

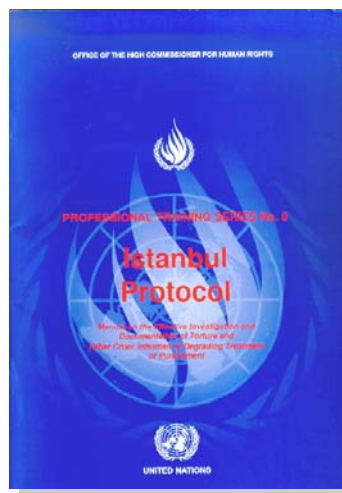
Reference Materials

The Istanbul Protocol: International Guidelines for the Investigation and Documentation of Torture

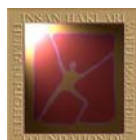
PSYCHOLOGICAL EVIDENCE OF TORTURE

A Practical Guide to the Istanbul Protocol
– for Psychologists

2004



This guide was written by the Human Rights Foundation of Turkey (HRFT) as part of the Istanbul Protocol Implementation Project, an initiative of Physicians for Human Rights USA (PHR USA), the Human Rights Foundation of Turkey (HRFT), the World Medical Association (WMA), and the International Rehabilitation Council for Torture Victims (IRCT)



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The Istanbul Protocol: International Guidelines for the
Investigation and Documentation of Torture

PSYCHOLOGICAL EVIDENCE OF TORTURE

A Practical Guide to the Istanbul Protocol
– for Psychologists

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REFERENCE MATERIALS REGARDING THE USE OF THE ISTANBUL PROTOCOL: INTERNATIONAL GUIDELINES FOR THE INVESTIGATION AND DOCUMENTATION OF TORTURE

The Istanbul Protocol is the first set of international guidelines for the investigation and documentation of torture. The Protocol provides comprehensive, practical guidelines for the assessment of persons who allege torture and ill-treatment, for investigating cases of alleged torture, and for reporting the findings to the relevant authorities. Initiated and co-ordinated by Physicians for Human Rights USA (PHR USA) and Action for Torture Survivors and the Human Rights Foundation of Turkey (HRFT), the Protocol was developed over three years with the involvement of more than 40 organisations, including the International Rehabilitation Council for Torture Victims (IRCT) and the World Medical Association (WMA).

With the generous support of the EU, the 'Istanbul Protocol Implementation Project' was carried out between March 2003 and March 2005 to increase awareness, national endorsement and tangible implementation of the Protocol in five target countries: Georgia, Mexico, Morocco, Sri Lanka and Uganda.

The resource materials presented here were developed as a source of practical reference for health and legal professionals during the trainings conducted as part of the project. The materials were widely disseminated to the 250 individual health professionals and 125 lawyers who participated in the trainings and were also distributed to relevant national institutions and government agencies in the five countries. It is hoped that these materials offer insights and create synergy between the two professions in a joint effort to combat torture.

INDEX

PSYCHOLOGICAL EVIDENCE OF TORTURE	1
PURPOSE OF THIS MANUAL	1
PART 1: GENERAL CONSIDERATIONS	2
THE CENTRAL ROLE OF THE PSYCHOLOGICAL EVALUATION	2
1.1 <i>Why is the psychological evaluation so crucial when investigating allegations of torture?</i>	2
1.2 <i>What are the aims of the psychological evaluation when investigating torture allegations?</i>	3
1.3 <i>What is the aim of torture?</i>	3
PART 2: PRECAUTIONARY REMARKS	6
2.1 <i>How important is the cultural background for the psychological evaluation?</i>	6
2.2 <i>Why is the context in which psychological evaluation takes place so important?</i>	7
2.3 <i>Considerations related to the terminology:</i>	7
2.4 <i>Which psychological processes are activated by torture?</i>	8
2.5 <i>Which factors are related to the appearance of symptoms due to torture?</i>	8
PART 3: INTERVIEW CONSIDERATIONS AND INTERVIEW PROCESS	11
3.1 <i>How to collect sufficient and appropriate information during the interview process without putting the examinee under legal and medical risk?</i>	11
3.2 <i>What should be the course of the interview? (Recommendations to consider for a better interview course)</i>	13
3.3 <i>What are the potential transference and counter-transference reactions which may be encountered?</i>	14
PART 4: PSYCHOLOGICAL CONSEQUENCES OF TORTURE	16
4.1 <i>What symptoms are commonly seen as consequences of torture?</i>	16
4.2 <i>What are the most common diagnostic categories of torture/trauma-related mental disorders?</i>	21
4.3 <i>What other diagnostic categories are common?</i>	23
4.4 <i>What are the components of psychological/psychiatric evaluation?</i>	26
PART 5: EVALUATION AND INTERPRETATION OF THE FINDINGS -CLINICAL IMPRESSION... 30	
5.1 <i>How to interpret the psychological findings and formulate a clinical impression?</i>	30
5.2 <i>Does the absence of a diagnosable psychopathology mean that the person was not tortured? How should the findings be interpreted in this case?</i>	31
5.3 <i>What kind of factors could lead to difficulties when obtaining and evaluating a history?</i>	31
5.4 <i>What to do regarding inconsistencies in the reported story of a person?</i>	33
5.5 <i>Reporting</i>	34
REFERENCES	37

PSYCHOLOGICAL EVIDENCE OF TORTURE

PURPOSE OF THIS MANUAL

This part of the training manual suggests complementary considerations and recent literature on the various issues treated in the psychological section of the Istanbul Protocol.

One of the aims here is to discuss, in the light of the Istanbul Protocol, significant points and frequently addressed questions, but also to point out critical situations, that the clinician might face when conducting the psychological evaluation of torture allegations.

Through specific questions related to the psychological effects of torture, it is shown how the Istanbul Protocol becomes a practical tool when being involved in the documentation process of alleged torture experience and its possible consequences for the psyche.

The first part of this section goes thoroughly into issues related to the psychological impact of torture on the individual, while the second part proposes to discuss the practices recommended in the Istanbul Protocol when conducting a psychological evaluation of torture allegations.

PART 1: GENERAL CONSIDERATIONS

THE CENTRAL ROLE OF THE PSYCHOLOGICAL EVALUATION

1.1 WHY IS THE PSYCHOLOGICAL EVALUATION SO CRUCIAL WHEN INVESTIGATING ALLEGATIONS OF TORTURE?

Over the years of systematic investigation of torture it has become obvious that the improved methods of detecting and proving physical torture has made the methods of torture more sophisticated in order not to leave visible evidence on the victim's body. Especially in situations where the public opinion is involved, the variety of methods, which leave no physical marks or permanent scars is very extensive.

When going through the Istanbul Protocol, the following paragraphs describe the intention of the torturers not to leave physical signs:

§259: "Psychological evaluations can provide critical evidence of abuse among torture victims 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."

§158: "It is important to realize that torturers may attempt to conceal their act. To avoid physical evidence of beating (....), falanga (....) or electro shocks, different precautions are taken in order to apply (....) forms of torture that have the intent of producing maximal pain and suffering with minimal evidence."

§160: "... 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 mark or permanent scars."

§260: "... Because psychological symptoms are so prevalent among survivors of torture, it is highly advisable that all evaluations of torture include a psychological assessment."

The research by Finn Somnier should be mentioned here. This research has shown that the psychological sequelae of torture were more persistent and troublesome than a possible physical disability. Most physical symptoms and signs of torture disappear quite quickly, while several aspects of psychological functioning may have suffered long-term damage (Somnier et al, 1992).

Other mental health professionals specialized in the psychological effects of torture have made similar findings in their work with torture survivors. Gurr and Quiroga (2001) state that contrary to the physical effects of torture, the psychological symptoms are more persistent and troublesome than the physical disability. If untreated, the victims may still experience anxiety, panic, irritability, rage, insomnia, nightmares, memory difficulties, lack of initiative, apathy, social withdrawal, helplessness, affective lameness, and flashbacks of the traumatic event even several months or years after torture (Somnier et al, 1992; Gurr & Quiroga, 2001).

All international discussions of torture acknowledge that mental suffering is often deliberately inflicted by the torturers (Alden, 2002). Furthermore, by not leaving permanent physical scars, the torturers

help their cause at the same time as making the work of their counterparts working for human rights more difficult (Jacobs, 2000).

In summary, the various methods of torture represent a serious attack on the psychological make-up of a person. In this sense, in order to obtain the best possible picture of the situation, it is highly recommended to include a psychological evaluation when investigating allegations of torture. As Kordon et al. (1988) put it, "one of the main objectives of torture is to destroy the psychological and social integrity of the victim, and all kinds of torture inevitably comprise psychological processes".

1.2 WHAT ARE THE AIMS OF THE PSYCHOLOGICAL EVALUATION WHEN INVESTIGATING TORTURE ALLEGATIONS?

§260: "Psychological evaluations provide useful evidence for medico-legal examinations, political asylum applications, establishing conditions under which false confessions may have been obtained, understanding regional practices of torture, identifying the therapeutic needs of victims, and as testimony in human rights investigations."

It is always important to consider the aims of the psychological evaluation, as they will define the level of confidentiality to which the expert is bound. If the psychological evaluation is necessary or requested in the context of a legal procedure, the person to be evaluated must be aware that this implies the lifting of the medical confidentiality.

If the legal procedure leads to trials or hearings, the expert who conducted the psychological evaluation may be called as a witness.

§260: "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."

