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PSYCHOLOGICAL EVALUATION OF TORTURE ALLEGATIONS

A practical guide to the Istanbul Protocol – for psychologists

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

irct International Rehabilitation Council for Torture Victims

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

Second edition 2007

Published 2009 by
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Printed by Scanprint, Viby J., Denmark

ISBN 978-87-88882-40-7 (paperback)
ISBN 978-87-88882-42-1 (PDF)

This publication has been produced with the financial assistance of the European Commission. The views expressed in this publication are those of the authors and can in no way be taken to reflect the official opinion of the organisations of those authors, the IRCT or the European Commission.

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FOREWORD

Mental health professionals play a significant role not only in the treatment and rehabilitation of torture victims, but also in the prevention of torture through the psychological evaluation of alleged torture victims and reporting of the findings for use in related legal processes. The Istanbul Protocol sheds light on the different aspects of this function and provides guidance on how it may be fulfilled in practice.

In spite of its international recognition among health, legal and human rights experts as well as relevant international bodies, awareness of the Istanbul Protocol is still relatively low. Only a limited number of professionals in few countries use the Istanbul Protocol on a systematic basis. For this reason further training and development of resource materials based on the Istanbul Protocol is much needed.

This guide is intended as an auxiliary instrument to the Istanbul Protocol and has been developed as a source of practical reference for psychologists engaged in the investigation and documentation of cases of alleged torture. It is researched and written by the Human Rights Foundation of Turkey (HRFT) within a framework of partnership led by the International Rehabilitation Council for Torture Victims (IRCT) in collaboration with the HRFT, Physicians for Human Rights USA (PHR USA), REDRESS, and the World Medical Association. Similar guides have been developed for medical doctors, "Medical physical examination of alleged torture victims: A practical guide to the Istanbul Protocol – for medical doctors" (IRCT, 2009a) and for lawyers, "Action against torture: A practical guide to the Istanbul Protocol – for lawyers" (IRCT, 2009b). It is hoped that these materials offer insights and create synergy between the health and legal professions in a joint effort to combat torture.

One of the aims of this guide is to discuss, in the light of the Istanbul Protocol, significant points and frequently asked questions, and to point out critical situations that the clinician might face in practice during the psychological evaluation of alleged torture victims. It also aims to provide some complementary considerations and underline various issues addressed in the Protocol.

The Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, in popular terms the Istanbul Protocol, contains the first set of internationally recognised standards for the effective examination, investigation and reporting of allegations of torture and ill-treatment. It was drafted by more than 75 experts in law, health and human rights during three years of collective effort involving more than 40 different organisations including the IRCT. The extensive work was initiated and coordinated by the HRFT and the PHR USA. Since its inception in 1999 the Istanbul Protocol has been endorsed and promoted by the UN and other key human rights bodies. It exists in Arabic, Chinese, English, French, Russian and Spanish.

ACKNOWLEDGEMENTS

The first version of this guide was prepared in 2004 by Turkcan Baykal, Caroline Schlar and Emre Kapkın. Revisions were made by Turkcan Baykal (HRFT) with comments, contributions and editing provided by Thomas Wenzel, Alper Tecer, Pinar Onen, Sirin Sabirli and Idil Cavus during the preparation of this version.

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PART A

THE IMPORTANCE OF THE PSYCHOLOGICAL EVALUATION IN THE MEDICAL INVESTIGATION AND DOCUMENTATION OF TORTURE ALLEGATIONS

I. THE CENTRAL ROLE OF THE PSYCHOLOGICAL EVALUATION

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

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

"Perpetrators often attempt to justify their acts of torture and ill-treatment by the need to gather information. Such 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. Torture is a means of attacking the individual's fundamental modes of psychological and social functioning. The torturer strives not only to incapacitate a victim physically, but also to disintegrate the individual's personality: The torturer attempts to destroy a victim's sense of being grounded in a family and society as a human being with dreams, hopes and aspirations for the future [...]" (Istanbul Protocol, § 235).

Internationally accepted definitions of torture acknowledge that provoking mental suffering is often the intention of the torturer (Allden, 2002):

- All kinds of torture inevitably comprise psychological processes (Kordon et al., 1988)
- Torture often causes psychological/psychiatric symptoms at various levels
- Torture methods are often designed not to leave physical lesions and physical methods of torture may result in physical findings that either resolve or lack specificity.

Improvement in the methods of detecting and providing proof for physical torture

has paradoxically led to more sophisticated methods of torture that do not leave visible evidence on victim's body (Jacobs, 2000). Most physical symptoms and signs of torture, if there are any, rapidly dissapear (Finn Somnier et al., 1992).

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

Torturers know that by not leaving permanent physical scars, they help their cause and make the work of their counterparts in the human rights arena more difficult (Jacobs, 2000). For this reason, in the Istanbul Protocol it is underlined that the absence of such physical evidence should not be construed to suggest that torture did not occur:

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

Contrary to the physical effect of torture, the psychological consequences of torture are often more persistent and troublesome than physical disability. Several aspects of psychological functioning may continue to be impaired in long-term; if not treated victims may suffer from the psychological consequences of torture even months or years following the event, sometimes for life, with varying degrees of severity. (Carlsson et al., 2006; 1992; Genefke & Vesti, 1998; Gurr & Quiroga, 2001; Jacobs, 2000; Somnier et al., 1992; Turner & Gorst-Unsworth, 1993).

(See § 159, § 161 and §§ 260-261 in the Istanbul Protocol.).

II. THE PSYCHOSOCIAL CONSEQUENCES OF TORTURE

The potential effects of torture include cumulative traumatic experiences on *individual level*, family trauma on *family level*, and community trauma on *community level* (Kira, 2002).

1. ON THE INDIVIDUAL LEVEL

Torture is a dynamic process that begins at the moment of losing liberty, involves a sequence of traumatic events that may take place at different times and places, ending with the release or demise of the victim (Somnier et al., 1992). Sometimes it may continue or repeat again. This cascade of events may start again within a short time-frame, without leaving any time for the individual to recover. The person experiences complete uncontrollability, inescapability, and is also challenged by the unpredictability of the torturer (Kira, 2002).

Generally torture has an extremely threatening and painful character, and can induce immediate reactions of panic and fear, including significant fear of death, with a very

high level of tension and, sometimes subsequently, of emotional numbness (Gurris & Wenk-Ansohn, 1997). These feelings may be accompanied by a sense of complete confusion, powerlessness, and of loss of control which can bring about a shattered understanding of oneself, of any meaningful existential system and of the predictability of the world (Fischer & Gurris, 1996; McFarlane, 1995). The outcome of torture is often an intentional destruction of the economic, social, and cultural worlds of the victims (Summerfield, 1995).

Torture can damage the victim on several levels (Fischer & Gurris, 1996; Gurr & Quiroga, 2001; Jacobs, 2000; Kira, 2002; Lira Kornfeld, 1995; Shapiro, 2003; Summerfield, 1995):

- Physical and psychological integrity and entity
- Cognitive, emotional, behavioural, social wellbeing
- Personality
- Identity
- Autonomy
- Self actualization
- Self respect, self-esteem
- Sense of safety and survival
- Dreams, hopes, aspirations for the future
- Belief system
- System of meaning about him/herself and the world
- Attachment
- Connectedness
- Trust
- Torture also shatters the victims' sense of being grounded in a family and in the society
- It may cause some secondary problems which deteriorate social, educational and occupational functioning.

2. ON THE FAMILY LEVEL

"[...]Torture can profoundly damage intimate relationships between spouses, parents, children and other family members, and relationships between the victims and their communities" (Istanbul Protocol, § 235).

Torture can traumatize the family, which leads to various forms of family dysfunction and disruptions (Kira, 2002):

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

All these factors may lead to destructive circular effects inside the family.

