_\_ reports that he never has any appetite and that she constantly has to convince him to eat something. He has lost about 5 lbs during the past year. She reports that he was almost totally unable to sleep since his arrival in the United States until very recently. Apparently, his sleep and appetite have improved slightly as a result of the medication but he complains constantly that the medicine makes him feel “lazy” and states that he would not take it on his own initiative. Most recently, Mr. \_\_\_ has been sleeping more than usual, whereas before he has complained of insomnia. It is unclear whether this is due to sedation from the Prozac. Mr. \_\_\_ has also been seeing a counselor at the \_\_\_ Center in (city B) but he and Ms. \_\_\_ were unable to determine whether this has been beneficial.

### **Behavioral Observations / Mental Status Examination:**

Mr. \_\_\_ is a male Sikh of short and thin build who appeared approximately his stated age of about 60 years old. He arrived in the company of Ms. \_\_\_ who had to persuade him to come along to the examination. He appeared somewhat lethargic, oriented to his name but unable to tell exact time. He said that he only knows that there is a 3, a 6, a 9 and a 12 on a clock but does not know what is in between. He had been to the same building for his medical exam with Dr. \_\_\_ but could not remember anything about it when he arrived. Throughout the examination, he demonstrated a child-like dependence on his niece. He remained suspicious of what I was doing in spite of explanations and reassurances that I had no connections with the Indian police. He most often spoke sideways to his niece without looking at me. However, there were times when this pattern could be interrupted and he engaged with me more directly. His paranoia did not have a primary psychotic quality in the sense that it was uniform, non-bizarre and apparently related specifically to his trauma history. His mood appeared slightly depressed but difficult to assess as his affect was blunted.

Much of the relevant information had to be obtained from Ms. \_\_\_, who appears to have been doing an admirable job of taking care of Mr. \_\_\_. When questioned directly, Mr. \_\_\_ had considerable difficulty understanding questions and articulating his thoughts. However, he was able to report directly that he was feeling afraid, that the questioning made it feel worse, and that part of the difficulty was that it took him considerable time to take in what I was saying. Through the translation, he said: “I hear something and then I feel scared. When that happens, I am somewhere else and I do not hear you. My other cousin calls me on the phone and then I do not hear her and she gets mad at me because she thinks I am ignoring her. I cannot tell what is going on with me. It takes me a while to get back to what you are saying. It has been happening since my injuries. Can I stay here (i.e. in the United States)? I am still not sure, and that bothers me.”

## Examination and Test Results:

It should be noted that almost all neuropsychological tests and procedures had to be administered through an interpreter. The results could not be subjected to norm-referenced interpretation for this reason, as well as due to the fact that American population norms are not applicable to an individual from Mr. \_\_\_'s culture. These factors were taken into consideration in interpreting the results, which will be described mainly by way of qualitative observation. Most of the procedures used were discontinued early on because it was very apparent that Mr. \_\_\_ was unable to perform the tasks. The level of his impairment was quite evident and I considered it unnecessary to make him more upset than he already was by exposing him to repeated failure. At the same time, Mr. \_\_\_'s impaired judgment and insight was upsetting to his niece, who also deserved protection from this exposure. When she thought herself unobserved I could see her pained expression in witnessing the extent of her uncle's inability to perform.

### Motor Functions

On examination of lateral dominance and motor functions, Mr. \_\_\_ exhibited marked dyspraxia, with considerable lack of initiation and motor slowing. When asked to demonstrate how he would throw a ball, he would not respond at first and seemed to fail to understand the directions, then made a feeble movement forward with both hands. He was able to repeat the same, equally faint, movement with only one hand when asked. He performed all one-handed movements with the right hand. When asked to demonstrate how he would cut with scissors, he complained that his niece would ask him to cut flowers or roses and that he has found himself quite unable to do so. He added that he used to be able to drive a tractor and cut a lot of things on the farm. When he was given a piece of paper and asked to cut it in half, he held the scissors awkwardly and upside down and required about a minute to finish the task. When questioned about any dressing dyspraxia, Mr. \_\_\_ stated that he is able to tie his shoes but that his brother-in-law has to help him with zippers on his clothes at times, which he finds difficult. He also stated that he is able to button a shirt but only very slowly. This is consistent with his performance observed on testing.

On the Grooved Pegboard, Mr. \_\_\_ required 3 minutes for the first three pegs and the test was discontinued. Mr. \_\_\_'s test performance was not only extremely low but showed clear evidence of stimulus boundedness and perseveration. Mr. \_\_\_ kept using the same unsuccessful strategy of trying to fit in a peg by turning it up to about 150 degrees when it needed to be turned 180 degrees. He kept repeating: "This one doesn't fit in." On Finger Tapping, Mr. \_\_\_ performed consistently and extremely

slowly, obtaining scores falling approximately 4 standard deviations below the American population norm.

#### Sensory-Perceptual Functions

On sensory-perceptual functions, Mr. \_\_\_ showed 5 left-sided suppressions on bilateral touch in 10 trials. According to Dr. \_\_\_'s and Mr. \_\_\_'s report, hearing loss should have been present on the right side. However, it appears that Dr. \_\_\_ did not perform a direct examination of Mr. \_\_\_'s ears. On examination by a slight rubbing fingers behind each ear, no significant difference was noted. During simultaneous testing of both ears, Mr. \_\_\_ showed hearing loss or suppressions in the left ear. The latter is particularly remarkable for its inconsistency with Mr. \_\_\_'s self report and because it is consistent with the left-sided suppressions on touch, which is considered a pathognomonic indicator for brain impairment of the right hemisphere.