According to the context and the country where the psychological evaluation takes place, different levels of consistency – for instance low, adequate, high, close-to-certain probability – might be requested.

Nevertheless, in some countries, the expert is expected to clearly define if the person has been tortured or not. If he or she does not have a clear position, the principle that suspicion should always favour the suspect might be applied, and therefore there is a risk of impunity for the perpetrators.

1.3 WHAT IS THE AIM OF TORTURE?

§234: "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. One of the central aims of torture is to reduce an individual to a position of extreme helplessness and distress that can lead to a deterioration of cognitive, emotional and behavioural functions. Thus, torture is a means of attacking the individual's fundamental modes of psychological and social functioning. Under such circumstances, the torturer strives not only to incapacitate physically a victim, but also to disintegrate 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. By dehumanizing and breaking the will of their victims, torturers set horrific examples for those who later 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."

Torture is a dynamic process beginning with the moment of arrest or deprivation of liberty, involving one or several sequences of traumatic events that may take place at different times and places, and ending with the release or demise of the victim (Somnier, 1992). This cascade of events can start again within a short time-frame, without leaving any time for the individual to recover.

Given the assumption that torture is intended to damage the person's self-esteem and personality, to destroy trust in fellow humans, and to terrorize the population (Gurr & Quiroga, 2001), the effects of torture can be analyzed from different angles. Indeed, the potential effects of torture include cumulative traumatic experiences on **the individual level**, family trauma on **the family level**, and community trauma on **the community level**.

From a **socio-political point of view**, the following authors suggest some additional considerations to this topic:

Lira (1995): At a broader level, the reason for torture is to intimidate third parties, thereby ensuring responses of fear, inhibition, paralysis, impotence and conformity within society. Violations of human rights cannot be viewed exclusively from the perspective of isolated individual abuses. Their implications are extensive, for they describe not only a system's response to conflict, but a general ambience of political threat, both of which lead to an atmosphere of chronic fear. In this sense, torture is not only a political, but also a social, ethical, psycho-social and mental health problem for society. Investigating torture means looking at experiences that affect a whole population not only as individuals per se, but as social beings in a social context.

Summerfield (1995): The context of atrocity is frequently the intended destruction of the economic, social, and cultural worlds of the victims.

In this sense, torture can cause community trauma that can cause different forms of community dysfunction. Torture can terrorize the population and create an order that is based on imminent, pervasive threat, fear, terror, and inhibition, rather than on autonomy and freedom. It can create a repressive ecology, which is a state of generalized insecurity, terror, lack of confidence, and rupture of the social fabric. Collective fear that is based on this massive threat of being tortured has long-lasting effects on the forms of collective behaviour. Moreover, research has found that torture can be transmitted cross-generationally, constituting a historical trauma (Kira, 2002).

Regarding the **impact on the family**, torture can lead to family traumas that can cause different forms of family dysfunction and disruptions in the course of family development.

Family assessment is one of the missing parts in most torture assessments. Assessing the effects of torture on the survivor's family dynamics could be important in the torture assessment. However, circumstances rarely allow an investigation of the family dynamics because of confidentiality issues, time constraints and missing skills in methods of approaching the family.

When it comes to what happens between **the perpetrator and the person experiencing torture**, the true aim of torture becomes more obvious. The following considerations from the specialized literature are suggested for discussion, in addition to the Istanbul Protocol. When the psychological evaluation is conducted in practice, it might be helpful to analyze the following aspects:

- Most victims of torture do not have any relevant information to disclose, a fact that the torturer is aware of.
- Torture is a complex trauma that consists of different kinds of traumas that are inflicted during a specific period, or periods, and are connected by complete uncontrollability, inescapability, and by the unpredictability of the torturer. Torture can cause mental defeat, alienation, and perceived permanent negative change (Kira, 2002).

- The expert is confronted with a double task. Firstly, he must take into account the external causality of violence collectively organized by some human beings against other human beings. Secondly, he must evaluate the psychological effects of these causalities. It is therefore a question of evaluating an interaction between the perpetrator of violence and the person subjected to it (Sironi, 1989).

Finally, it is important to investigate what the torture does to the human being. Techniques of torture, increasingly sophisticated, are invented in order to attack the individual's body and mind in a systematic way, intentionally to break the limits of the personality. The aim of torture is not simply to inflict pain and suffering, but to break the victim's will by applying methods of provoking pain and suffering.

While considering that the physical and psychological effects of torture are closely linked, the knowledge of the methods used by the torturers facilitates the identification of the internal repercussions. Indeed, the individual exposed to torture is reduced to a position of extreme helplessness, defencelessness, impotence, constant threat and distress, provoking the disintegration of the cognitive, emotional and behavioural functions as an immediate, medium or long-term consequence (Fischer & Gurrus, 1996; Lira, 1995).

This situation is accompanied by feelings of complete confusion, powerlessness, and of losing one's sense of control. These feelings can bring about a shattered understanding of oneself, of the existential system of meaning and of the predictability of the world (Fischer & Gurrus, 1996; McFarlane, 1995).

Furthermore, torture aims at destroying the inner mental life and social relations of its victims, specifically through psychological means. The aim of torture is reached through the psychological consequences this has on both the primary victim and on those who come to fear a similar fate (Jacobs, 2000).

At the beginning of the arrest, the demonstration of power by the perpetrators (e.g. often with blindfolding, blows to the entire body) causes a feeling of vulnerability in the detained person.

Situations of torture have an extremely threatening and painful character, are unpredictable and bring about a significant fear of death. They produce immediate reactions of panic, fear and pain, with a very high level of excitement and, subsequently, of emotional numbness (Gurrus & Wenk-Ansohn, 1997).

Torture is a complex mechanism that can traumatize the body, the autonomy and identity of the individual, his/her self-actualization enterprises, and his/her sense of safety and survival. It also impacts on his/her attachment and connectedness, as well as on beliefs and system of meaning about him/herself and the world (Kira, 2002).

PART 2: PRECAUTIONARY REMARKS

2.1 HOW IMPORTANT IS THE CULTURAL BACKGROUND FOR THE PSYCHOLOGICAL EVALUATION?

In the Istanbul Protocol, as well as in numerous specialized articles, the crucial importance of the cultural context in which torture happens has been stressed on many occasions. Indeed, symptoms need to be understood in the environment in which they occur and through the meaning they represent to the individual experiencing them (Summerfield, 1995; Burnett & Peel, 2001a).

As Summerfield puts it, every culture has its own beliefs and traditions which determine psychological norms and frameworks for mental health (Summerfield, 2000).

§235: “The unique cultural, social and political meanings that torture has for each individual, influences his or 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.”

§261: “Awareness of culture-specific syndromes and native language-bound idioms of distress through which symptoms are communicated is of paramount importance for conducting the interview and formulating the clinical impression and conclusion. When the interviewer has little or no knowledge about the victim’s culture, the assistance of an interpreter is essential. Ideally, an interpreter from the victim’s country knows the language, customs, religious traditions, and other beliefs that will need to be considered during the investigation.”

For instance, people who experienced torture may live as refugees, asylum seekers and migrants far away from their place of origin. If so, they differ in their cultural backgrounds and may use different strategies to cope with the painful experiences, compared to the population, which is still resident within their own social context.

So when doing a psychological evaluation of a person from a different cultural background, one should always keep in mind that people who have experienced extreme trauma tend to react in accordance with the meaning it has for them. Generating these meanings is an activity that is socially, culturally and often politically framed. There is no easy way of predicting how victims prioritize their personal traumas. In this sense, traumatic experience and the search for meaning which it triggers, must be understood in terms of the relationship between the individual and his or her society, with outcomes influenced by cultural, social and political forces (Summerfield, 1995).

Regarding medical diagnostic systems, some clinicians question the cultural validity of the western classification approaches that ignore survivors’ own traditions, meaning systems, and active priorities (Mollica & Caspi-Yavin, 1992, Summerfield, 1995, Kira, 2002).

§239: “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 (....) Ideally, adopting an attitude of informed learning rather than the rush to diagnose and classify will communicate to the individual that his or 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.”

Furthermore, some refugees face the risk of inappropriate psychiatric diagnoses because of ignorance of cross-cultural factors and lack of interpreters (Summerfield, 2000). For instance, many symbols might be used when talking in a specific cultural context about one’s life events, while symbolic language might be taken for real in other cultural contexts. When there is a lack of cultural

sensitivity, the understanding of the boundary between reality and the unreal might be diminished, and this could lead to misinterpretations of the situation.

2.2 WHY IS THE CONTEXT IN WHICH PSYCHOLOGICAL EVALUATION TAKES PLACE SO IMPORTANT?

§237: “Evaluations occur in a variety of political contexts. This results in important differences in the manner in which evaluations should be conducted”

§238: “Whether or not certain questions can be asked safely will vary considerably and depend on the degree to which confidentiality and security can be assured. For example, an examination by a visiting physician in a prison that may be limited to fifteen minutes cannot follow the same course as a forensic examination in a private office that may last for several hours.”

Additional concerns arise when trying to assess whether psychological symptoms or behaviours are pathological or adaptive. When a person is examined while in detention or living under considerable risk or extensive oppression, the symptoms should be evaluated in that context.

The evaluation of several symptoms may not be possible due to certain life conditions. For example, during detention avoidance symptoms can be harder to assess because they might represent coping strategies aiming to protect oneself. Likewise, hyper-vigilance and avoidance behaviours may be necessary, adaptive and crucial for those living in repressive societies (Simpson, 1995).