In most torture assessments, evaluation of the impact of torture on the family system, the family dynamics and on the other members of the family is usually overlooked (Kira, 2002). Although such an assessment could be important, circumstances rarely allow it due to time constraints, limitations of resources, insufficient skills in methods of approaching the family, and sometimes confidentiality issues.

3. ON THE COMMUNITY LEVEL

"[...]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 [...]" (Istanbul Protocol, § 235).

One of the aims of torture is to intimidate third parties, thereby ensuring responses of fear, inhibition, paralysis, impotence and conformity within society. In this sense, torture is not only a political, but also a social, ethical, psycho-social and mental health problem for the society (Lira Kornfeld, 1995). 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. 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 also a general environment of political threat, both of which lead to an atmosphere of chronic fear (Lira Kornfeld, 1995; Summerfield, 1995).

Torture always explicitly or implicitly conveys a threat and attack to the whole community and the value system of the community. Torture can terrorize the entire population, create an atmosphere of pervasive threat, chronic fear, terror, and inhibition (Kira, 2002). It can create a repressive ecology, which is a state of generalized insecurity, lack of confidence, and rupture of the social fabric. Torture may have long-lasting effects on most forms of collective behaviour. The impacts of torture and persecution can also be transmitted cross-generationally.

PART B

INTERVIEW – ETHICAL AND CLINICAL CONSIDERATIONS

The interview has the key role for the effective investigation of torture. A detailed report can be prepared only by means of an appropriate and comprehensive interview. The interview has to be structured and conducted according to the guidelines defined in the "General considerations for interviews", "Procedural safeguards with respect to detainees" and "Relevant ethical codes" chapters of the Istanbul Protocol. These considerations apply to all persons carrying out interviews whether they are lawyers, medical doctors, psychologists, psychiatrists, human rights monitors or members of any other profession (Istanbul Protocol, § 120). The expert who makes the psychological evaluation should keep in mind that all the procedural safeguards mentioned in the Istanbul Protocol should be taken into consideration not only during the physical examination but also during the psychological evaluation.

In all the medical and psychological examination and evaluation processes, it is fundamental to adhere to the basic principle "Primum non nocere – First, do no harm" (Wenzel, 2002).

"[…]The limitations of certain conditions for interviews, however, do not preclude aspiring to application of the guidelines set forth in this manual. It is especially important in difficult circumstances that governments and authorities involved be held to these standards as much as possible" (Istanbul Protocol, § 239).

I. PRIVACY

Examinations must be conducted in private under the control of the clinician. Privacy during the interviews is not only necessary for ethical reasons, but also when talking about sensitive issues which are embarrassing for the person being evaluated. The clinician should establish and maintain privacy during the whole interview (Istanbul Protocol, § 83 and §124).

Police or other law enforcement officials should never be present in the examination room. The presence of police officers, soldiers, prison officers or other law enforcement officials in the examination room, for whatever reason, should be noted in the clinician's report. Their presence during the examination may be grounds for disregarding a negative medical report (Istanbul Protocol, §§ 124-125).

If any other persons are present in the interview room during the interview; the identity, titles and affiliations of these should be indicated in the report (Istanbul Protocol, § 125).

II. SAFETY AND SECURITY

The clinician should carefully consider the context in which they are working, take necessary precautions and provide safeguards accordingly. If interviewing people who are still imprisoned or in similar situations in which reprisals are possible, all precautions should be taken to ensure that the interview does not place the detainee in danger (or in additional difficulty).

In other situations, the possibility that the person may still be persecuted or oppressed has to be kept in mind. Whether or not certain questions can be asked safely will vary considerably and depends on the degree to which confidentiality and security can be ensured. When necessary, questions about forbidden activities should be avoided.

If the forensic medical examination supports allegations of torture, the detainee should not be returned to the place of detention, but rather should appear before the prosecutor or judge to determine the detainee's legal disposition.

(See § 91, § 93, § 126, § 129, § 239 and § 264 in the Istanbul Protocol.)

III. TRUST

The establishment of an effective and trustful relationship during the interview is a basic requirement for a well-conducted psychological evaluation. If an effective and trustful relationship with the examinee cannot be established and a complete and adequate history cannot be taken, it is very likely to be impossible to carry out a proper investigation of torture.

Creating a climate of trust requires active listening, meticulous communication, courtesy, genuine empathy and honesty. Obtaining trust is very cruicial, however, it is even more important not, even unwittingly, to betray that trust.

(See § 129 and § 164 in the Istanbul Protocol.)

IV. CONFIDENTIALITY AND INFORMED CONSENT

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

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

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

The clinicans shall obtain informed consent before any evaluation is undertaken. The clarification of the limits of confidentiality could be seen as part of the process of obtaining consent (Alnutt & Chaplow, 2000).

Clinicians must ensure that informed consent is:

- based on *adequate understanding of the potential benefits and adverse consequences* of the evaluation
- given *voluntarily* without coercion by others.

The person has the right to refuse to cooperate with all or part of the interview and/or evaluation. In such circumstances:

- The clinician should document the reason for refusal of the interview and/or evaluation
- If the person is a detainee, the report should be signed by his or her lawyer and another health official.

(See § 149 and § 165 in the Istanbul Protocol.)

V. SOME DILEMMAS ENCOUNTERED DURING THE INTERVIEW PROCESS

1. BEING OBJECTIVE VERSUS BEING EMPATHIC

Medical evaluations for legal purposes should be conducted with objectivity and impartiality. Objectivity and impartiality 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). The clinician should communicate that he or she is an ally of the individual

and adopt a supportive, non-judgmental approach. It is not appropriate to observe the strict "clinical neutrality". Clinicians need to be sensitive and empathic in their questioning while remaining objective in their clinical assessment.

(See § 162, § 262 and § 263 in the Istanbul Protocol.)

2. 'RISK OF RE-TRAUMATIZATION' VERSUS 'NECESSITY OF OBTAINING SUFFICIENT AND APPROPRIATE INFORMATION'

"Several basic rules must be respected (see chapter III, section C.2 (g)). Information is certainly important, but the person being interviewed is even more so, and listening is more important than asking questions[...]" (Istanbul Protocol, § 135).

Physical and psychological examinations by their very nature may re-traumatize the patient by provoking and/or exacerbating psychological distress and symptoms by eliciting painful affect and memories. The interview must be structured so as to minimize the risk of re-traumatizing the torture survivor. 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). 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; Wenzel, 2002). Interviewers should show sensitivity in their questioning and watch out for signs of tiredness or distress (Giffard, 2000). A subjective assessment has to be made by the clinician about whether and to what extent pressing for details is necessary for the effectiveness of the report in court, especially if the interviewee demonstrates obvious signs of distress.

(See § 135, § 149 and § 264 in the Istanbul Protocol.)

3. DILEMMAS ARISING FROM DUAL OBLIGATIONS

Dilemmas may occur when ethics and law are in contradiction. Circumstances can arise where their ethical duties oblige health professionals not to obey a particular law, such as a legal obligation to reveal confidential medical information about a patient. There is consensus in international and national declarations of ethical precepts that other imperatives, including the law, cannot oblige health professionals to act contrary to medical ethics and to their conscience. In such cases, health professionals must decline to comply with the law or a regulation rather than compromise basic ethical precepts. Whatever the circumstances of their employment, all health professionals owe a fundamental duty to care for the people they are asked to examine or treat. They cannot be obliged by contractual or other considerations to compromise their professional independence. They must make an unbiased assessment of the patient's health interests and act accordingly.

(See § 66 and § 68 in the Istanbul Protocol.)