#### Constructions and Visual-Spatial Processing

Mr. \_\_\_ was utterly unable to draw or write his name. His attempt to draw a clock was a very faint, poorly constructed circle without any further elaboration. He stated that he was once able to write his own name in Punjabi but that he can no longer do it. Likewise, he was unable to read his own name in Punjabi, which I had asked Ms. \_\_\_ to provide for him without telling him what it was. Further drawing tasks were not attempted. On Block Design, Mr. \_\_\_ was only able to construct the first two rudimentary designs, albeit with repeated instructions and great effort. He had to be instructed twice to construct the designs as seen on top rather than from the side. On Picture Completion, he was completely unable to identify any missing details, even though he was able to name the first three objects.

#### Executive Functions

The severe impairment of planning and organizational abilities as documented by history was particularly evident from Mr. \_\_\_'s performance on the Fuld Object-Memory Test. He was unable to inhibit the impulse to look at an object while trying to identify it by touch and needed to have instructions repeated again and again. His behavior was characterized by disinhibition, disorganization, and perseveration, which are pathognomonic indicators of frontal lobe impairment.

#### Memory

Consistent with recent history, Mr. \_\_\_ was only able to remember 4 out of 10 objects that had been presented during the touch trial of the Fuld Object-Memory evaluation. This is a particularly poor performance given the fact that no interference task was administered and that Mr. \_\_\_'s lack

of executive control had made a standard administration impossible thus giving him more than the usual exposure to the objects.

**Conclusions:**

Interview and test results reveal overwhelming evidence of severe brain impairment. Due to the fact that Mr. \_\_\_ speaks no English, only nonverbal areas of functioning could be assessed. While this places certain constraints on a neuropsychological examination, the results outlined above are unequivocal. The findings are most consistent with a predominantly right-hemispheric coup lesion involving the frontal, temporal and parietal lobes of the brain. Such a lesion is in turn consistent with the location and quality of the scar as documented by Dr. \_\_\_ . Most likely, the blow(s) to the head resulted in a depressed fracture with direct impact on the underlying brain tissue. Given the pervasive nature of the impairment present, however, these are tentative hypotheses and the extent of the damage to the brain is likely not limited to the areas specified above.

These findings and conclusions were discussed in a professional consultation with Dr. \_\_\_ , Clinical Professor of Neurology at \_\_\_ University and internationally renowned expert on neuropsychology. Dr. \_\_\_ concurred entirely with the interpretations and conclusions provided above.

**Recommendations:**

Mr. \_\_\_ will likely remain completely dependent on others to help him manage the basic affairs of life. His prognosis for improvement is guarded, if not poor, with regard to the brain impairment. There is some hope, however, that the symptoms of Posttraumatic Stress Disorder, particularly the paranoid fears, might improve somewhat once he is granted asylum status. His daily living and his treatment have to be carefully monitored as he requires considerable persuasion to participate in his treatment. The treatment with antidepressant medication appears to have had some benefit but may require reevaluation in light of the apparent sedation. He is fortunate to have a dedicated relative in Ms. \_\_\_ , who has been taking very good care of him so far. She gives every indication that she will continue to do so. I encouraged Ms. \_\_\_ to evaluate her own resources and not shy away from seeking help if the task becomes too heavy. Unfortunately, Mr. \_\_\_ is unlikely to derive much benefit from counseling due to the severity of his condition.

Respectfully submitted,

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Uwe Jacobs, Ph.D.  
PSY 15165

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Date

## Providing Testimony in Court

The main purpose of appearing in immigration court in person in support of the individual's application for political asylum, is to present orally the material that has been submitted in the written report and to respond to questions from the judge and the government attorney. Usually, a judge will 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 individual's own testimony, it is preferable for the clinician to appear in court personally.

The primary participants in the immigration court are the judge, the applicant for asylum (called the "respondent" in this type of proceeding), the respondent's attorney, the government attorney, the translator (if necessary), and witnesses called by the respondent's attorney to support the case.

The tone and style of the hearing may vary considerably depending on the case, the judge, and the government attorney. It is best for the health professional to be prepared for a challenging and even adversarial attitude, although this is often not the case. Prior to the court date, the applicant's attorney should arrange a meeting with the assessor to discuss the assessor'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 assessor 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 the INS 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 respondent's attorney 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 testimony consists of a period of direct examination by the respondent's attorney, during which the clinician's findings are presented, followed by cross-examination by the INS attorney and redirected questioning by the respondent's attorney. INS proceedings are quite flexible in format and the judge can, and often will, inject his/her own ques-

tions at any point in the proceeding. Sometimes there will be very little questioning from the judge and INS 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 applicant'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 respondent? Do you have first hand knowledge? Aren't you simply reporting what the respondent 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 traumatized patients and with commonly accepted professional standards such as the DSM-IV and other diagnostic criteria.

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 asylum applicant breaks into tears, explains how she was raped, nearly suffocated, threatened with death and says she is afraid to go back to the country where this happened, 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 immigration court is Stanley Brodsky’s *Testifying in Court: Guidelines and Maxims for the Expert Witness*.<sup>97</sup> Dr. Brodsky prepares the psychological expert for the most aggressive cross-examination of the expert’s credentials and conclusions. The government attorneys in immigration court are rarely as aggressive as those in the descriptions Brodsky provides. The most helpful aspect of the book 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.