Markedly diminished interest in significant activities may be more difficult to demonstrate in detention where “significant” activities are prohibited. It is also difficult to assess the “feeling of detachment and estrangement from others” if there is solitary confinement or forced isolation (partial or complete).

Such situations cause difficulties in the evaluation, and can cause errors in assessments of the diagnostic criteria, and lead to underestimations of the extent of significant post-traumatic pathology. It is important to have a flexible and integrative approach so as not to cause false negative results (Simpson, 1995).

At the same time, the expert should vouch for the best possible conditions when conducting the evaluation. For instance, privacy during the interviews is not only necessary for ethical reasons, but also when talking about sensitive issues which are embarrassing for the person being evaluated. More generally, the specificities of the location where the evaluation is conducted influence whether or not the individual will develop feelings of trust and safety. If the evaluation is taking place under time constraints, the gathered information and the outcome of the interview might be limited.

(For additional information, please see Chapter IV, in the Istanbul Protocol.)

2.3 CONSIDERATIONS RELATED TO THE TERMINOLOGY:

Indeed, since evaluations of torture allegations are not necessarily considered only by specialized health professionals, the language used in the report should be accessible for a larger public.

The terms ‘physical torture’ or ‘psychological torture’ are frequently used. However:

§144: “The distinction between physical and psychological methods is artificial. For example, sexual torture generally causes both physical and psychological symptoms, even when there has been no physical assault.”

In order to gain an understanding of the psychological consequences of torture, as mentioned previously, it is important to consider the methods and the aim of torture. One of the main objectives

of torture is to force the psychological integrity of the victim to adapt to an abnormal situation, and therefore all kinds of torture inevitably comprise psychological processes (Kordon, at al. 1988). In this sense, methods aiming to give physical pain should be considered as a means of breaking psychological resistance. For this reason, torture cannot be separated into two distinct categories.

2.4 WHICH PSYCHOLOGICAL PROCESSES ARE ACTIVATED BY TORTURE?

In this part of the training manual, the activation of psychological processes provoked by torture are mentioned in an overview. Without being exhaustive on this issue, the overview illustrates the dynamic and non-static aspects conveyed by torture, independently of the constitution of the individual.

§233: “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.”

§235: “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.”

In an abnormal situation with restricted survival likelihood, as is the case with torture, every human being calls up his capacity of adaptation in order to remain alive and to safeguard his identity as far as possible (Vesti, Somnier, Kastrop, 1996a and b). The psychological adaptation dictated by the effects of torture implies the change from one stable personality structure to another.

It is important to note that the symptoms presented can change over time. There are often dissociative reactions that suppress symptoms until immediate survival or resettlement needs are met and the person is in a safe enough environment to cope with reliving the horror and other emotions of the trauma memories (Gurr & Quiroga, 2001).

Nevertheless, the presence of symptoms according to well-known classifications indicates that there could be psychological evidence of torture. However, as the main concern here is to investigate and document psychological evidence, we should have in mind that many factors are involved in the presentation of symptoms.

2.5 WHICH FACTORS ARE RELATED TO THE APPEARANCE OF SYMPTOMS DUE TO TORTURE?

§233: “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 the same as those due to 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.”

Indeed, as raised in the Istanbul Protocol, the specialized literature regarding psychological effects of torture agrees that many aspects determine the response to systematic persecution, torture, as well as to other severe traumas. It should be stressed that there is a complex relationship between the stressor and the symptomatology. The multi-determined nature of torture symptoms requires a profound and multidimensional assessment (McFarlane, 1995).

Although the factors influencing the psychological responses are not known exactly, several dimensions may be of significance in the evaluation of the victims (Vesti, 1996 a+b; Summerfield, 2000; Van der Kolk et al, 1996; Somnier et al, 1992; Gurr & Quiroga, 2001; Ehrenreich, 2003, Yehuda & McFarlane, 1995).

These factors include, but are not limited to:

- The perception, interpretation and meaning of torture by the victim:
- Individuals react to extreme trauma like torture in accordance with what it means to them. The generation of these meanings is an activity that is socially, culturally and politically framed (Summerfield, 1995; Varvin, 1998). The psychological reactions to trauma are closely linked with the psychological meaning of the trauma to the person (Turner et al., 2003, McFarlane, 1995; Mc Farlane & Yehuda, 1996).
- The social context before, during and after torture; (such as community and peer resources and values and attitudes about traumatic experiences: political and cultural climate, traumatic conditions after torture, exposure to subsequent reactivating stressors):

A certain cultural environment may moderate the impact of traumatic events (Ehrenreich, 2003). Cultural factors have an important role to play in the genesis and presentation of torture symptoms and how it is perceived and responded to. There is a general consensus that supportive social relationships both diminish the effects of stressful events and serve to prevent recurrence (Kira, 2002). Studies on different traumas, different cultures, different genders and different age groups have shown that experience and/or perception of positive social support predicted lower symptoms in the recovery process.

Losses and changes in the individual's life during the post trauma period also have a great impact on the psychological response.

- The severity and duration of the traumatic events, the circumstances and the nature of the torture:

It is difficult to make a hierarchical list of the severity of the atrocities on the individual and it is problematic to estimate objectively the degree of severity. Humiliation, threat to beloved ones or witnessing the torture of another person may have a more profound effect on the victim than to suffer from electric shocks or falanga. There are contradictory reports in the literature about the relationship of the severity of trauma and the consequences.

When evaluating background information, the interviewer should also keep in mind that the duration and severity of responses to trauma are affected by multiple factors which interact with each other.

- The developmental phase and age of the victim:

In general, only limited empirical research has been carried out regarding factors, which are related to torture symptoms. One study, carried out in a more general context of traumatic experiences, confirms earlier investigations that have shown a relationship between the age of onset of the trauma, the nature of the traumatic experience, and the complexity of the clinical outcome (van der Kolk et al, 1996).

Personal variables such as cultural and political background, belief systems of the individual, gender, preparedness regarding the anticipation of torture experience, and losses during and after the torture are all factors which may influence the severity of the symptoms.

In addition, affects, cognition, coping capabilities, adaptation strategies, physical health and disabilities, pre-existing psychological disorders, pre-existing personality or genetic and

biological vulnerabilities should be considered. In any case, unilateral investigations may have the tendency to result in an exacerbation of isolated factors, without being able to create a complete picture of the situation.

More recently, some authors have started to go thoroughly into the concept of resilience in a context of extreme trauma. Indeed, the concept of resilience offers an interactive approach providing a better understanding of the dynamics related to external factors like for instance the traumatic event, the social environment of a person and factors inherent to the individual, namely the personal psychology, including affects and cognitions, coping capabilities and personal ideology (Gurr & Quiroga, 2001).

PART 3: INTERVIEW CONSIDERATIONS AND INTERVIEW PROCESS

The interview has to be structured and conducted according to the guidelines defined in “the general considerations for the interview” and “procedural safeguards” of the Istanbul Protocol. The expert who makes the psychological evaluation should keep in mind that all the procedural safeguards mentioned in the Istanbul Protocol are valuable, not only for physical examination but also for psychological evaluation, and they should be taken into account during the entire interview process.

The establishment of an effective and trustful relationship during the interview is a basic condition for a well-conducted psychological evaluation. If the interview is not structured accordingly, it is much more difficult to obtain the appropriate information. The interview should be conducted with special attention to the aspects defined under “interview considerations”. If an effective and trustful relationship with the examinee cannot be established and a complete and adequate history cannot be taken, it is likely to be impossible to carry out a proper psychological investigation of torture.

(For additional information, please see: Chapter IV, Chapter III section C.2, Chapter V section A and Chapter VI section C.2 in the Istanbul Protocol.)

3.1 HOW TO COLLECT SUFFICIENT AND APPROPRIATE INFORMATION DURING THE INTERVIEW PROCESS WITHOUT PUTTING THE EXAMINEE UNDER LEGAL AND MEDICAL RISK?

Some dilemmas encountered during the interview process:

i) Re-traumatisation risk versus necessity of obtaining sufficient and appropriate information.

The primary goal of documenting allegations of torture is to create an accurate, reliable, precise and detailed record of events by taking into account the personal situation and the psychological condition of the individual (Giffard, 2000).

One of the main issues to consider when proceeding to a psychological evaluation is the need to take special care and to avoid re-traumatisation and to end up with insufficient findings (Wenzel, 2002).

The clinician needs to balance two important requirements which should be complementary, but may sometimes conflict: the need to obtain a useful account, and the importance of respecting the needs of the person being interviewed (Giffard, 2000).

Indeed, it is of utmost importance to obtain sufficient and appropriate information in the evaluation of torture allegations. The preparation of a report on the basis of all the information gathered is crucial for documenting and providing evidence of torture claims; this is of potential benefit for the claimant and might prevent the impunity of the perpetrators. However, a detailed report can be prepared only by means of an appropriate and comprehensive interview. Thus, the clinician should attempt to obtain as much detail as possible (Iacopino, 2002).

At the same time, physical and psychological examinations by their very nature may re-traumatise the patient by provoking and/or exacerbating psychological distress and symptoms by eliciting painful affect and memories (§148). The interview must be structured so as to minimize the risk of re-traumatizing the torture survivor. Several basic rules must be

respected. Information is certainly important, but the person being interviewed is even more important (§134).