VI. INTERVIEW

1. INTERVIEW SETTINGS

Psychological evaluation of torture allegations should be conducted at a location that the physician deems most suitable. The clinicians should ensure that the patient, particularly if the interviewee is a detainee, is not forced into accepting a place with which they are not comfortable and safe.

Generally the clinician may not have much control over the setting in which the interview takes place, however, the clinician should make sure to explore all opportunities to establish a settting which is as private, safe and comfortable as possible. Attention should be paid to arranging the room in a way that it is not reminiscent of an official surrounding and the process of interrogation.

Sufficient time should be allotted for interview and the timing has to be outlined beforehand. If the evaluation is taking place under time constraints, the gathered information and the outcome of the interview might be limited.

If possible:

- The room should have appropriate physical conditions (light, ventilation, size, temperature)
- There should be access to toilet facilities and refreshment opportunities. It would be good to have water and tissue within the reach of the interviewee
- The seating should allow the interviewer and interviewee to be able to establish eye contact and see each others faces clearly
- It should not be reminiscent of a hierarchic and official positioning (where the interviewer sits higher or in an armchair, while the interviewee sits on a chair)
- Try to allow the interviewee to arrange the distance according to his/her own preference. The proper distance changes according to culture and person. Sitting too close or too far away may cause stress for the interviewee.

(See § 93, § 124 and § 163 in the Istanbul Protocol.)

2. THE COURSE OF THE INTERVIEW

At the beginning of the interview:

- The clinican should introduce himself/herself with full information on his/her identity (including his/her roles, specialization, affiliations, status)
- The clinician should inform the interviewee clearly on:
  - His/her responsibilities and boundaries
  - The reason and the purpose of the interview
  - The context, frame, course of the interview
  - Possible procedures during the interview (and the evaluation)
  - Any limits of the confidentiality
  - Possible consequences of this interview/evaluation
- Informed consent should be taken
- The interview should be started with open-ended general questions. On the basis of the information elicited, more specific details should be sought, where appropriate
- The clinician should be attentive sequencing of questions e.g. the interview should begin with less sensitive issues, sensitive questions should be asked only after some degree of rapport has developed
- The interview should be concluded with

a relaxing topic to ensure that the emotional arousal has subsided. Before closing the interview, the interviewee should be asked if s/he wants to ask any questions, or has thing s/he wants to add.

(See chapter IV and § 163, § 168 and §§ 262-263 in the Istanbul Protocol.)

3. INTERVIEW STYLE

The clinician should inform the patient that he/she can take a break or interrupt the interview if needed. The clinican also should acknowledge the patient's right to choose not to respond to any question he or she may not wish to.

If possible, the interview should be designed according to the needs of the examinee. The interviewer should arrange short episodes with breaks.

The clinician should:

- Avoid any manner, approach or style which may recall the torture situation
- Not make the patient wait
- Avoid authoritative instructions and questions
- Be sensitive in tone, phrasing and sequencing of questions
- Create a climate of trust, courtesy, honesty and empathy
- Be aware of the cultural norms and beliefs
- Communicate in a sense of understanding of the individual's experiences and suffering
- Give time and opportunity to the interviewee's own needs and questions
- Ensure the patient feel s/he is in control
- Formulate the questions in an open-ended manner.
- Avoid leading questions.

(See chapter IV and § 93, § 124, §§ 163-164, § 168, §§ 262-263 in the Istanbul Protocol and Giffard & Thompson, 2002; Iacopino, 2002; Peel et al., 2000; Peel et al., 2005.)

VII. POTENTIAL TRANSFERENCE AND COUNTER-TRANSFERENCE REACTIONS

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

1. TRANSFERENCE

"Transference refers to feelings a survivor has towards the clinician that relate to the past experiences but are misunderstood as directed towards the clinician personally[...]" (Istanbul Protocol, § 265).

The evaluator's questions may be experienced as:

- forced exposure akin to an interrogation
- sign of mistrust or doubt on the part of the examiner.

The evaluator may be perceived as:

- a person in a position of authority (in a positive or negative sense)
- an enemy or accomplice to the torturer
- saviour, protector, camarade
- having voyeuristic and sadistic motivations.

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 become too trusting and expectant.

(See § 265 and § 268 in the Istanbul Protocol.)

2. COUNTER-TRANSFERENCE

"[...]The clinician's emotional response to the torture survivor, known as countertransference, may affect the psychological evaluation" (Istanbul Protocol, § 265).

If a clinician is unaware of counter-transference, it may cause some additional problems, barriers during the interviews and also may diminish the clinician's effectivity and ability to evaluate and document the consequences of torture.

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.

During the interview, all these factors may lead the evaluator:

- to underestimate the severity of the consequences of torture
- to forget some details
- to have ungrounded doubts about the truth of the alleged torture
- to fail to establish needed empathic approach
- to experience difficulty in maintaining objectivity
- to experience over-identification with the torture survivor
- not to be able to obtain the history
- not to be able to formulate the case and to prepare the report on time and properly.

Torture can also lead to vicarious traumatisation, secondary traumatization and/or burn-out reactions on the side of the interviewer.

(See §§ 148-149 and §§ 263-273 in the Istanbul Protocol and Bustos, 1990; Herman, 1992; Smith et al., 1996; Steele et al., 2001)

VIII. FACTORS LEADING TO INCONSISTENCIES AND DIFFICULTIES IN RECALLING AND RECOUNTING THE STORY OF TORTURE

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.

Impaired attention and memory disorders are part of PTSD, but these symptoms may also be present in other disorders such as depression, anxiety, brain injury or electrolyte imbalance. Memory impairment might also be a symptom of dissociation, which often can be 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 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. Perpetrators' efforts to discredit the survivor and to hide the atrocities can contribute to difficulties in a later assessment. Impaired recall can therefore be a major obstacle to history taking and any possible legal procedures, but it can be also an indicator of sequels which should be considered in the evaluation (Burnett & Peel, 2001b; Wenzel, 2002).

1. POTENTIALLY INTERFERING FACTORS WHEN REPORTING ONE'S STORY OR WHEN TAKING THE HISTORY

Factors directly related to the torture experience:

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

Factors related to the psychological impact of torture:

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

Cultural factors:

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

Factors related to interview conditions or barriers of communication:

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

(See §§ 142-144, § 253 and § 290 in the Istanbul Protocol and Iacopino, 2002; Mollica & Caspi-Yavin, 1992; Sironi, 1989; van der Kolk & Fisler, 1995; Wenzel, 2002.)

PART C

PSYCHOLOGICAL EVALUATIONS FOR THE INVESTIGATIONS OF TORTURE ALLEGATIONS

I. THE OBJECTIVES OF THE PSYCHOLOGICAL EVALUATIONS

In the cases of allegations of torture, psychological evaluations provide critical information and evidences for:

- Medico-legal examinations
- Political asylum applications
- Human rights investigations and monitoring
- Clarification of the facts and establishment
- Establishing conditions under which false confessions may have been obtained
- Identifying the therapeutic needs of the victims
- Demonstration the needs for full reparation and redress from the State
- Understanding regional practices of torture
- Acknowledgement of individual and State responsibility for the victims and their families
- Facilitation of prosecution and/or disciplinary sanctions
- Preventing impunity.

"[...]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[...]" (Istanbul Protocol, § 261).

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. In some countries, the expert is expected to clearly define if the person has been tortured or not. If he or she does not put forward a clear position, this might increase the likelihood of impunity for the perpetrators (as the principle of "in dunio pro reo" – if in doubt, evidence should be interpreted in favor of the suspect- could be applied for the perpetrators).

(See § 78 and § 261 in the Istanbul Protocol.)

II. COMPONENTS OF THE PSYCHOLOGICAL EVALUATIONS

The whole psychological 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 in the Istanbul Protocol.