# APPENDIX I

## Diagnostic Tests

Diagnostic tests are being developed and tested all the time. Those described below were considered to be of value at the time of writing this Manual. However, where there is a requirement for additional supporting evidence, clinicians should attempt to find up-to-date sources of information, for example by approaching a specialized center for the documentation of torture.

## 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), radioisotopic 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 are readily available. 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.

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 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.

#### *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) radionuclide 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 1 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 radionuclide 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.<sup>98</sup>

#### *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

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<sup>98</sup> See footnotes 49-51; also refer to standard radiology and nuclear medicine texts for further information.

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.

### *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.

### 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 traumatized psyche.

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<sup>99</sup> Thomsen, H.K., Danielsen, L., Nielsen, O., Aalund, O., Nielsen, K.G., Karlsmark, T., & Genefke, I.K., “Early Epidermal Changes in Heat- and Electrically Injured Pig Skin I: A Light Microscopic Study,” *Forensic Science International* 1981; 17:133-43.

<sup>100</sup> Thomsen, H.K., Danielsen, L., Nielsen, O., Aalund, O., Nielsen, K.G., Karlsmark, T., Genefke, I.K., & Christoffersen, P., “The Effect of Direct Current, Sodium Hydroxide, and Hydrochloric Acid on Pig Epidermis: A Light Microscopic and Electron Microscopic Study,” *Acta Pathologica, Microbiologica et Immunologica Scandinavica* Sect A, 1983; 91:307-16.

<sup>101</sup> Thomsen, H.K., *Electrically Induced Epidermal Changes. A Morphological Study of Porcine Skin After Transfer of Low-Moderate Amounts of Electrical Energy* (Dissertation), University of Copenhagen: F.A.D.L., 1984; 1-78.

<sup>102</sup> Karlsmark, T., Danielsen, L., Thomsen, H.K., Aalund, O., Nielsen, K.G., Johnson, E., & Genefke, I.K., “Tracing the Use of Torture: Electrically Induced Calcification of Collagen in Pig Skin,” *Nature*, 1983; 301:75-78.

<sup>103</sup> Karlsmark, T., Danielsen, L., Aalund, O., Thomsen, H.K., Nielsen, O., Nielsen, K.G., Lyon, H., Ammitsboll, T., Moller, R., & Genefke, I.K., “Electrically-Induced Collagen Calcification in Pig Skin: A Histopathologic and Histochemical Study,” *Forensic Science International*, 1988; 39: 163-74.

<sup>104</sup> Karlsmark, T., “Electrically Induced Dermal Change: A Morphological Study of Porcine Skin after Transfer of Low to Moderate Amounts of Electrical Energy” (Dissertation), University of Copenhagen, *Danish Medical Bulletin*, 1990; 37:507-20.

### *Rationale for biopsy:*

There has been extensive laboratory research measuring the effects of electric shocks on the skin of anaesthetized pigs.<sup>99, 100, 101, 102, 103, 104</sup> 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.<sup>105, 106, 107, 108</sup> 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.<sup>109</sup>

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<sup>105</sup> Danielsen, L., Karlsmark, T., Thomsen, H.K., Thomsen, J.L. & Balding, L.E., "Diagnosis of Electrical Skin Injuries: A Review and a Description of a Case," *Am. J. Forensic Med. Pathol.*, 1991; 12:222-6.

<sup>106</sup> oztop, F., Lok, V., Baykal, T., & Tunca, M., "Signs of Electrical Torture on the Skin," in Human Rights Foundation of Turkey, *Treatment and Rehabilitation Centers Report 1994*, HRFT Publication 11:97-104.

<sup>107</sup> Danielsen, L., Karlsmark, T., & Thomsen, H.K., "Diagnosis of Skin Lesions Following Electrical Torture," *Romanian Journal of Legal Medicine*, 1997; 5:15-20.

<sup>108</sup> Jacobsen, H., "Electrically Induced Deposition of Metal on the Human Skin," *Forensic Science International*, 1997; 90:85-92.

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.<sup>110</sup>)

*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

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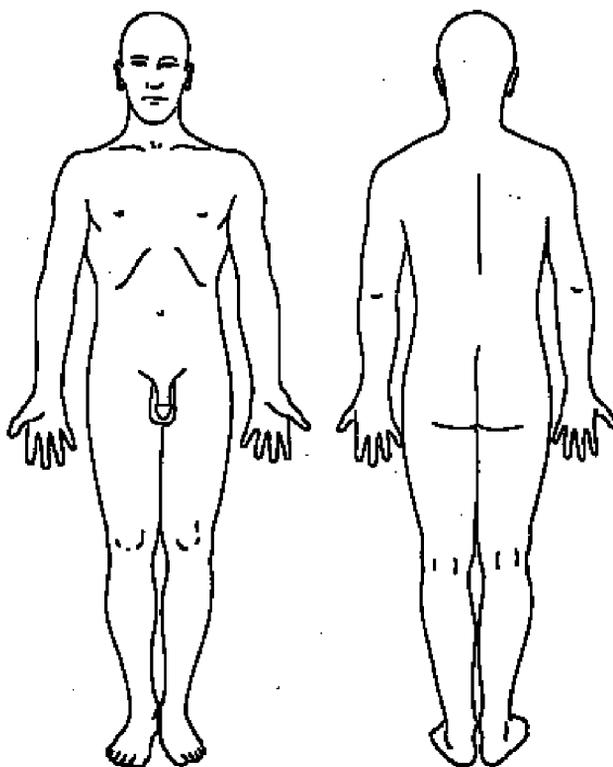
<sup>109</sup> Giirpinar, S., & Korur, Fincanci S., *Insan Haklari Ihlallari ve Hekim Sorumlulugu* (Human Rights Violations and Responsibility of the Physician), in *Birinci Basamak Icin Adli Tip El Kitabı* (Handbook of Forensic Medicine for General Practitioners), Turkish Medical Association, Ankara, 1999.