Interviewers should show sensitivity in their questioning and watch out for signs of tiredness or distress. They should also be aware of culturally taboo subjects. Not only may the interview become unpleasant for the person being interviewed, it is also possible that the account may become less reliable if the person is tired or upset (Giffard, 2000).

A subjective assessment has to be made by the evaluator about whether and to what extent pressing for details is necessary for the effectiveness of the report in court, especially if the claimant demonstrates obvious signs of distress (§148).

In addition, the possibility that the person may still be under persecution and oppressed has to be kept in mind (§263). In all the medical and psychological examination and evaluation processes, it is fundamental to adhere to the basic principle “Primum non nocere” (Wenzel, 2002).

(See §134, §148 and §263 in the Istanbul Protocol).

ii) Being objective versus being empathic.

Medical and psychological evaluations of patients for medico-legal purposes should be conducted with objectivity and impartiality (§161). “The interview may induce fear and mistrust on the part of the individual and possibly remind him or her of previous interrogations. To reduce the effects of retraumatisation, 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 or she is an ally of the individual and adopt a supportive, non-judgmental approach” (§261). Clinicians need to be sensitive and empathic in their questioning while remaining objective in their clinical assessment (§262).

Objectivity is not in contradiction with being empathic. In this sense, it is essential to maintain the professional boundaries and at the same time to acknowledge pain and distress (Giffard, 2000).

(See §161, §261 and §262 in the Istanbul Protocol).

iii) Confidentiality versus medico-legal obligations

The clinician conducting the assessment and preparing the report may often experience an ethical conflict situation related to his/her role and responsibilities, agency and moral obligations.

There are a number of practical ethical issues that are important to consider, including role and boundaries, informed consent, the limits of confidentiality, and respect for autonomy and privacy (Alnutt & Chaplow, 2000).

All ethical codes, from the Hippocratic oath to modern times, include the duty of confidentiality as a fundamental principle. Dilemmas from dual obligations arise where health professionals are pressured or required by law to disclose information (§64, see also §70). On the one hand, confidentiality is an important component when establishing a trustful relationship, on the other hand, the circumstances leading to a medical or psychological evaluation may require the lifting of the secrecy.

The clarification of confidentiality and its limits at the beginning of the interview are of paramount importance for a well-conducted interview (§148). “Clinicians and interpreters have a duty to maintain confidentiality of information and to disclose information only with the patient’s informed consent” (§164). He or she should be clearly informed of any limits to the confidentiality of the evaluation and of any legal obligations for disclosure of the information. “Clinicians must ensure that informed consent is based on adequate understanding of the potential benefits and adverse consequences of the evaluation and that consent is given voluntarily without coercion by others” (§164). In other words, the clarification of the limits of confidentiality could be seen as part of the process of obtaining consent (Alnutt & Chaplow, 2000).

§263: “It is important to consider the reasons for the psychological evaluation, as they will determine the level of confidentiality to which the expert is bound. If an evaluation of the credibility of an individual’s report of torture is requested within the framework of a judicial procedure by a State authority, the person to be evaluated must be told that this implies lifting of medical confidentiality for all the information presented in the report. However, if the request for the psychological evaluation comes from the tortured person, the expert must respect the medical confidentiality”

(See §64, §148, §164 and §263 in the Istanbul Protocol)

For additional information, please see §62-72 in the Istanbul Protocol

3.2 WHAT SHOULD BE THE COURSE OF THE INTERVIEW? (RECOMMENDATIONS TO CONSIDER FOR A BETTER INTERVIEW COURSE)

At the beginning of the interview, the clinician should introduce himself, his roles and boundaries, the purpose of the interview, the limits of the confidentiality, the context, frame and process of the interview (§261).

The explanation should be given in a manner that explains in detail the procedures to be followed (questions asked about psycho-social history including history of torture and current psychological functioning) and that prepares the individual for the difficult emotional reactions that the questions may provoke (§262).

The examinee should be informed that he/she can request breaks or interrupt the interview at any time. Also, he/she must be allowed to leave if the stress level becomes intolerable, and be given the option of having a subsequent appointment (§262).

The interview must be started with open-ended general questions in order to encourage elaboration by the examinee. On the basis of the information elicited, more specific details should be sought, where appropriate. The interviewer’s attitude, while attentive, friendly and encouraging, should retain an appropriate objectivity in relation to the examinee and his/her situation.

If and when circumstances allow, the interview should be designed according to the needs of the examinee. Short episodes with breaks, beginning with less sensitive issues, then probing deeper, closing the interview with a relaxing topic to ensure that the emotional arousal has subsided.

If the interviewer tries to gather information by only asking questions, he/she will only receive answers to his/her questions. The examinee should be given the opportunity and time to express him or herself (§134). Stimuli reminiscent of the traumatic interrogation should be avoided.

The clinician should establish and maintain privacy during the interview. Police or other law enforcement officials should never be present in the examination room (§123).

The evaluator may not have much control over the setting in which the interview takes place, but even small gestures from the evaluator's side can help an interviewee to feel more comfortable. The clinician should make sure to explore all opportunities to establish a setting which is as comfortable and private as possible (Giffard, 2000), and sufficient time should be allotted to conduct a detailed interview and examination (§162).

The history should be taken sensitively, allowing the survivor to control the pace of revelation and giving priority to the needs identified by the survivor. A trusting relationship must be developed if progress is to be made, so this is the highest priority, beyond diagnosis or the torture history. Cultural understanding is essential in choosing the methodology of the assessment (Gurr & Quiroga, 2001).

(See §123, §134, §261, §262 in the Istanbul Protocol).

For additional information, please see Chapter IV, in the Istanbul Protocol.)

3.3 WHAT ARE THE POTENTIAL TRANSFERENCE AND COUNTER-TRANSFERENCE REACTIONS WHICH MAY BE ENCOUNTERED?

The torture survivor's personal reactions to the interviewer (and the interpreter, if included in the setting) can have an effect on the interview process and, in turn, the outcome of the investigation. Likewise, the personal reactions of the investigator toward the person can also affect the process of the interview and the outcome of the investigation. It is important to examine the barriers to effective communication and understanding which these personal reactions might impose on the investigation (§147).

§ 264: "Clinicians who conduct physical and psychological evaluations should be aware of the potential emotional reactions that evaluations of severe trauma may elicit in the interviewee and interviewer. These emotional reactions are known as transference and counter-transference. Transference relates to feelings an examinee has towards the clinician that relate to the past experiences but are misunderstood as directed towards the clinician personally. In addition, the clinician's emotional responses to the torture survivor, known as counter-transference, may affect the psychological evaluation. Transference and counter-transference are mutually interdependent and interactive".

Transference

§265: "The potential impact of transference reactions on the evaluation process becomes evident when it is considered that 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. Thus, even though a torture survivor may consent to an evaluation with the hope of benefiting from it, the resulting exposure will be experienced in light of the trauma experience itself. This may include 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,
- The evaluator is perceived as a person in a position of authority, which is often the case (in a positive or negative sense)
- 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.
- If the gender of the evaluator and the torturer is the same, the interview situation may be perceived as resembling more strongly the torture situation than if the genders are different.

- Because the evaluator hasn't been arrested and tortured or as he/she is a member of different culture and ethnicity, the examinee may believe that the evaluator cannot understand him or believe him, or may perceive the evaluator as being on the side of the enemy.

For all these and other similar perceptions, the subject may experience distress, fear, mistrust, forced submission, anger, rage, shame, worry or suspicion, or he/she may be too trusting and expectant (§266, §267, §268, §269).

Counter-transference

The interviewer should be aware of potential personal reactions to the survivor and the descriptions of torture that might influence the interviewer's perceptions and judgments (§262).

§271: "Counter-transference reactions are often unconscious and when one is not aware of one's counter-transference, it becomes a problem. Having 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 counter-transference reactions are crucial because counter-transference can have significantly limiting effects on the ability to evaluate and document the physical and psychological consequences of torture." (§271)

Common counter-transference reactions include:

- Avoidance, withdrawal, defensive indifference,
- Disillusionment, helplessness, hopelessness and over-identification,
- Omnipotence and grandiosity in the form of feeling like a saviour, the great expert on trauma or the last hope of the survivor,
- Feelings of insecurity, feelings of guilt, excessive rage toward torturers and persecutors or toward the individual (§271)
(Steele et al, 2001, Smith et al, 1996; Herman, 1992; Bustos, 1990).

All these factors mean that the evaluator is at risk of underestimating the severity of the consequences of torture and forgetting some details, leading to ungrounded doubts about the truth of the alleged torture and failure to establish the necessary empathic approach. It can also lead to vicarious traumatization, burn-out of the interviewer, difficulty in maintaining objectivity, and over-identification with the torture survivor.

(See §147-148 and §263-272 in the Istanbul Protocol)

PART 4: PSYCHOLOGICAL CONSEQUENCES OF TORTURE

This part of the psychological training manual suggests to elaborate on the symptoms-related chapters in the psychological evidence section of the Istanbul Protocol. Several clusters of symptoms are enriched by complementary remarks and quotations from specialized literature.

Torture is an extraordinary life experience capable of causing a wide range of physical and psychological suffering (§233). Many victims of torture experience profound emotional reactions and psychological symptoms (§235).