The psychological evaluation starts at the beginning of the interview, with the very first contact. Dressing, posture, the manner of recalling and recounting of the trauma, signs of anxiety or emotional distress, numbness or over-excitement, moments of emotional intensity, startled responses, posture and bodily expression while relating the events of torture, avoidance of eye contact, and emotional fluctuations in his/her voice can give important clues about the personal history and psychological functioning of 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) are important for the psychological evaluation (Jacobs, 2000; Reyes, 2002). The person might have difficulties in recollecting and recounting what he experienced or in talking about his/her complaints. Therefore, non-verbal communication supplies important information about his/her symptoms, as well as some clues for establishing and maintaining an effective relationship that allows the evaluator to elicite relevant data (Jacobs, 2000).

The psychological evaluation should provide a detailed description of the individual's history, a mental status examination, an assessment of social functioning, and a formulation of clinical impressions/opinions. The impact of the symptoms on daily life can be highly relevant for forensic procedures or questions of recompensation of torture cases. If appropriate, a psychiatric diagnosis should be given.

The components of psychological/psychiatric evaluation are as follows:

1. HISTORY OF TORTURE AND ILL-TREATMENT

*"Every effort should be made to document **the full history of torture**, persecution and other relevant traumatic experiences (see chapter IV, section E). 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[...]"* (Istanbul Protocol, § 276).

*"[...]**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[...]"* (Istanbul Protocol, § 145).

The history of torture and ill treatment should include:

Summary of detention and abuse

Before obtaining a detailed account of events, elicit summary information, including dates, places, duration of detention, frequency and duration of torture sessions

Circumstances of Apprehension

What time, from where, by whom (with details, if possible); other persons around witnesses/bystanders; interaction with family members; violence/threats used during the apprehension; use of restraints or blindfold

Place and conditions of detention

What happened first, where, any identification process, transportation, distinctive features; other procedures; condition of the cell/room; size/dimensions, ventilation, lighting, temperature, toilet facilities, food; contact with third persons (family members, lawyer, health professionals); conditions of overcrowding or solitary confinement, etc.

Methods of torture and ill-treatment

- Assessment of background: Where, when, how long, by whom; special features of the environment, perpetrators, devices/instruments; usual "routine" sequences and other information
- For each form of abuse; body position, restraint, nature of contact, duration, frequency, anatomical location, the area of the body affected and how and other information
- Sexual assaults
- Deprivations (sleep, food, toilet facilities, sensory stimulation, human contact, motor activities); threats, humiliations, violations of taboos, behavioural coercions and other methods
- Previous medico-legal reporting process (if any).

(For more information see chapter IV, sections E, F and G in the Istanbul Protocol.)

2. CURRENT PSYCHOLOGICAL COMPLAINTS

Assessment of current psychologial functioning constitues the core of the evaluation:

- All affective, cognitive, and behavioral symptoms that appeared since the torture should be described. For each symptom; first emergence, duration, intensity, frequency, content, fluctuation should be asked and recorded with examples and all details
- Adaptative and maladaptive strategies and triggers such as anniversary reactions, specific stimuli or places, situations and topics causing avoidance

should be noted
- Specific questions about the most common symptoms and diagnostic criteria for most common diagnosis need to be asked.

(See § 277 in the Istanbul Protocol.)

3. POST-TORTURE HISTORY

The clinician should inquire current life circumstances, including:

- Sources of additional stress, traumas, losses, difficulties
- Formal and/or informal social support resources
- Marital and family situation
- Employment status, livelihood
- Vocational, social status and conditions
- Life conditions and quality of life of the interviewee and his/her family.

(See § 278 in the Istanbul Protocol.)

4. PRE-TORTURE HISTORY

If relevant, describe:

- The victim's past story (childhood, adolescence, early adulthood), family background, family illnesses and family composition
- The victim's educational and occupational history
- Any history of past trauma
- The victim's cultural and religious background.

Assessment of mental health status and level of psychosocial functioning prior to traumatic events gives the interviewer the opportunity to compare the current health conditions of the individual with that of before torture.

It should be noted that often due to time constraints and other problems, all this information can not be obtained. The clinician usually has to decide which information is indispensable or has higher priority and make a careful decision. In some situations background information can be left for the end of the interview since to ask for it in the beginning may have a negative effect on the interview process.

(See §§ 279-280 in the Istanbul Protocol.)

5. MEDICAL HISTORY

Medical history should include:

- Pre-trauma health conditions
- Current health conditions
- Body pain, somatic complaints
- Physical injuries and findings.

  Physical findings that might be related to trauma should be noted. It is important that the health professional who is making the psychological evaluation should also look for and document the physical findings of trauma. In some instances, the one who makes the psychological evaluation can be the first or the only health professional that the victim can come into contact with.

- Use of medications and their side effects or obstacles in using medications
- Relevant sexual history
- Past surgical procedures and other medical data.

(See § 281 and chapter V, section B, for Medical history; for Physical evidence of torture see chapter V, sections C and D in the Istanbul Protocol.)

6. PSYCHIATRIC HISTORY

History of any mental or psychological disturbances, including the nature and degree of problems, treatment (or non treatment)

and the nature of treatment should be inquired upon.

(See § 282 in the Istanbul Protocol.)

7. SUBSTANCE USE AND ABUSE HISTORY

(See § 283 in the Istanbul Protocol.)

8. MENTAL STATUS EXAMINATION

The following components should be evaluated and reported (Sadock, 2005):

- Appearance (personal identification, behaviour and psychomotor activity, general description such as posture, bearing, etc)
- Speech; mood and affect; thought and perception (process and content of thinking, thought disturbances, perceptual disturbances such as hallucinations and illusions, depersonalization and derealization; dreams and fantasies)
- Sensorium and cognition (alertness, orientation; concentration and calculation; memory impairment – long term memory, intermediate recall and immediate recall; knowledge; abstract thinking; insight; judgement).

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 (Jacobs et al., 2001)

(See § 284 in the Istanbul Protocol.)

9. ASSESSMENT OF SOCIAL FUNCTIONING

Trauma and torture can directly and indirectly affect a person's ability to function. 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.

The impact of symptoms on daily life can be highly relevant in forensic procedures or questions of recompensation of torture cases.

(See § 285 in the Istanbul Protocol.)

10. PSYCHOLOGICAL TESTING AND THE USE OF CHECKLISTS AND QUESTIONNAIRES

Indications and limitations of psychological testing

"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 chapter VI, section C.4: 'Neuropsychological as-

sessment'). 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" (Istanbul Protocol, § 286).

It is observed that in some countries and/or in some situations courts and/or other authorities tend to give more importance to the results of psychometric tests and consider them more objective or give more priority than the clinical impression that the clinicians obtain as a result of several interviews. However, for the psychological evaluation of trauma; the clinical interview, evaluation and the subsequent clinical formulation the clinician reaches is fundamental, whereas the psychological tests have complementary value. It is the clinician himself/herself who will decide if there is any need to use any psychological testing for all the evaluation processes; the clinician must make his own decision without any interference to his/her clinical independence.

(See also chapter VI, section C.4 in the Istanbul Protocol.)

11. 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.

(See also §§ 287-288 and §§ 157-160 in the Istanbul Protocol and Part E in this guide).

12. RECOMMENDATIONS

The recommendations following the psychological evaluation depend on the questions posed at the time the evaluation was requested. The issues under consideration may concern legal and judicial matters, asylum, resettlement, and a need for treatment. Recommendations can be for further assessments, such as neuro-psychological testing, medical or psychiatric treatment or a need for security or asylum. The clinician should not hesitate to insist on any consultation and examination that he or she considers necessary.