<sup>110</sup> Danielsen, L., Karlsmark, T, Thomsen, H.K., Thomsen, J.L. & Balding, L.E., "Diagnosis of Electrical Skin Injuries: A Review and a Description of a Case," *American Journal of Forensic Medical Pathology*, 1991; 12:222-6.

# APPENDIX II

## Anatomical Drawings for Documentation of Torture and Ill Treatment

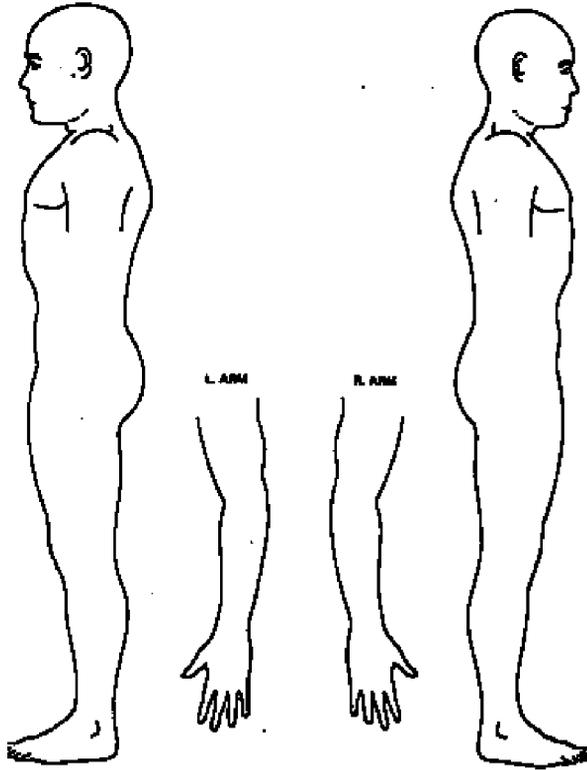
Full Body, Male – Anterior and Posterior Views (Ventral and Dorsal)



Name \_\_\_\_\_ Case No. \_\_\_\_\_

Date \_\_\_\_\_

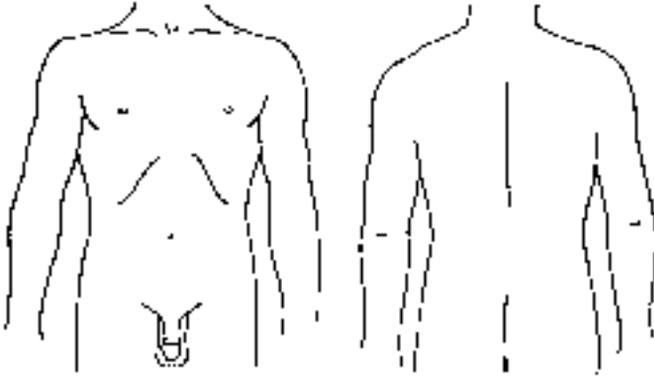
Full Body, Male – Lateral View



Name \_\_\_\_\_ Case No. \_\_\_\_\_

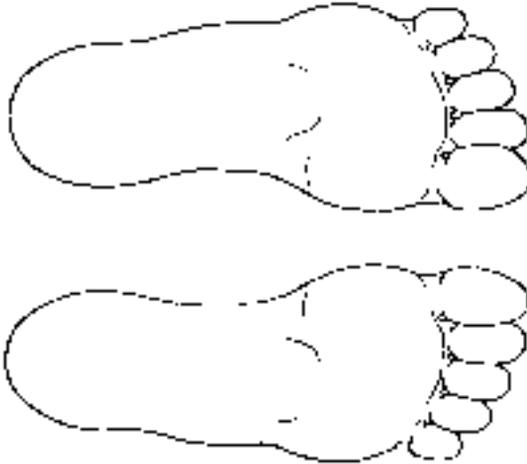
Date \_\_\_\_\_

**Thoracic Abdominal, Male – Anterior and Posterior Views**



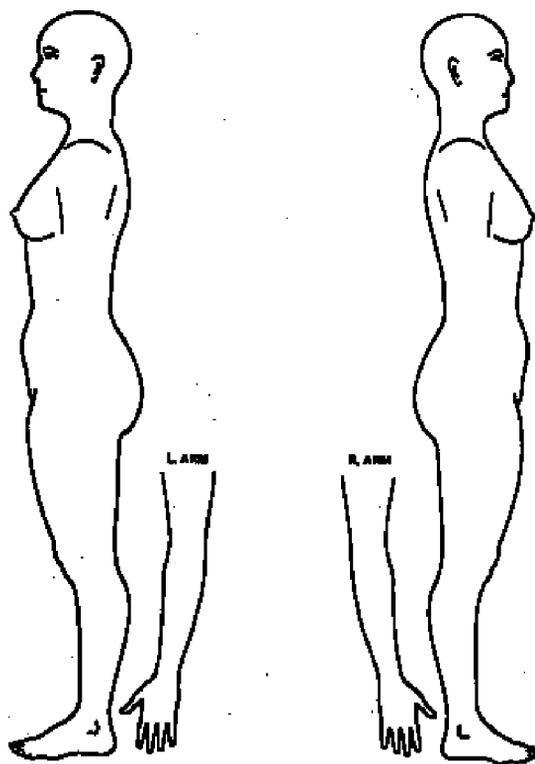
Name \_\_\_\_\_ Case No. \_\_\_\_\_  
Date \_\_\_\_\_