4.1 WHAT SYMPTOMS ARE COMMONLY SEEN AS CONSEQUENCES OF TORTURE?

“Before entering into a technical description of symptoms and psychiatric classifications, it should be noted that such classifications are generally considered to be western medical concepts, and that the application, either implicitly or explicitly, to non-western populations presents certain difficulties.” It can be argued that western cultures suffer from an undue medicalisation 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” (§239).

What is considered disordered behaviour or a disease in one culture may not be viewed as pathological in another (§235) (Kleinman, 1986; Engelhardt, 1975; Westermeyer, 1985).

While some symptoms may be present across differing cultures, they may not be the symptoms that concern the individual the most (§236).

Symptoms need to be understood in the context in which they occur and through the meaning they represent to the individual experiencing them: distress and suffering are not in themselves pathological conditions. There is also the concern that for survivors of torture, the symptoms are a “normal” response to societal pathology (Becker, 1995; Gurr & Quiroga, 2001; Summerfield, 2000; Summerfield, 2001; Burnett & Peel, 2001a).

The most common symptoms seen in people having experienced torture include, but are not limited to, the following:

Common psychological responses

a) Re-experiencing the trauma (§240)

“A victim may have flashbacks or intrusive memories, in which the traumatic event is happening all over again, even while the person is awake and conscious; or a victim may have recurrent nightmares, which include elements of the traumatic event (or events) in the original or in a symbolic form. Distress at exposure to cues that symbolize or resemble the trauma is frequently manifested by a lack of trust and by fear of persons with authority, including physicians and psychologists, especially in countries or situations where authorities and/or physicians participate in human rights violations.”

b) Avoidance and emotional numbing

- i) “Avoidance of any thought, conversation, activity, place or person that arouse a recollection of the trauma;”

Certain levels of avoidance reaction can be recognized; sometimes avoidance may lead to a complete denial of the trauma (Yehuda & Mc Farlane, 1995). In some situations, it may be difficult to notice an avoidance reaction in chronic cases, as a result of strategies that have been developed in daily life over many years. The victim hardly mentions the avoidance symptoms because these symptoms are experienced as a part of his/her personality and way of living (Haenel, 2001).

- ii) “Profound emotional constriction;
- iii) Profound personal detachment and social withdrawal;
- iv) Inability to recall an important aspect of the trauma.”

c) Hyper-arousal

- i) “Difficulty in either falling or staying asleep
- ii) Irritability or outbursts of anger
- iii) Concentration difficulties
- iv) Hyper-vigilance, exaggerated startled response
- v) Generalized anxiety
- vi) Shortness of breath, sweating, dry mouth or dizziness and gastrointestinal distress.”

d) Symptoms of depression (§241)

The following symptoms of depression may be present:

- I) Depressed mood
- li) Anhedonia: markedly diminished interest or pleasure in activities
- iii) Appetite disturbance and resulting weight loss
- iv) Insomnia or hypersomnia
- v) Psychomotor agitation or retardation
- vi) Fatigue and loss of energy
- vii) Feelings of worthlessness and excessive guilt
- viii) Difficulty in paying attention, concentrating or recalling from memory
- ix) Thoughts of death and dying, suicidal ideation or suicide attempts

e) Damaged self-concept and foreshortened future (§242)

The victim has a subjective feeling of having been irreparably damaged and of having undergone an irreversible personality change (Holtan, 1998). He or she has a sense of foreshortened future: not expecting to have a career, marriage, children or a normal life span.

f) Dissociation, depersonalisation and atypical behaviour (§243)

Dissociation is a disturbance or alteration in the normally integrative function of consciousness, self-perception, memory and actions (van der Kolk et al, 1996). A person may be cut off or unaware of certain actions or may feel split in two and feel as if observing him or herself from a distance.

It is a common response during extremely traumatic events that could lead to the underreporting and the misperception of various aspects of the trauma (McFarlane, 1995). Elements of the experience are not integrated into a unitary whole, but are stored in memory as isolated fragments and stored as sensory perceptions, affective states or as behavioural re-enactments (van der Kolk & Fisler, 1995).

Depersonalisation is a state of feeling detached from oneself or one's body. The person complains of a feeling of being distant or "not really here", as if he/she is an outside observer of his/her mental processes or body (e.g. feeling like one is in a dream). For example, the person may complain that his/her emotions, feelings or experience of the inner self are detached, strange and not their own, or that he/she feels unpleasantly lost as if acting in a play.

Impulse control problems result in behaviours that the survivor considers highly atypical compared to his or her pre-trauma personality: a previously cautious individual may engage in high-risk behaviour.

Impulse control problems include difficulty in modulating anger, chronic self-destructive and suicidal behaviours, difficulty in modulating sexual involvement, and impulsive and risk-taking behaviours (van der Kolk et al, 1996).

g) Somatic complaints (§244)

Somatic symptoms such as pain, headache or other physical complaints, with or without objective findings, are common problems among tortured and traumatized people. Pain may be the only manifest complaint. It may shift in location and vary in intensity. Somatic symptoms can be directly due to physical consequences of torture or they can be psychological in origin, or both: it is often difficult to tell the origin of pain.

Chronic pain is a further aspect of torture sequels about which detailed information and understanding are still lacking, probably because of the wide range of torture techniques applied. Physical and psychological levels of pain are frequently linked and are difficult to distinguish in practice (Wenzel, 2002).

Typical somatic complaints include:

- i) 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.
- ii) Back pain (for more information, please see medical-physical training manual pp. XXXX)

- iii) Musculo-skeletal pain (for more information, please see medical-physical training manual pp. 14)

h) Sexual dysfunction (§245)

§245: 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 mixture of both, and include:

- i) Aversion to and avoidance of all genital sexual contact with a sexual partner
- ii) Lack or loss of sexual desire
- iii) Lack of sexual enjoyment
- iv) Decreased interest in sexual activity
- v) Disturbance in sexual arousal
- vi) Fear of sexual activity
- vii) Fear that any sexual partner will “know” that the victim has been sexually abused
- viii) Fear of having been damaged sexually – torturers may have threatened this
- ix) Fear of homosexuality in men who have been anally abused (some heterosexual men might have had an erection and, on occasion, ejaculated during non-consensual anal intercourse. They can be reassured that this is a physiological response).
- x) Inability to trust a sexual partner
- xi) Failure of genital response like erectile dysfunction or failure of vaginal lubrication
- xii) Disturbance in sexual arousal and erectile dysfunction
- xiii) Vaginismus
- ixv) Dyspareunia (genital pain associated with sexual intercourse in either a male or a female)
- xv) Orgasmic dysfunction (delay or absence of orgasm)
- xvi) Premature ejaculation

(For additional information, please see chapter V section D.8, in the Istanbul Protocol)

i) Psychosis (§246)

Cultural and linguistic differences may be confused with psychotic symptoms. Before labelling someone as psychotic, one must evaluate the symptoms within the individual’s own cultural context. Psychotic reactions may be brief or prolonged and the psychotic symptoms may

occur while the person is detained and tortured as well as afterwards. The following is a list of possible findings:

- i) Delusions
- ii) Hallucinations: auditory, visual, tactile, olfactory
- iii) Bizarre ideation and behaviour
- iv) 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 torture victims occasionally to report hearing screams, his or her name being called, or seeing shadows, but not have florid signs or symptoms of psychosis.
- v) Paranoia and delusions of persecution: care must be taken when defining paranoid delusions since in some countries persecution during and/or after detention is frequent.
- vi) Recurrence of psychotic disorders or mood disorders with psychotic features 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 schizo-affective disorder may re-experience an episode of that disorder.

j) Substance abuse (§247)

Alcohol and drug abuse often develop secondarily in torture survivors as a way of obliterating traumatic memories, regulating affect and managing anxiety. The chronic state of inner tension and anxiety may be associated with a tendency to excessive drinking or use of drugs.

k) Neuro-psychological impairment (§248)

“Torture can involve physical trauma that lead to various levels of brain impairment. Blows to the head, suffocation and prolonged malnutrition may have long-term neurological and neuro-psychological consequences that may not be readily assessed during the course of a medical examination. As in all cases of brain impairment that cannot be documented through head imaging or other medical procedures, neuro-psychological assessment and testing may be the only reliable way of documenting its effects. Frequently, the symptoms for such assessments have significant overlap with the symptomatology arising from PTSD and major depressive disorders. Fluctuations or deficits in level of consciousness, orientation, attention, concentration, memory and executive functioning may result from functional disturbances as well as organic causes. Therefore, specialised skill in neuro-psychological assessment, as well as awareness of problems in cross-cultural validation of neuro-psychological instruments is necessary when such distinctions are to be made.”

l) Other

- a permanent hostile or distrustful attitude toward the world
- a constant feeling of emptiness or hopelessness
- a permanent feeling of being changed or of being different from others (estrangement / alienation)
- a reduction in awareness of his or her surroundings
- feelings of shame and survivor’s guilt

(See §233, §235, and §236, and chapter VI section B: §239-248 in the Istanbul Protocol)

4.2 WHAT ARE THE MOST COMMON DIAGNOSTIC CATEGORIES OF TORTURE/TRAUMA-RELATED MENTAL DISORDERS?

Diagnostic Classifications (§249)

§249: “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 or her cultural, social and political context, it is wise for evaluators to become familiar with the most commonly diagnosed disorders among trauma and torture survivors.”

There are clusters of symptoms and psychological reactions that have been observed and documented in torture survivors with some regularity.