In the course of documenting psychological evaluation of torture allegations the clinicians are not absolved of their ethical obligations. Evaluation for documentation of torture for medical-legal reasons should be combined with an assessment for other needs of the victim. Those who appear to be in need of further medical or psychological care should be referred to the appropriate services. Clinicians should be aware of the local rehabilitation and support services.

(See §§ 275-291 in the Istanbul Protocol.)

PART D

PSYCHOLOGICAL CONSEQUENCES OF TORTURE ON INDIVIDUALS

General considerations for the psychological evaluation

- Psychological evaluation and interpretation should always be made with an awareness of the cultural, political and social context as well as the conditions of the interview and assessment (Istanbul Protocol, § 262)
- 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 (Istanbul Protocol, § 236)
- A diagnosis of a trauma-related mental disorder supports the claim of torture, but not meeting criteria for a diagnosis does not mean that the person was not tortured (Istanbul Protocol, § 289).

I. FACTORS ASSOCIATED WITH THE PSYCHOLOGICAL RESPONSE TO TORTURE

"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[...]" (Istanbul Protocol, § 234).

The type, duration and severity of psychological responses to trauma are affected by multiple factors which interact with each other. There is a complex relationship between trauma and symptomatology (McFarlane, 1995). The multi-determined nature of torture symptoms requires a profound and multidimensional assessment (Kira, 2002).

Although the factors influencing the psy-

chological responses are not known exactly, several dimensions may be of significance in the evaluation of the victims (Istanbul Protocol, § 280). These factors include, but are not limited to the following:

1. GENERAL

- The perception, interpretation and meaning of torture by the victim:

  "[...]The psychological consequences of torture occur in the context of personal attribution of meaning, personality development, and social, political and cultural factors [...]" (Istanbul Protocol, § 234).

  Individuals react to extreme trauma like torture in accordance with what it means to them (Istanbul Protocol, § 236). The generation of these meanings is an activity that is socially, culturally and politically framed. Besides this frame, the unique implications that torture has for each individual influence his/her ability to describe and speak about it. The psychological reactions to trauma are closely linked with the psychological meaning of the trauma to the person.

- The social context before, during and after torture (such as political and cultural climate, values and attitudes toward traumatic experiences):
- Social supports
- Existence of formal and/or informal support system
- Access and utilization of the social supports.

2. TORTURE HISTORY

- The circumstances and the nature of the torture:
  – The severity of the traumatic events.

    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. Additionally, the psychological impact of traumatic events on the person depends on how the individual subjectively perceives the severity of the event rather than the objective severity. Humiliation, threat to loved ones or witnessing the torture of another person may have a more profound effect on the victim than to exposure to electric shocks or falanga. There are contradictory reports in the literature about the relationship between the severity of trauma and its consequences.

  – The intensity, chronicity, duration, frequency of the traumatic events
  – Nature of trauma (cumulative, repeated, prolonged, subsequent, continous...)
  – Additional traumas during torture period (such as witnessing atrocities, death of family members or friends during the same event.
- The developmental phase and age of the victim
- Physical injuries, pain, symptoms related to torture-ill-treatment
- Ongoing threat to oneself and/or family members (perceived or actual), risk of persecution and re-arrestment.

3. PRE-TORTURE HISTORY

- Previous torture, previous detention history
- Previous exposure to different types of trauma
- Awareness of and preparedness for torture event
- Awareness of psychological response to torture
- Vulnerability or resilience traits
- Personal variables such as belief system,

pre-existing psychological disorders, pre-existing psychosocial functioning, family history of psychopathology, personality traits, patterns of coping.

4. HISTORY AFTER TORTURE EVENT (POST-TORTURE HISTORY)

- Concurrent and/or consequent additional traumas, (such as imprisonment, civilian attacks,[...])
- Traumatic conditions after torture
- Losses:
  - Family, friends
  - Home, possessions, personal belongings
  - Employment, livelihood, social status
- Separations (family, country, friends)
- Flight from his/her own settlement or forced migration
- Additional difficulties:
  - Difficulties in the new settlement (such as acculturation, language barriers, discrimination in the host settlement)
  - Decrease in the quality of life
  - Deprivation of food, shelter, medical attention
- The weakness of restorative justice, impunity
- Social and/or cultural isolation
- Concern for the safety of him/herself and/or other family members or significant others
- Intense fear and/or suspicion about being re-arrested, forced to go underground to avoid being arrested again.

(See § 234, § 280 and § 288 in the Istanbul Protocol and American Psychiatric Association (APA), 2004; Australian Centre for Posttraumatic Mental Health (ACPMH), 2007; Ehrenreich, 2003; Gurr & Quiroga, 2001; Iacopino, et. al., 2001; Kira, 2002; Mayou et al., 2002; Mc Farlane, 1995; McFarlane & Yehuda, 1996; National Institute for Clinical Excellence (NICE), 2005; Peel et al., 200, 2005; Somnier et al., 1992; Summerfield, 1995; Summerfield, 2000; Turner et. al., 2003; van der Kolk et al., 1996; Varvin, 1998; Vesti, 1996a, 1996b; Yehuda & McFarlane, 1995.)

II. FREQUENTLY SEEN PSYCHOLOGICAL RESPONSES

"Before entering into a technical description of symptoms and psychiatric classifications, it should be noted that psychiatric classifications are generally considered to be Western medical concepts, and that their application to non-Western populations presents, either implicitly or explicitly certain difficulties[...]. The idea that mental suffering represents a disorder that resides in an individual and features a set of typical symptoms may be unacceptable to many members of non-Western societies" (Istanbul Protocol, § 240).

What is considered disordered behaviour or a disease in one culture may not be viewed as pathological in another (Kagee, 2005). While some symptoms may be present across differing cultures, they may not be the symptoms that concern the individual most. 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, the symptoms are sometimes a "normal" response to societal pathology (Gurr & Quiroga, 2001).

"[...]Additional problems arise when trying to assess whether psychological symptoms or behaviours are pathological or adaptive. When a person is examined while in deten-

tion or living under considerable threat or oppression, some symptoms may be adaptive[...]" (Istanbul Protocol, § 239).

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. 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 some additional 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)

(See §§ 236-249 in the Istanbul Protocol and Becker, 1995; Burnett & Peel, 2001a; Gurr & Quiroga, 2001; Kagee, 2005; Kira, 2002; Mollica & Caspi-Yavin, 1992; Simpson, 1995; Summerfield, 1995, 2000, 2001.)

1. SYMPTOMS OF PTSD

Re-experiencing the trauma such as intrusive memories, thoughts, recurrent nightmares or distressing dreams, intense psychological distress at and/or physiological reactivity to exposure to cues that symbolize or resemble the trauma, flashbacks.

Avoidance and emotional numbing such as avoidance of any thought, conversation, activity, place or person that arouse a recollection of the trauma; profound emotional constriction; profound personal detachment and social withdrawal; inability to recall an important aspect of the trauma, feeling of estrangement from others, restricted range of affect, sense of foreshortened future.

Hyperarousal such as difficulty in either falling or staying asleep, irritability or outbursts of anger, concentration difficulties, hyper-vigilance, exaggerated startled response, generalized anxiety, shortness of breath, sweating, dizziness and gastrointestinal distress.

(See § 241 in the Istanbul Protocol.)

2. SYMPTOMS OF DEPRESSION

- Depressed mood, markedly diminished interest or pleasure in activities
- Appetite disturbance and weight loss
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue and loss of energy
- Diminished ability to think or to concentrate in memory functions
- Indecisiveness
- Feelings of worthlessness and excessive guilt, diminish, difficulties in concentration, recurrent thoughts of death.

(See § 242 in the Istanbul Protocol.)

3. SYMPTOMS OF DISSOCIATIVE DISORDERS

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 vari-

ous 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 his/her 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).

(See § 244 in the Istanbul Protocol.)