**Feet – Left and Right Plantar Surfaces**



Name \_\_\_\_\_ Case No. \_\_\_\_\_  
Date \_\_\_\_\_

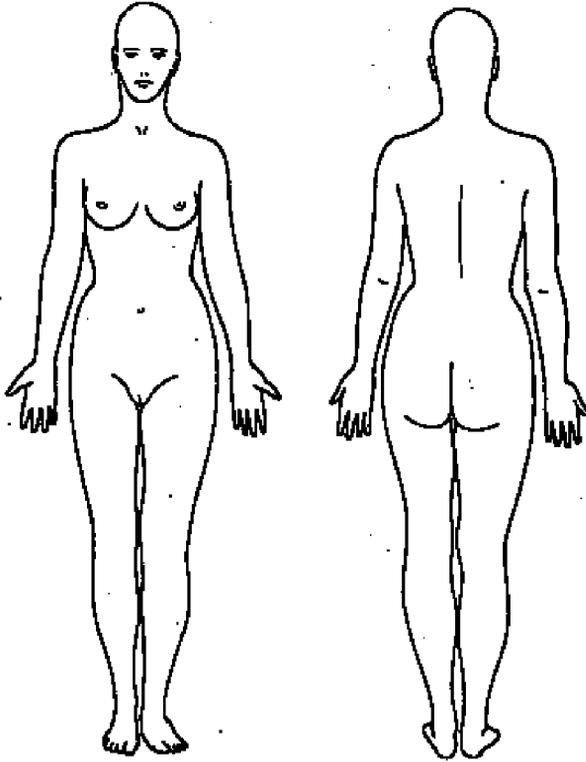
Full Body, Female – Lateral View



Name \_\_\_\_\_ Case No. \_\_\_\_\_

Date \_\_\_\_\_

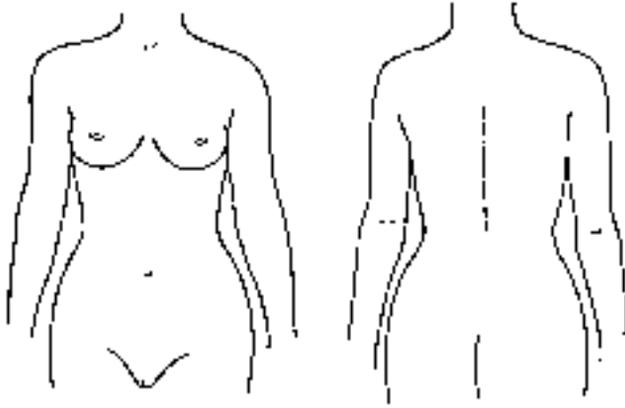
Full Body, Female – Anterior and Posterior Views



Name \_\_\_\_\_ Case No. \_\_\_\_\_

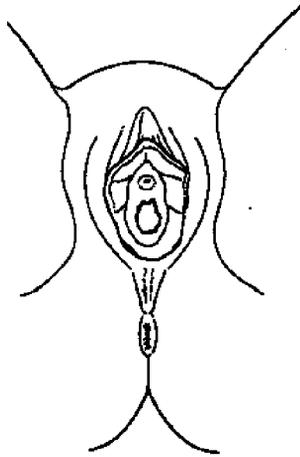
Date \_\_\_\_\_

**Thoracic Abdominal, Female – Anterior and Posterior Views**



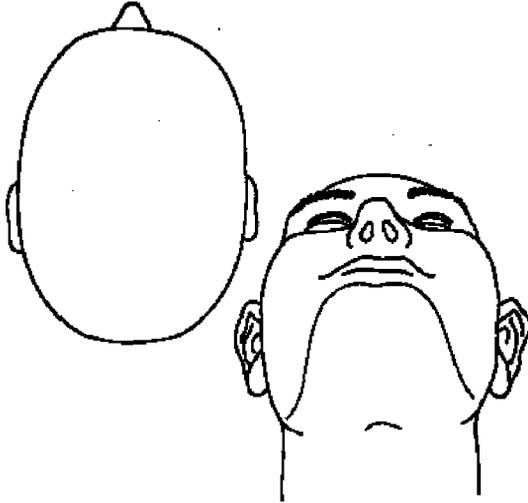
Name \_\_\_\_\_ Case No. \_\_\_\_\_  
Date \_\_\_\_\_

**Perineum – Female**



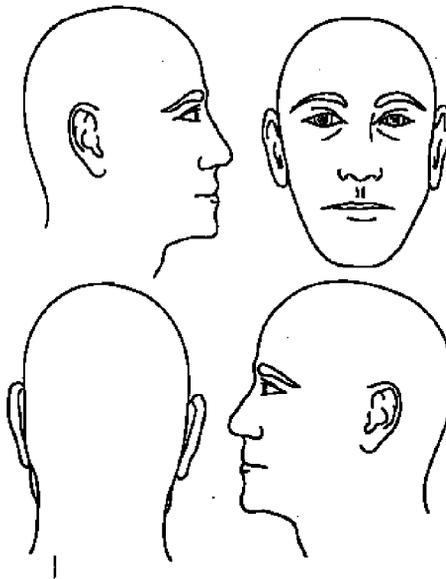
Name \_\_\_\_\_ Case No. \_\_\_\_\_  
Date \_\_\_\_\_