§249: “It is not uncommon for more than one mental disorder to be present, as there is considerable symptom overlap as well as co-morbidity among trauma-related mental disorders. Various manifestations of anxiety and depression are the most common symptoms resulting from torture.”

The two prominent classification systems are the International Classification of Disease (ICD-10) (WHO, 1994) Classification of Mental and Behavioural Disorders and the American Psychiatric Association’s Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) (APA, 1994). For complete descriptions of diagnostic categories, please refer to ICD-10 and DSM-IV.

The most common trauma-related diagnoses are PTSD and major depression. Furthermore, enduring personality change should also be considered, especially because it takes into account the potential long terms effects of prolonged extreme stress (§255).

a) Depressive disorders

Depressive states are almost always present 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 aetiologies. Depressive disorders include major depressive disorder, single episode or major depressive disorder, and recurrent depression (more than one episode). Depressive disorders can 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):

- i) Depressed mood
- ii) Markedly diminished interest or pleasure in all or almost all activities,
- iii) Weight loss or change of appetite,
- iv) Insomnia or hypersomnia,
- v) Psychomotor agitation or retardation,
- vi) Fatigue or loss of energy,
- vii) Feelings of worthlessness or excessive or inappropriate guilt,

- viii) Diminished ability to think or concentrate, and
- ix) Recurrent thoughts of death or suicide. To make this diagnosis the symptoms must cause significant distress or impaired social or occupational functioning, not be due to a physiological disorder, and not be accounted for by another DSM-IV diagnosis.” (§250)

b) Post-traumatic stress disorder

“The diagnosis most commonly associated with the psychological consequences of torture is post-traumatic stress disorder (PTSD)”. (§251)

In recent years, the diagnosis of post-traumatic stress disorder (PTSD) has been applied to an increasingly broad array of individuals suffering from the impact of widely varying types of violence (§236).

“The association between torture and PTSD 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 (§251). “

“However, the utility of this diagnosis in non-western cultural groups has not been established. Nevertheless, evidence suggests that there are high rates of PTSD and depression symptoms among traumatized refugee populations from multiple different ethnic and cultural backgrounds.” (§236) (Mollica et al, 1993; Allden et al., 1996).

“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” (§252).

“The ICD-10 diagnosis of PTSD is very similar to that of DSM-IV. 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 reach a 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:

- i) Intrusive distressing recollections of the event,
- ii) Recurrent distressing dreams of the event,
- iii) Acting or feeling as if the event were happening again including hallucinations, flashbacks, and illusions,
- iv) Intense psychological distress at exposure to reminders of the event, and
- v) Physiological reactivity when exposed to cues that resemble or symbolize aspects of the event” (§252).

“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:

- i) Efforts to avoid thoughts, feelings or conversations associated with the trauma,
- ii) Efforts to avoid activities, places or people that remind him/her of the trauma,
- iii) Inability to recall an important aspect of the event,
- iv) Diminished interest in significant activities,
- v) Detachment or estrangement from others,
- vi) Restricted affect, and
- vii) 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:

- i) Difficulty falling or staying asleep,
- ii) Irritability or angry outbursts,
- iii) Difficulty concentrating,
- iv) Hyper-vigilance, and
- v) Exaggerated startle response” (§253).

“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 report increased intrusive memories, nightmares and flashbacks. At other times, the survivor may appear relatively asymptomatic or emotionally constricted and withdrawn” (§254). The absence of the symptom at the time of the interview is posing a diagnostic dilemma for any cross-sectional or one-time effort at assessment (Jaranson et al., 2001).

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.

One must keep in mind that not meeting diagnostic criteria of PTSD does not mean that torture was not inflicted.

(See §249-254 and §255; and §235, §233, §236 in the Istanbul Protocol)

4.3 WHAT OTHER DIAGNOSTIC CATEGORIES ARE COMMON?

Torture-related mental disorders are not limited to depression and PTSD and evaluators must have comprehensive knowledge of the most frequent diagnostic classifications among trauma and torture survivors. In this sense, a detailed evaluation is always very important. Overemphasizing the PTSD and depression criteria might result in missing the other possible diagnoses.

A simplistic view of PTSD as a singular response to trauma should be avoided, as this perception may result in an underestimation of the complexity and disabling quality of the disorder (McFarlane & Yehuda, 2000).

PTSD has been described as the characteristic sequel to extreme events in life such as war and especially torture. This limitation to a single approach in regard to diagnosis and treatment has been criticised as being too narrow to describe the effects following extreme events in life. Research on sequels to extreme trauma should not be restricted to a simple diagnosis of PTSD, but should continue to look for a broader conceptualisation, including neglected categories like the axial syndrome, as PTSD is common, but might not be the only factor of importance for research and treatment (Wenzel et al., 2000).

The other possible diagnoses include, but are not limited to:

a) Enduring personality change (§255-256)

Reactions to extreme stress such as torture are so heterogeneous and broad that a number of clinical and research studies have investigated the suitability of the diagnostic categories like “cumulative trauma disorders” and “complex PTSD” to include the broad range of sequelae of extreme trauma. There is a long discussion during the preparation of DSM IV on the “complex post-traumatic stress disorder.” In conclusion, in the DSM IV, the symptoms of complex post-traumatic stress disorder are described under the “associated features” of the post-traumatic stress disorder diagnosis. In ICD-10, a virtually identical diagnosis is included in the category of enduring personality changes following catastrophic stress. (Lira 1995; Herman, 1992; van der Kolk & Fislser, 1995; Fornari & Pelcovitz 1999).

After catastrophic or prolonged extreme stress, disorders of adult personality may develop in persons with no previous personality disorder. 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, following exposure to catastrophic stress (e.g., concentration camp experience; torture; disaster; prolonged exposure to life-threatening situations). The personality change should be associated with inflexible and maladaptive behaviours 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 behavioural 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 of the personality.” This personality change is characterized by a hostile or distrustful attitude towards the world, social withdrawal, constant feelings of emptiness or hopelessness (this may be associated with increased dependency on others, inability to express negative or aggressive feelings and prolonged depressive mood), an enduring feeling of “being on edge” as if constantly being threatened (this chronic state of inner tension and feeling of being threatened may be associated with a tendency to excessive drinking or use of drugs); a permanent feeling of being changed or of being different from others (estrangement), this feeling that may be associated with an experience of emotional numbness.

b) Substance abuse (§257)

Clinicians have observed that alcohol and drug abuse often develop secondarily in torture survivors as a way of suppressing traumatic memories, regulating unpleasant effects, and managing anxiety. Although co-morbidity of PTSD with other disorders is common, systematic research has seldom studied substance abuse by torture survivors. There is considerable evidence from other populations at risk of PTSD that substance abuse is a potential co-morbid diagnosis for torture survivors (Friedman&Jaranson, 1994).

c) Generalized anxiety disorder (§258)

Features excessive anxiety and worry about a variety of different events or activities, motor tension and increased autonomic activity.

d) Panic disorder (§258)

Is manifested by recurrent and unexpected attacks of intense fear or discomfort including four symptoms such as sweating, choking, trembling, rapid heart rate, dizziness, nausea, chills or hot flushes.

e) Acute stress disorder (§258)

Essentially has similar symptoms to PTSD, but is diagnosed within one month of exposure to the traumatic event. In order to make a diagnosis of Acute Stress Disorder, either while or after experiencing the distressing event, the following should be present:

Besides the similar symptoms of PTSD (re-experience, avoidance and increased arousal), three (or more) of the dissociative symptoms: a subjective sense of numbing, detachment or absence of emotional responsiveness; a reduction in awareness of his or her surroundings (e.g., "being in a daze"); de-realization; de-personalization; dissociative amnesia (e.g., inability to recall an important aspect of trauma).

The disturbance causes clinically significant distress or impairment in functioning and the disturbance lasts for a minimum of two days and a maximum of four weeks and occurs within four weeks of the traumatic event.

f) Somatoform disorders (§258)

Featuring physical symptoms that cannot be accounted for by a medical condition.

g) Bipolar disorders (§258)

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.

h) Disorders due to a general medical condition (§258)

Often in the form of brain impairment with resultant fluctuations or deficits in levels of consciousness, orientation, attention, concentration, memory and executive functioning.

i) Phobias

- such as social phobia and agoraphobia. (§258)

j) Others

- Dissociative disorders (ICD-10, DSM IV)
- Conversion disorders (DSM IV)
- Acute and Transient Psychotic Disorders, with associated acute stress (ICD-10); Brief Psychotic Disorder with marked stressor (s) (DSM IV)
- Depersonalization-Derealization disorder

(See §255-258 in the Istanbul Protocol).

4.4 WHAT ARE THE COMPONENTS OF PSYCHOLOGICAL/PSYCHIATRIC EVALUATION?

The whole psychological/psychiatric evaluation should be carried out and interpreted according to the information given under the headings of General Considerations, Cautionary Remarks, Ethical and Clinical Considerations and Interview Process..

(Pls. refer to §260-261, §274, §290 in the Istanbul Protocol).

The psychological evaluation starts at the beginning of the interview, at the very first contact. Dressing, posture, the manner of recalling and recounting the trauma, signs of anxiety or emotional distress, numbness or over-excitement, the moments of emotional intensity, startled responses, his/her posture and bodily expressions while relating the events of torture, avoidance of eye contact, and emotional fluctuations in his/her voice can give important clues about the personal history and psychological functioning of the person. Not only the verbal content of the examinee (what he/she says), but also his/her manner of speaking (how he/she says it) is important for the psychological evaluation. The person might have difficulties in recollecting and recounting what he experienced or in talking about his/her complaints, but non-verbal communication supplies important information on his/her symptoms, as well as some clues for establishing and maintaining an effective relationship for eliciting relevant data (Jacobs, 2000).