4. SOMATIC SYMPTOMS

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 reflect an interaction of both factors (Wenzel, 2002).

These somatic complaints include headaches, back pain, musculo-skeletal pain (for more information, please see the "Medical physical examination of alleged torture victims: A practical guide to the Istanbul Protocol – for medical doctors").

(See § 245 in the Istanbul Protocol.)

5. SYMPTOMS OF SEXUAL DYSFUNCTION

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. Possible symptoms are: lack or loss of sexual desire, sexual enjoyment; decreased interest in or fear of sexual activity; diminished sexual arrousal; inability to trust a sexual partner; fear of having been damaged sexually; fear of being homosexual; failure of genital response like erectile dysfunction or failure of vaginal lubrication; vaginismus, dyspareunia, orgasmic dysfunction, premature ejaculation.

(For additional information, see § 246 and chapter V, section D.8, in the Istanbul Protocol.)

6. SYMPTOMS OF PSYCHOTIC DISORDERS

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. Possible findings are: delusions, hallucinations (auditory, visual, tactile, olfactory); bizarre ideation and behaviour; illusions or perceptual distortions, 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).

(See § 247 in the Istanbul Protocol.)

7. SUBSTANCE ABUSE

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 some trauma-related health problems such as insomnia, anxiety, pain or others. In many studies of trauma survivors, higher rates of substance use are observed after the traumatic event (American Psychiatric Associaction (APA), 2004).

(See § 248 in the Istanbul Protocol.)

8. NEURO-PSYCHOLOGICAL IMPAIRMENT

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. 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.

(See § 249 in the Istanbul Protocol.)

III. MOST COMMON DIAGNOSTIC CATEGORIES

"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[...]" (Istanbul Protocol, § 250).

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

"[...]Also, 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[...]" (Istanbul Protocol, § 250).

The two prominent classification systems are the International Classification of Diseases and Related Health Problems (ICD-10) (WHO, 1994, 2007) Classification of Mental and Behavioural Disorders and the American Psychiatric Association's Diagnostic and Statistical Manual, Fourth Edition-Text Version (DSM-IV-TR) (APA, 2000). For complete descriptions of diagnostic categories, please refer to ICD-10 and DSM-IV-TR.

The most common trauma-related diagnoses

are PTSD, Acute Stress Disorder 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 (Istanbul Protocol, § 256).

The association between torture and PTSD 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 (Istanbul Protocol, § 252). Torture-related mental disorders are not limited to depression and PTSD and evaluators should have comprehensive understanding of all the possible diagnostic categories 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.

Below you can find a selection of the diagnostic categories which can be considered during the psychological evaluation of torture allegations.

[http://www.who.int/classifications/apps/icd/icd10online]

INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES AND RELATED HEALTH PROBLEMS

10TH REVISION – (ICD-10) – VERSION FOR 2007

MOOD [AFFECTIVE] DISORDERS (F30-F39)

F32 Depressive episode

In typical mild, moderate, or severe depressive episodes, the patient suffers from lowering of mood, reduction of energy, and decrease in activity. Capacity for enjoyment, interest, and concentration is reduced, and marked tiredness after even minimum effort is common. Sleep is usually disturbed and appetite diminished. Self-esteem and self-confidence are almost always reduced and, even in the mild form, some ideas of guilt or worthlessness are often present. The lowered mood varies little from day to day, is unresponsive to circumstances and may be accompanied by so-called "somatic" symptoms, such as loss of interest and pleasurable feelings, waking in the morning several hours before the usual time, depression worst in the morning, marked psychomotor retardation, agitation, loss of appetite, weight loss, and loss of libido. Depending upon the number and severity of the symptoms, a depressive episode may be specified as mild, moderate or severe.

Includes: single episodes of:
– depressive reaction
– psychogenic depression
– reactive depression

Excludes: adjustment disorder (F43.2)
recurrent depressive disorder (F33.-)
when associated with conduct disorders in F91.- (F92.0)

F32.0 Mild depressive episode
Two or three of the above symptoms are usually present. The patient is usually distressed by these but will probably be able to continue with most activities.

F32.1 Moderate depressive episode
Four or more of the above symptoms are usually present and the patient is likely to have great difficulty in continuing with ordinary activities.

F32.2 Severe depressive episode without psychotic symptoms
An episode of depression in which several of the above symptoms are marked and distressing, typically loss of self-esteem and ideas of worthlessness or guilt. Suicidal thoughts and acts are common and a number of "somatic" symptoms are usually present.

Agitated depression
Major depression } single episode without psychotic symptoms
Vital depression

F32.3 Severe depressive episode with psychotic symptoms
An episode of depression as described in F32.2, but with the presence of hallucinations, delusions, psychomotor retardation, or stupor so severe that ordinary social activities are impossible; there may be danger to life from suicide, dehydration, or starvation. The hallucinations and delusions may or may not be mood-congruent.

Single episodes of:
– major depression with psychotic symptoms
– psychogenic depressive psychosis
– psychotic depression
– reactive depressive psychosis

F32.8 Other depressive episodes

F32.9 Depressive episode, unspecified

Under "Mood [affective] disorders (F30-F39)" see also:
F30 Manic episode
F31 Bipolar affective disorder
F33 Recurrent depressive disorder
F34 Persistent mood [affective] disorders
F38 Other mood [affective] disorders

NEUROTIC, STRESS-RELATED AND SOMATOFORM DISORDERS (F40-F48)

F43 Reaction to severe stress, and adjustment disorders

This category differs from others in that it includes disorders identifiable on the basis of not only symptoms and course but also the existence of one or other of two causative influences: an exceptionally stressful life event producing an acute stress reaction, or a significant life change leading to continued unpleasant circumstances that result in an adjustment disorder. Although less severe psychosocial stress ("life events") may precipitate the onset or contribute to the presentation of a very wide range of disorders classified elsewhere in this chapter, its etiological importance is not always clear and in each case will be found to depend on individual, often idiosyncratic, vulnerability, i.e. the life events are neither necessary nor sufficient to explain the occurrence and form of the disorder. In contrast, the disorders brought together here are thought to arise always as a direct consequence of acute severe stress or continued trauma. The stressful events or the continuing unpleasant circumstances are the primary and

overriding causal factor and the disorder would not have occurred without their impact. The disorders in this section can thus be regarded as maladaptive responses to severe or continued stress, in that they interfere with successful coping mechanisms and therefore lead to problems of social functioning.

F43.0 Acute stress reaction
A transient disorder that develops in an individual without any other apparent mental disorder in response to exceptional physical and mental stress and that usually subsides within hours or days. Individual vulnerability and coping capacity play a role in the occurrence and severity of acute stress reactions. The symptoms show a typically mixed and changing picture and include an initial state of "daze" with some constriction of the field of consciousness and narrowing of attention, inability to comprehend stimuli, and disorientation. This state may be followed either by further withdrawal from the surrounding situation (to the extent of a dissociative stupor - F44.2), or by agitation and over-activity (flight reaction or fugue). Autonomic signs of panic anxiety (tachycardia, sweating, flushing) are commonly present. The symptoms usually appear within minutes of the impact of the stressful stimulus or event, and disappear within two to three days (often within hours). Partial or complete amnesia (F44.0) for the episode may be present. If the symptoms persist, a change in diagnosis should be considered.