Head – Surface and Skeletal Anatomy, Lateral View



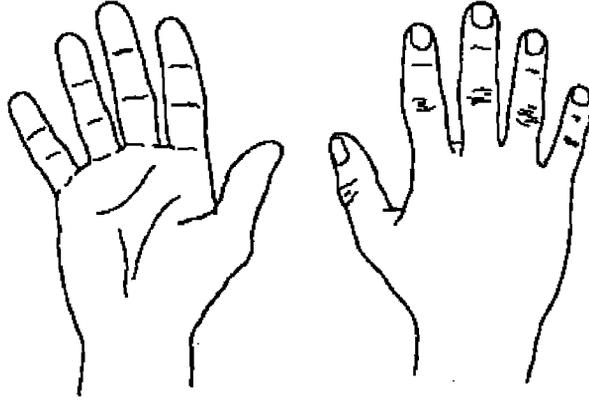
Name \_\_\_\_\_ Case No. \_\_\_\_\_  
Date \_\_\_\_\_

Head – Surface and Skeletal Anatomy, Superior View – Inferior View of Neck



Name \_\_\_\_\_ Case No. \_\_\_\_\_  
Date \_\_\_\_\_

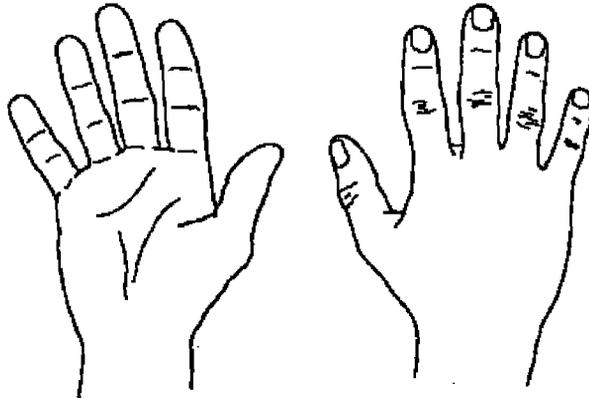
**Right Hand – Palmar and Dorsal**



Name \_\_\_\_\_ Case No. \_\_\_\_\_

Date \_\_\_\_\_

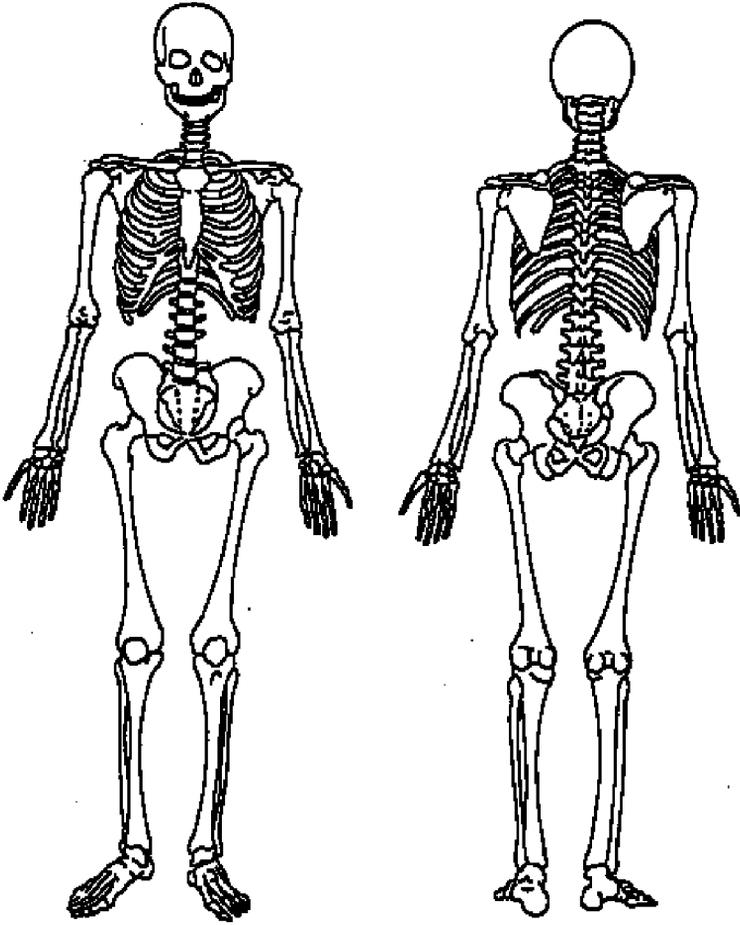
**Left Hand – Palmar and Dorsal**



Name \_\_\_\_\_ Case No. \_\_\_\_\_

Date \_\_\_\_\_

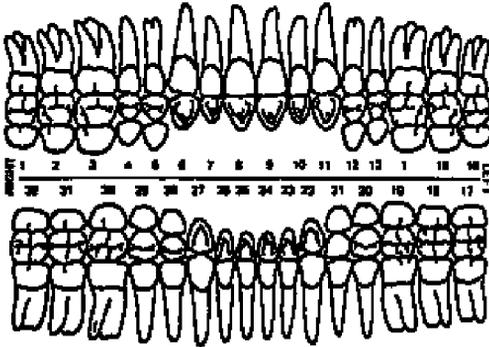
Skeleton – Anterior and Posterior Views



Name \_\_\_\_\_ Case No. \_\_\_\_\_

Date \_\_\_\_\_

Mark All Existing Restorations and Missing Teeth on This Chart



Describe completely all Prosthetic Appliances or Fixed Bridges

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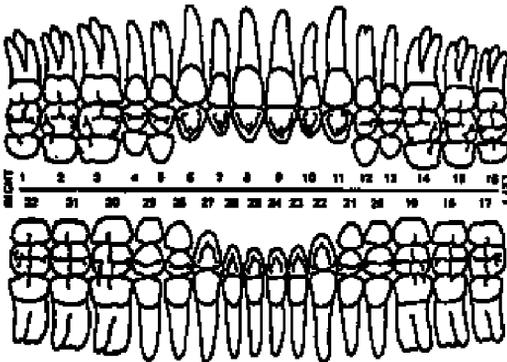
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Mark all caries on this chart

Outline all caries and "X" out all missing teeth



Estimated Age \_\_\_\_\_  
 Sex \_\_\_\_\_  
 Race \_\_\_\_\_

Circle descriptive term  
 Prosthetic appliances present

Maxilla  
 Full denture  
 Partial denture  
 Fixed bridge

Mandible  
 Full denture  
 Partial denture  
 Fixed bridge

Stains on teeth  
 Slight  
 Moderate  
 Severe

Circle descriptive term  
 Relationship  
 Normal  
 Undershot  
 Overbite

Periodontal Condition  
 Excellent  
 Average  
 Poor

Calculus  
 Slight  
 Moderate  
 Severe

# APPENDIX III

## Resources for Referrals: Torture Treatment Centers Within the United States and Canada

### ASTT (Advocates for Survivors of Torture and Trauma)

P.O. Box 5645  
Baltimore, MD 21210, USA  
Tel: 410-554-2504  
Fax: 410-467-7664  
(attn. Karen Hanscom, PhD)  
Contact: Karen Hanscom, PhD,  
klh@igc.org

### Amanecer

1145 Wilshire Blvd., Ste. 210  
Los Angeles, CA 90017  
Tel: 213-481-1347  
Fax: 213-482-9466  
<http://www.ccs.amanecer.aol.com>  
Contact: Barbara Breitman, Clinical  
Director

### AMIGOS (Amigos de los Sobrevivientes)

P.O. Box 50473  
Eugene, OR 97405, USA  
Tel: 541-484-2450  
Fax: 541-485-7293  
E-mail: [amigos@efn.org](mailto:amigos@efn.org)  
Contacts: German Nieto-Maquehue,  
Executive Director  
Saul Toobert,  