The psychological/psychiatric evaluation should provide a detailed description of the individual's history, a mental status examination, an assessment of social functioning, and the formulation of clinical impressions. It should always be made with an awareness of the cultural context. A psychiatric diagnosis should be made if appropriate.

The components of psychological/psychiatric evaluation are as follows:

a) History of torture and ill-treatment (§275)

“The interviewer needs to know the legal issue at hand because that will determine the nature and amount of information necessary to achieve documentation of the facts.”

Every effort should be made to document the full history of torture, persecution and 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 (if it is possible). The interview should start with a general summary of events before eliciting the details of the torture experiences.

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.

(For more information, see chapter IV sections E, F, G).

b) Current psychological complaints (§276)

An assessment of current psychological functioning constitutes the core of the evaluation. 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 behavioural symptoms should be described in detail, and the frequency as well as examples, of nightmares, hallucinations, startled response should be stated.”

Adaptative strategies and triggers such as anniversary reactions, specific stimuli or places, situations and topics causing avoidance should be taken into consideration. Physical and psychological complaints that appeared since the torture are recorded, as well as their first emergence, their duration and intensity.

“An absence of symptoms can be due to the episodic or often delayed nature of post-traumatic stress disorder or to denial of symptoms because of shame.”

c) Post-torture history (§277)

“This component of the psychological evaluation seeks 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 or her family, and availability of social supports.”

d) Pre-torture history (§278, §279)

“If relevant, describe the victim’s childhood, adolescence, early adulthood, his or her family background, family illnesses and family composition. There should also be a description of the victim’s educational and occupational history. Describe any history of past trauma, such as childhood abuse, war trauma or domestic violence, as well as the victim’s cultural and religious background.”

“The description of pre-trauma history is important to assess mental health status and level of psycho-social 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 torture.

In evaluating background information the interviewer should keep in mind that the duration and severity of responses to trauma are affected by multiple factors. In many interview situations, due to time limitations and other problems, it may be difficult to obtain all this information. It is important, nonetheless, to obtain enough data about the individual’s previous mental health and psycho-social functioning to obtain an impression of the degree to which torture has contributed to psychological problems.”

e) Medical history (§280)

“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.” (See chapter V section B, for Medical history; for Physical evidence of torture see chapter V sections C and D).

f) Psychiatric history (§281)

“Inquiry should be made about a history of mental or psychological disturbances, the nature of problems and whether they received treatment or required psychiatric hospitalisation. The inquiry should also cover prior therapeutic use of psychotropic medication.”

g) Substance use and abuse history (§282)

“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 are not only alcohol, cannabis, and opium, but also regional substances of abuse such as betel nut and many others.”

h) Mental status examination (§283)

“The interviewer should make note of the person’s appearance, such as signs of malnutrition, 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 the means the individual uses to establish communication.”

The following components should be covered, and all aspects of the mental status examination should be included in the report of the psychological evaluation; aspects such as:

- appearance (personal identification, behaviour and psychomotor activity, general description like posture, bearing, etc);
- speech; mood and affect; thinking and perception (form of thinking, content of thinking, thought disturbances, perceptual disturbances like hallucinations and illusions, depersonalization and derealization; dreams and fantasies);
- sensorium (alertness, orientation; concentration and calculation; memory impairment – long term memory, intermediate recall and immediate recall –; knowledge; abstract thinking; insight; judgement)(Sadock, B.J., 1999).

Patients’ responses to specific mental status items are affected by their culture of origin, educational level, literacy, language proficiency, and level of acculturation (Trujillo, 1999). The mental status examination of torture survivors requires flexibility on the part of the examiner, who must have a good understanding of the client’s cultural, linguistic, and educational background before attempting any formal assessment. The level of education is an important factor in determining the appropriate questions and tasks (Jacobs et al., 2001).

i) Assessment of social functioning (§284)

“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 himself or herself, earn a living, support a family, pursue an education. The clinician should assess the individual’s current level of functioning by inquiring about daily activities, social role (as housewife, student, worker), social and recreational activities, and perception of health status. The interviewer should ask the individual to assess his or her own health condition, to state the presence or absence of feelings of chronic fatigue, and to report potential changes in overall functioning.”

j) Psychological testing and the use of checklists and questionnaires (§285)

“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 limit severely the utility of psychological testing in the evaluation of torture victims. Neuro-psychological testing may, however, be helpful in assessing cases of brain injury resulting from torture. (See also chapter VI section C.4).

An individual who has survived torture may have trouble expressing in words his or her experiences and symptoms. In some cases, it may be helpful to use trauma event and symptom checklists or questionnaires. If the interviewer believes it may be helpful to utilize trauma event and symptom checklists, there are numerous questionnaires available, although none are specific to torture victims.”

k) Clinical impression

An essential aspect of the psychiatric evaluation is the formulation of a concise statement of the interviewer's understanding of the case. Interpretation of the findings and formulation of a clinical impression is the last stage where the whole interview is discussed and evaluated; therefore care must be taken while formulating a clinical decision. This is discussed in detail under a separate heading.

(Please refer to §286-287 and §156-159 in the Istanbul Protocol).

l) Recommendations (§290)

The recommendations following the psychological evaluation depend on the question posed at the time the evaluation was requested. "The issues under consideration may concern legal and judicial matters, asylum, resettlement, and a need for treatment. Recommendations can be for further assessments, such as neuro-psychological testing, medical or psychiatric treatment or a need for security or asylum."

PART 5: EVALUATION AND INTERPRETATION OF THE FINDINGS - CLINICAL IMPRESSION

5.1 HOW TO INTERPRET THE PSYCHOLOGICAL FINDINGS AND FORMULATE A CLINICAL IMPRESSION?

For the documentation of psychological evidence of torture, in establishing a clinical picture, there are important questions to be asked: (§286)

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

The findings should be considered altogether and the relationship of individual components with each other should be taken into consideration. The relationship and consistency between events and symptoms should be evaluated and described.

Most of the medico-legal investigations require understanding of the psychological phenomena, not only diagnosis. It is often more appropriate to address the medico-legal issues in terms of the phenomena and relevant symptoms and to avoid comments on diagnosis until the issue has been addressed (Allnutt & Chaplow, 2000).

If the interviewer relies solely on a collection of psychiatric symptoms as reported by the tortured person, this might prevent a sufficient appreciation of the qualitative, narrative and observational aspects in assessing the trauma of torture. Obvious but sometimes overlooked sources of clinical data include the way in which the person dresses as well as his/her posture, gait, facial expressions, complexion, weight and movement. How he/she narrates his/her story, the precise manner in which events are described, what emotions are manifest and what non-verbal clues he communicates during the interview, the internal consistency of the account and the particulars in the description of the experiences (nightmares, etc.) are crucial for assessing an alleged history of torture (Jacobs, 2000).

Behavioural, cognitive and emotional aspects of the individual observed during verbal and non-verbal communication should be noted with all the details. "Clinicians should comment on the consistency of

psychological findings and the extent to which these findings correlate with the alleged abuse. (...) Factors such as the onset of specific symptoms associated with the trauma, the specificity of any particular psychological findings and patterns of psychological functioning should also be noted.

Additional factors such as forced migration, resettlement, difficulties of acculturation, language problems, unemployment, loss of home, family and social status should be taken into account. (...) Physical conditions, such as head trauma or brain injury, may require further evaluation. Neurological or neuro-psychological assessment may be recommended.”

If the survivor has symptom levels consistent with one or more DSM IV or ICD 10 psychiatric diagnoses, the diagnosis should be stated. If not, the degree of consistency between the psychological findings and the history of the individual should be evaluated as a whole and stated in the report (§288).

Please see chapter VI section C.3 (k), and chapter IV section L, in the Istanbul Protocol).

5.2 DOES THE ABSENCE OF A DIAGNOSABLE PSYCHOPATHOLOGY MEAN THAT THE PERSON WAS NOT TORTURED? HOW SHOULD THE FINDINGS BE INTERPRETED IN THIS CASE?

“It is important to recognize that not everyone who has been tortured develops a diagnosable mental illness” (§235). The interpretation of the findings should not depend solely on the collection of signs and symptoms and if there is a diagnosis, the interpretation should not be limited to stating this.

It must be stressed that even though a diagnosis of trauma-related mental disorder supports the claim of torture, not meeting criteria for a psychiatric diagnosis does not mean the person was not tortured (§288). The absence of conclusive physical and/or psychological signs and symptoms does not exclude the possibility that the person was tortured and therefore does not invalidate an allegation of torture (Peel et al., 2000). “A survivor of torture may not have the level of symptoms required to fully meet the diagnostic criteria for a DSM IV or ICD 10 diagnosis and in such cases, as with all the others, the symptoms that the survivor has, and the torture that he/she claims to have experienced, should be considered as a whole. The degree of consistency between the account of torture and the symptoms that the individual reports should be evaluated and described in the report” (§288). (Please see Chapter VI in the Istanbul Protocol, especially §235, §254, §276 and §288).