Acute:
– crisis reaction
– reaction to stress
Combat fatigue
Crisis state
Psychic shock

F43.1 Post-traumatic stress disorder
Arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. Predisposing factors, such as personality traits (e.g. compulsive, asthenic) or previous history of neurotic illness, may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence. Typical features include episodes of repeated reliving of the trauma in intrusive memories ("flashbacks"), dreams or nightmares, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. The onset follows the trauma with a latency period that may range from a few weeks to months. The course is fluctuating but recovery can be expected in the majority of cases. In a small proportion of cases the condition may follow a chronic course over many years, with eventual transition to an enduring personality change (F62.0)

Traumatic neurosis

F43.2 Adjustment disorders
States of subjective distress and emotional disturbance, usually interfering with social functioning and performance, arising in the period of adaptation to a significant life change or a

stressful life event. The stressor may have affected the integrity of an individual's social network (bereavement, separation experiences) or the wider system of social supports and values (migration, refugee status), or represented a major developmental transition or crisis (going to school, becoming a parent, failure to attain a cherished personal goal, retirement). Individual predisposition or vulnerability plays an important role in the risk of occurrence and the shaping of the manifestations of adjustment disorders, but it is nevertheless assumed that the condition would not have arisen without the stressor. The manifestations vary and include depressed mood, anxiety or worry (or mixture of these), a feeling of inability to cope, plan ahead, or continue in the present situation, as well as some degree of disability in the performance of daily routine. Conduct disorders may be an associated feature, particularly in adolescents. The predominant feature may be a brief or prolonged depressive reaction, or a disturbance of other emotions and conduct.

Culture shock
Grief reaction
Hospitalism in children

F43.8 Other reactions to severe stress

F43.9 Reaction to severe stress, unspecified

F44 Dissociative [conversion] disorders

The common themes that are shared by dissociative or conversion disorders are a partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements. All types of dissociative disorders tend to remit after a few weeks or months, particularly if their onset is associated with a traumatic life event. More chronic disorders, particularly paralyses and anaesthesias, may develop if the onset is associated with insoluble problems or interpersonal difficulties. These disorders have previously been classified as various types of "conversion hysteria". They are presumed to be psychogenic in origin, being associated closely in time with traumatic events, insoluble and intolerable problems, or disturbed relationships. The symptoms often represent the patient's concept of how a physical illness would be manifest. Medical examination and investigation do not reveal the presence of any known physical or neurological disorder. In addition, there is evidence that the loss of function is an expression of emotional conflicts or needs. The symptoms may develop in close relationship to psychological stress, and often appear suddenly. Only disorders of physical functions normally under voluntary control and loss of sensations are included here. Disorders involving pain and other complex physical sensations mediated by the autonomic nervous system are classified under somatization disorder (F45.0). The possibility of the later appearance of serious physical or psychiatric disorders should always be kept in mind.

Includes: conversion:
– hysteria
– reaction
hysteria
hysterical psychosis

F44.0 Dissociative amnesia
The main feature is loss of memory, usually of important recent events, that is not due to organic mental disorder, and is too great to be explained by ordinary forgetfulness or fatigue. The amnesia is usually centred on traumatic events, such as accidents or unexpected bereavements, and is usually partial and selective. Complete and generalized amnesia is rare, and is usually part of a fugue (F44.1). If this is the case, the disorder should be classified as such. The diagnosis should not be made in the presence of organic brain disorders, intoxication, or excessive fatigue

Under dissocative [conversion] disorder see also:
F44.1 Dissociative fugue
F44.2 Dissociative stupor
F44.3 Trance and possession disorders
F44.4 Dissociative motor disorders
F44.5 Dissociative convulsions
F44.6 Dissociative anaesthesia and sensory loss
F44.7 Mixed dissociative [conversion] disorders
F44.8 Other dissociative [conversion] disorders

F45 Somatoform disorders

The main feature is repeated presentation of physical symptoms together with persistent requests for medical investigations, in spite of repeated negative findings and reassurances by doctors that the symptoms have no physical basis. If any physical disorders are present, they do not explain the nature and extent of the symptoms or the distress and preoccupation of the patient.

F45.0 Somatization disorder
The main features are multiple, recurrent and frequently changing physical symptoms of at least two years' duration. Most patients have a long and complicated history of contact with both primary and specialist medical care services, during which many negative investigations or fruitless exploratory operations may have been carried out. Symptoms may be referred to any part or system of the body. The course of the disorder is chronic and fluctuating, and is often associated with disruption of social, interpersonal, and family behaviour. Short-lived (less than two years) and less striking symptom patterns should be classified under undifferentiated somatoform disorder (F45.1).

Briquet's disorder
Multiple psychosomatic disorder
Excludes: malingering [conscious simulation] (Z76.5)

F45.4 Persistent somatoform pain disorder
The predominant complaint is of persistent, severe, and distressing pain, which cannot be explained fully by a physiological process or a physical disorder, and which occurs in association with emotional conflict or psychosocial problems that are sufficient to allow the conclusion that they are the main causative influences. The result is usually a marked increase in support and attention, either personal or medical. Pain presumed to be of psychogenic origin occurring during the course of depressive disorders or schizophrenia should not be included here.

Psychalgia
Psychogenic:
– backache
– headache
Somatoform pain disorder
Excludes: backache NOS (M54.9)
pain:
– NOS (R52.9)
– acute (R52.0)
– chronic (R52.2)
– intractable (R52.1)
tension headache (G44.2)

Under F45 Somatoform disorders see also:
F45.1 Undifferentiated somatoform disorder
F45.2 Hypocondriacal disorder
F45.3 Somatoform autonomic dysfunction
F45.8 Other somatoform disorders

Under "Neurotic, stress-related and somatoform disorders (F40-F48)" see also:
F40 Phobic anxiety disorders
F41 Other anxiety disorders
F41.0 Panic disorder (episodic paroxysmal anxiety)
F41.1 Generalized anxiety disorder
F41.2 Mixed anxiety and depressive disorder
F41.3 Other mixed anxiety disorders
F41.8 Other specified anxiety disorders
F41.9 Anxiety disorder, unspecified
F42 Obsessive-compulsive disorder

DISORDERS OF ADULT PERSONALITY AND BEHAVIOUR (F60-F69)

F62 Enduring personality changes, not attributable to brain damage and disease

Disorders of adult personality and behaviour that have developed in persons with no previous personality disorder following exposure to catastrophic or excessive prolonged stress, or following a severe psychiatric illness. These diagnoses should be made only when there is evidence of a definite and enduring change in a person's pattern of perceiving, relating to, or thinking about the environment and himself or herself. The personality change should be significant and be associated with inflexible and maladaptive behaviour not present before the pathogenic experience. The change should not be a direct manifestation of another mental disorder or a residual symptom of any antecedent mental disorder.

Excludes: personality and behavioural disorder due to brain disease, damage and dysfunction (F07.-)

F62.0 Enduring personality change after catastrophic experience
Enduring personality change, present for at least two years, following exposure to catastrophic

stress. The stress must be so extreme that it is not necessary to consider personal vulnerability in order to explain its profound effect on the personality. The disorder is characterized by a hostile or distrustful attitude toward the world, social withdrawal, feelings of emptiness or hopelessness, a chronic feeling of "being on edge" as if constantly threatened, and estrangement. Post-traumatic stress disorder (F43.1) may precede this type of personality change.
Personality change after:

– concentration camp experiences
– disasters
– prolonged:
  · captivity with an imminent possibility of being killed
  · exposure to life-threatening situations such as being a victim of terrorism
– torture

Excludes: post-traumatic stress disorder (F43.1)

BEHAVIOURAL SYNDROMES ASSOCIATED WITH PHYSIOLOGICAL DISTURBANCES AND PHYSICAL FACTORS (F50-F59)

F52 Sexual dysfunction, not caused by organic disorder or disease

Sexual dysfunction covers the various ways in which an individual is unable to participate in a sexual relationship as he or she would wish. Sexual response is a psychosomatic process and both psychological and somatic processes are usually involved in the causation of sexual dysfunction.