Psychological Services, Director  
<http://www.pacinfo.com/eugene/tsnet>

### Bellevue/NYU Program for Survivors of Torture

c/o Division of Primary Care Medicine  
NYU Medical Center  
550 First Avenue  
New York, NY 10016  
Tel: 212-683-7446  
Fax: 212-263-8234  
Contacts: Allen Keller, MD,  
Program Director,  
Edna Impalli, Clinical Coordinator  
<http://www.survivorsoftorture.org>

### Bosnian Mental Health Program

4750 N. Sheridan, Ste. 300  
Chicago, IL 60640, USA  
Tel: 773-271-1073  
Fax: 773-271-0601  
Contact: Mary Fabri, PsyD,  
Clinical Administrator

### Boston Center for Refugee Health and Human Rights Health Law Department

Boston University School of  
Public Health  
Talbot Building, 3rd Floor West  
715 Albany St.  
Boston, MA 02118  
Tel: 617-638-4626  
Fax: 617-414-1464  
Contact: Michael Grodin, MD, FAAP  
Alejandro Moreno, MD  
<http://www.flphr.org/bcrhhr>

**Center for International Health  
Regions Hospital**

640 Jackson Street  
St. Paul, MN, 55101-2595, USA  
Tel: 651-291-4894  
Fax: 651-254-3801  
E-mail:  
patriciaf.walker@healthpartners.com  
Contacts: Patricia Walker,  
Medical Director  
Karen Ta, MD

**CPRV (Center for the Prevention and  
Resolution of Violence)**

P.O. Box 65720  
Tucson, AZ 85728  
Tel: 520-628-7525  
Fax: 520-797-8656  
Contact: Amy Shubitz

**CST (Center for Survivors of  
Torture) - Dallas**

P.O. Box 72063  
Dallas, TX 75372, USA  
Tel: 214-352-9489  
Fax: 214-827-1972  
E-mail: centerforsurvivors@yahoo.com  
Contacts: Tom Francis,  
Program Director  
Manuel Balbona, MD

**CST (Center for Survivors of  
Torture) - San Jose**

2400 Moorpark Ave., Suite 300  
San Jose, CA 95128, USA  
Tel: 408-975-2730 x250  
Fax: 408-975-2745  
Contact: Gerald Gray, LCSW

**CVT (Center for Victims of Torture)**

717 East River Road  
Minneapolis, MN 55455, USA  
Tel: 612-626-1400  
Fax: 612-626-2465  
E-mail: cvt@cvt.org  
<http://www.cvt.org>  
Contacts: Douglas Johnson,  
Executive Director  
Rosa García-Peltoniemi, PhD,  
Director of Client Services

**Consejo Counseling and  
Referral Service**

3808 South Angeline Street  
Seattle, WA 98228, USA  
Tel: 206-461-4880  
Fax: 206-461-6989  
Contacts: Jaci Oseguera, Executive  
Director of Consejo  
Alberto Rabago, Executive Director of  
Adult Mental Health