5.3 WHAT KIND OF FACTORS COULD LEAD TO DIFFICULTIES WHEN OBTAINING AND EVALUATING A HISTORY?

Torture survivors may have difficulties in recalling and recounting the specific details of the torture experience and other parts of the history for several important reasons. There might also be other factors which make it difficult to obtain sufficient information during an interview.

Memory disorders and impaired attention are part of PTSD, but these symptoms may also be present in affective disorders, anxiety, brain injury or electrolyte imbalance. Memory disorders might also be a symptom of dissociation, which is known to be used often as a protective coping strategy in these circumstances. Indeed, dissociation has been frequently observed in torture survivors and should be expected to interfere during the evaluation.

Torture strategies are often intentionally constructed in such a way as to confuse, to give wrong information, or to create a disorientation in time and space, and this must be seen as a special problem when trying to get an unequivocal or complete report on events. All the efforts of discrediting the survivor and of hiding inflicted atrocities can contribute to difficulties in a later assessment. Impaired memory recall can therefore be a major obstacle to history taking and to possible legal procedures, but it is also an indicator of sequels which should be considered in the evaluation. (Wenzel, 2002, Burnett & Peel 2001,b).

Factors interfering potentially when reporting one's story or when taking the history: (Mollica & Caspi-Yavin, 1992, Sironi, 1989, Wenzel, 2002, Iacopino 2002).

Factors directly related to the torture experience:

- Factors during torture itself such as blindfolding, drugging, lapses of consciousness, etc.
- Disorientation in time and place during torture due to the nature of torture or extreme stress experienced during torture
- Neuro-psychiatric memory impairment from head injuries, suffocation, near drowning, starvation, hunger strikes or vitamin deficiencies
- Experiencing repeated and similar events may also have led to difficulties recalling the details of specific events clearly.

Factors related to the psychological impact of torture

- PTSD-related memory disturbances recalling the traumatic event such as intrusive memories, nightmares and the inability to remember important details of the event.
- Denial and avoidance, used in these particular circumstances as protective coping mechanisms.
- High emotional arousal and impaired memory secondary to trauma-related mental illnesses, such as depression and post-traumatic stress disorder.
- Other psychological symptoms such as concentration difficulties, fragmentation or repression of traumatic memories, confusion, dissociation, amnesia (van der Kolk & Fisler, 1995).
- Feelings of guilt or shame.

Cultural factors:

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

Factors related with interview conditions or communicational barriers

- Fear of placing oneself or others at risk
- Lack of trust in the examining clinician and/or interpreter
- Lack of feeling safe during the interview
- Environmental barriers such as lack of privacy, comfort of interview setting, inadequate time for the interview (Iacopino, 2002)
- Physical barriers such as pain or other discomforts, fatigue, sensory deficits (Iacopino, 2002)

- Socio-cultural barriers such as the gender of the interviewer, language and cultural differences (Iacopino, 2002)
- Barriers due to transference/counter-transference reactions during the interview
- Misconducted and/or badly structured interviews

(See §141-143, §252, §289 in the Istanbul Protocol)

5.4 WHAT TO DO REGARDING INCONSISTENCIES IN THE REPORTED STORY OF A PERSON?

The many possible reasons for the impairment of memory or concentration underline the need for a comprehensive evaluation using data on the region, social background, physical findings, and all other data that do not put an inordinate amount of stress on the survivor.

The fear of disclosing shameful experiences, especially rape and other forms of sexual torture can lead to incomplete reporting, especially in cultures in which known victims of rape are stigmatized or persecuted even by family members (Wenzel, 2002).

Simulated or aggravated profiles should only to be expected under special circumstances, as the stigma attached to a psychiatric diagnosis and the lack of information about torture sequelae makes it an improbable option in most countries (Wenzel, 2002).

However, 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 for personal or political reasons. The investigator must always be aware of these possibilities and try to identify potential reasons for exaggeration or fabrication. Nevertheless, the clinician should also keep in mind that such fabrication requires a detailed knowledge about trauma-related symptoms that individuals rarely possess (§289).

Be aware that inconsistencies do not necessarily mean that an allegation is false (Giffard, 2000), instead, inconsistencies might indicate precisely the opposite. Interpreting inconsistencies immediately as representing malingering and false allegations may introduce errors in the evaluation, which might have serious consequences for the person being evaluated.

Inconsistencies in a person's story may arise from any or all of the above-mentioned factors leading to difficulties in recalling and recounting the history.

"The individual may be unable 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" (§252).

By asking the same questions in a different way or by reviewing inconsistencies from several angles, it might sometimes be possible to resolve them (Giffard, 2000).

"If possible, the investigator should ask for further clarification. When this is not possible, the investigator should look for other evidence that supports or refutes the story. A network of consistent supporting details can corroborate and clarify the person's story. Although the individual may not be able to provide the details desired by the investigator such as dates, times, frequencies, exact identities of perpetrators, overall themes of the traumatic events and torture will emerge and stand up over time" (§142).

“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 refer the individual to another clinician and ask for the colleague’s opinion.
- The suspicion of fabrication should be documented with the opinion of two clinicians” (§289).

(See §142, §143, §252, §289 in the Istanbul Protocol)

5.5 REPORTING

In most cases, the reports are not prepared by a cooperating team, or the physical evaluation and the psychological evaluation are made by different clinicians at different times and under different conditions. In these cases, the clinician who makes the psychological evaluation has to prepare an independent report reflecting all the gathered information during the assessment and an indication of his/her own opinion of the situation.

“The physician should not assume that the official requesting a medical-legal evaluation has related all the material facts. It is the physician’s responsibility to discover and report upon any material findings that he or she considers relevant, even if they may be considered irrelevant or adverse to the case of the party requesting the medical examination. Findings that are consistent with torture or other forms of ill treatment must not be excluded from a medical-legal report under any circumstance” (§161).

When preparing a report on the psychological evaluation, all the basic principles in reporting should be followed (see Annex IV in the Istanbul Protocol).

A report format in accordance with the “Guidelines for medical evaluation of torture and ill-treatment” in Istanbul Protocol Annex IV should be used. These guidelines are not intended to be a fixed prescription, but should be applied after an assessment of available resources and taking the purpose of the evaluation into account.

“The medical report should be factual and carefully worded. Jargon should be avoided. All medical terminology should be defined so that it is understandable to lay persons” (§161).

Making the report easy to read and understand is important. Resnick suggests using the principles of clarity, brevity, simplicity and humanity. Hedging statements and ambiguity should be avoided; instead simple words should be used as much as possible. If the use of technical terms is unavoidable, their meanings should be explained in parenthesis. All of the information obtained needs to be included in the report (Allnutt & Chaplow, 2000).

The psychological evaluation report should include the following sections in detail:

“The introduction should contain mention of the referral source, a summary of collateral sources (such as medical, legal and psychiatric records) and a description of the methods of assessment used (interviews, symptom inventories and checklists, neuro-psychological testing)” (§274)

- Case information (including personal data, ID information, informed consent and conditions of medical evaluations among others) (Annex IV-Section1) (See also §122-125)
- Background information (Annex IV-Section 4) (See also §135, §278)

- History of torture and ill-treatment (Annex IV-Section 5) (See also chapter IV sections E, F, G, and §275)

Psychological history/examination

The following elements of the psychological evaluation should be described in detail in the final report:

- Current psychological complaints (For more information see §239-248; §276, and also §233, §235, §236, §253)
- Post-torture history (§277)
- Pre-torture history (§278, §135)
- Medical history (§280, chapter V sections B, C, D, E)
- Past psychological/psychiatric history (§281)
- Substance use and abuse history (§282)
- Mental status examination (§283)
- Assessment of social functioning (§284)
- Psychological testing, neuro-psychological testing, etc. (for indications and limitations please see §285, §292-297).
- Consultations (Annex IV-Section 11) (if applicable)
- Interpretation of findings – clinical impressions (Annex IV-Section XII) should be formulated in accordance with the information given in the Istanbul Protocol (see §141-143, §156-159, §235, §252, §254, §276, §286-289) and summarized in the “Interpretation of findings” chapter of this manual.

The evaluation report should: (annex IV)

- a) Correlate the degree of consistency between the psychological findings and the alleged report of torture in a detailed and explanatory way.
- b) Provide an assessment of whether the psychological findings are expected or typical reactions to extreme stress within the cultural and social context of the individual.
- c) Indicate the status of the individual in the fluctuating course of trauma-related mental disorders over time; i.e. what is the time frame in relation to the torture events and where is the individual in the course of recovery.
- d) Identify any coexisting stressors impinging on the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role, etc.) and the impact these may have on the individual.
- e) Mention physical conditions that may contribute to the clinical picture, especially with regard to possible evidence of head injury sustained during torture and/or detention.

(See Annex IV in the Istanbul Protocol)

(For more information, see also Chapter IV sections A, B, G, L; Chapter VI section C.3 (k); §161, §235, §252, §254, §276, §288, §289).

Conclusions and recommendations should include the following: (Annex IV-Section 13)

- 1) Statement of opinion on the consistency between all sources of evidence and the allegations of torture and ill treatment.
- 2) Reiterate the symptoms and/or disabilities that the individual continues to suffer as a result of the alleged abuse.
- 3) Provide any recommendations for further evaluation and/or care for the individual.

Clinician's signature, date and place, clinician's qualifications and relevant annexes.

(See also Chapter VI, section C.3 and section C.4 (b))

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