**Harvard Program in Refugee Trauma**

8 Story Street, 3rd Floor  
Cambridge, MA 02138, USA  
Tel: 617-496-5550  
Fax: 617-496-5530  
Contacts: Richard Mollica, MD, MAR,  
Director, HPRT  
James Lavelle, LICSW

**Healing Center for Survivors of  
Political Torture**

Californian Institute of Integral Studies  
9 Peter Yorke Way  
San Francisco, CA 94109  
Tel: 415-241-1562  
Fax: 415-703-7222  
Contact: Terry Zucker,  
Director of Services

**Human Rights Clinic**  
Doctors of the World  
375 West Broadway, 4th Floor  
New York, NY 10012, USA  
Tel: 212-226-9890 x230  
Contact: Maki Katoh, Director

**Institute for Survivors of Torture and Human Rights Abuses**  
1430 West Pratt #1  
Chicago, IL 60626, USA  
Tel: 773-381-9543  
Fax: 773-257-8400  
Contact: Antonio Martinez, President

**ISPT (Institute for the Study of Psychopolitical Trauma)**  
c/o 380 Edlee Ave.  
Palo Alto, CA 94306, USA  
Tel: 408-342-6545 / 342-6500  
Fax: 408-342-6540  
Contact: Carlos J. Gonsalves, PhD

**International Institute of New Jersey Program for Survivors of Torture**  
880 Bergen Ave., 5th Floor  
Jersey City, NJ 07306  
Tel: 201-653-3888 x 12  
Fax: 201-963-0252  
Contact: Sara Kahn, Director

**Intercultural Psychiatric Program**  
Department of Psychiatry, Oregon Health and Sciences University  
3181 SW Sam Jackson Park Road UHN-88  
Portland, OR, 97201-3098, USA  
Tel: 503-494-4222  
Fax: 503-494-6143  
Contact: Professor J. David Kinzie, MD

**(ISC) International Survivors Center**  
International Institute of Boston  
1 Milk Street, 4th Floor  
Boston, MA 02190, USA  
Tel: 617-695-9990  
Fax: 617-695-9191  
E-mail: kallden@iiboston.org,  
salexand@iiboston.org  
Contact: Kathleen Allden, MD, Medical Director; Sarah Alexander, LICSW

**Khmer Health Advocates**  
29 Shadow Lane  
W. Hartford, CT 06110, USA  
Tel: 860-561-3345  
Fax: 860-561-3538  
E-mail: mfs47@aol.com  
Contact: Mary Scully

**Marjorie Kovler Center for the Treatment of Survivors of Torture**  
4750 North Sheridan Rd., Suite 300  
Chicago, IL 60640, USA  
Tel: 773-271-6357  
Fax: 773-271-0601  
E-mail: kovler@mcs.net  
Contacts: Scott Portman,  
Program Coordinator  
Lauren Heidbrink,  
Social Worker/Case Manager

**Naim Foundation**  
3000 Connecticut Avenue, NW  
Suite. 136  
Washington, DC 20008  
Tel: 202-462-5715  
Contact: Nuha Abudabbeh, PhD

**PSTT (Program for Survivors of Torture and Severe Trauma)**

Center for Multi-Cultural Studies  
701 W. Broad St., Suite 305  
Falls Church, VA 22046  
Tel: 703-533-3302  
Fax: 703-237-2083  
Contact: Judy Okawa, PhD, Director

**PVT (Program for Torture Victims)**

3655 South Grand Ave., Ste. 290  
Los Angeles, CA 90007  
Tel: 213-747-4944  
Fax: 213-747-4662  
E-mail: [jquirogamd@aol.com](mailto:jquirogamd@aol.com)  
Contacts: Jose Quiroga, MD,  
Medical Director  
Ana Deutsch, Director of Psychological  
Services, (818) 509-7780

**Rocky Mountain Survivor Center**

1547 Gaylord Street  
Denver, CO 80206, USA  
Tel: 303-321-3221  
Fax: 303-321-3314  
E-mail: [rmsc@rmscdenvr.org](mailto:rmsc@rmscdenvr.org)  
Contact: Eric Johnston, Community  
Resource Coordinator  
<http://www.rmscdenvr.org>

**Solace (A Program for Survivors of Torture and Refugee Trauma)**

Victim Services  
74-09 37th Avenue, Rm. 412  
Jackson Heights, NY 11372, USA  
Tel: 718-899-1233, x101 or x108  
Fax: 718-457-6071  
E-mail: [eduff@victimservices.org](mailto:eduff@victimservices.org)  
[aljubicic@victimservices.org](mailto:aljubicic@victimservices.org)  
Contacts: Ernest Duff,  
Project Coordinator  
Aleksandar Ljubicic, Clinical Director

**Survivors International**

447 Sutter Street, Ste. 811  
San Francisco, CA 94108, USA  
Tel: 415-765-6999  
Fax: 415-765-6995  
E-mail: [survivorsIntl@aol.com](mailto:survivorsIntl@aol.com)  
Contacts: Margaret Kokka,  
Executive Director  
Uwe Jacobs, PhD, Clinical Director  
<http://www.survivorsintl.org>

**Survivors of Torture International**

PO Box 151240  
San Diego, CA 92175-1240, USA  
Tel: 619-278-2400  
Fax: 619-294-9405  
E-mail: [survivors@notorture.org](mailto:survivors@notorture.org)  
<http://www.notorture.org>  
Contact: Kathi Anderson, MA,  
President

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