Under "F52 Sexual dysfunction, not caused by organic disorder or disease" see:
F52.0 Lack of loss of sexual desire
F52.1 Sexual aversion and lack of sexual enjoyment
F52.2 Failure of genital response
F52.3 Organic dysfunction
F52.4 Premature ejaculation
F52.5 Nonorganic vaginismus
F52.6 Nonorganic dyspareunia

Under "Behavioural syndromes associated with physiological disturbances and physical factors (F50-59)", see also:
F50 Eating disorders
F51 Non organic sleep disorders

ORGANIC, INCLUDING SYMPTOMATIC, MENTAL DISORDERS (F00-F09)

F07 Personality and behavioural disorders due to brain disease, damage and dysfuncuton

Alteration of personality and behaviour can be a residual or concomitant disorder of brain disease, damage or dysfunction.

F07.2 Postconcussional syndrome
A syndrome that occurs following head trauma (usually sufficiently severe to result in loss of consciousness) and includes a number of disparate symptoms such as headache, dizziness, fatigue, irritability, difficulty in concentration and performing mental tasks, impairment of memory, insomnia, and reduced tolerance to stress, emotional excitement, or alcohol.
Postcontusional syndrome (encephalopathy)
Post-traumatic brain syndrome, nonpsychotic

SCHIZOPHRENIA, SCHIZOTYPAL AND DELUSIONAL DISORDERS (F20-F29)

F23 Acute and transient psychotic disorders

A heterogeneous group of disorders characterized by the acute onset of psychotic symptoms such as delusions, hallucinations, and perceptual disturbances, and by the severe disruption of ordinary behaviour. Acute onset is defined as a crescendo development of a clearly abnormal clinical picture in about two weeks or less. For these disorders there is no evidence of organic causation. Perplexity and puzzlement are often present but disorientation for time, place and person is not persistent or severe enough to justify a diagnosis of organically caused delirium (F05.-). Complete recovery usually occurs within a few months, often within a few weeks or even days. If the disorder persists, a change in classification will be necessary. The disorder may or may not be associated with acute stress, defined as usually stressful events preceding the onset by one to two weeks.

Under "F 23 Acute and Transient Psychotic Disorders", see
F23.0 Acute polymorphic psychotic disorder without symptoms of schizophrenia
F23.1 Acute polymorphic psychotic disorder with symptoms of schizophrenia
F 23.2 Acute schizophrenia-like psychotic disorder
F 23.3 Other acute predominantly delusional psychotic disorders
F 23.8 Other acute and transient psychotic disorders

F23.9 Acute and transient psychotic disorder, unspecified
Brief reactive psychosis NOS
Reactive psychosis

PART E

INTERPRETATION OF THE FINDINGS – CLINICAL IMPRESSION

I. 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:

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 role)? What impact do these issues have on the individual?*
v. *Which physical conditions contribute to 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?"* (Istanbul Protocol, § 287).

The history of detention and torture, pre-torture conditions, post-torture conditions, behavioural, cognitive and emotional aspects of the individual observed during verbal and non-verbal communications and symptoms with details should be evaluated as a whole. All these findings should be considered altogether. The relationship of individual components with each other should also be taken into consideration.

The relationship and consistency between events and symptoms should be evaluated and described, taking into account the possible influence of psychological symptoms, culture, and physical symptoms such as brain trauma on concentration, reporting, and memory recall, as discussed in more detail above.

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 (Jacobs, 2000).

Behavioral, 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.

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

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

"It is important to recognize that not everyone who has been tortured develops a diagnosable mental illness" (Istanbul Protocol, § 236).

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 (Istanbul Protocol, § 289), The absence of physical and/or psychological signs and symptoms does not invalidate an allegation of torture (Peel et al., 2000).

The medico-legal investigations require understanding of the whole psychological phenomena, not only a diagnosis (Allnutt & Chaplow, 2000). 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.

Besides these considerations, the clinician should also take into consideration the possibility that an absence of symptoms can be due to the episodic or often delayed nature of PTSD or to denial of symptoms because of shame, or other difficulties mentioned above (Istanbul Protocol, § 277).

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 consistency between the psychological findings and the history of the individual should be evaluated as a whole and stated in the report (Istanbul Protocol, § 289).

(See chapter VI in the Istanbul Protocol.)

III. WHAT TO DO IF THERE ARE INCONSISTENCIES IN THE STORY AND/OR IF THE INTERVIEWER/CLINICIAN SUSPECTS FABRICATION?

Be aware that inconsistencies do not necessarily mean that an allegation is false (Giffard, 2000), instead, inconsistencies might indicate precisely the opposite. Inconsistencies in a torture victim's story may arise from any or all of the above-mentioned factors leading to difficulties in recalling and recounting the story (see Part B. "VIII. Factors leading to inconsistencies and difficulties in recalling and recounting the story of torture" in this guide). 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.

It is important to recognize that some people may falsely allege torture for a range of reasons, and that others may exaggerate a relatively minor experience for personal or political gains. 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.

If there are inconsistencies in the story:

- If possible, the investigator should ask for further clarification, (Giffard, 2000).

If this is not possible, the clinician should look for other evidence that supports or refutes the story. A network of consistent supporting details can corroborate and clarify the person's story. Although the individual may not be able to provide the details desired by the 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.

If the interviewer/clinician still suspects fabrication:

- Additional interviews should be scheduled to 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.

(See § 143, § 144, § 253 and § 290 in the Istanbul Protocol.)

PART F

REPORTING

Following the compilation of all the necessary evaluations the clinican should prepare an accurate written report promptly.

When writing a comprehensive report on the psychological evaluation, all the basic principles in reporting should be followed. The report format should be in accordance with the Istanbul Protocol (See Annex IV "Guidelines for the medical evaluation of torture and ill-treatment" in the Istanbul Protocol). These guidelines are not intended to be a fixed prescription, but should be applied following an assessment of the available resources, taking the purpose of the evaluation into account.

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 information gathered during the assessment and his/her own opinion of the situation.

Indeed, since evaluations of torture allegations are not necessarily considered only by specialized health professionals, the language used in the report should be understandable for a larger public. The medical report should be factual and carefully worded. Making the report easy to read and understand is important. Medical or technical jargon should be avoided. If the use of technical terms is unavoidable, their meanings should be explained in parenthesis. (Allnutt & Chaplow, 2000; Istanbul Protocol, § 162).

"[…]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" (Istanbul Protocol, § 162).

I. BY WHOM CAN MEDICAL EVALUATION BE REQUESTED IN THE CASE OF TORTURE ALLEGATIONS?

In some countries, two faulty/wrong practices are often encountered concerning requests for medical investigation:

- Medical evaluation is generally requested by law enforcement
- The request expressed by the alleged torture victim or his/her lawyers is not taken into consideration and is not granted.

However, in the Istanbul Protocol it is underlined that:

- Requests for medical evaluations by law enforcement officials are to be considered invalid unless they are requested by written orders of a public prosecutor
- Medico-legal evaluation of torture allegations should be conducted in response to official written requests by public prosecutors or other appropriate officials
- Alleged torture victims themselves, their lawyers or relatives have the right to request a medical evaluation to seek evidence of torture and ill-treatment
- Alleged torture victims also have the right to obtain a second or alternative medical evaluation by a qualified physician during and after the period of detention.

(See § 123 in the Istanbul Protocol.)

II. WHO CAN OBTAIN THE MEDICAL REPORT?

"The report shall be confidential and communicated to the subject or his or her nominated representative. The views of the subject and his or her representative about the examination process shall be solicited and recorded in the report.[...]The report shall not be made available to any other person, except with the consent of the subject or on the authorization of a court empowered to enforce such a transfer" (Istanbul Principle, 6, c).

"The original, completed evaluation should be transmitted directly to the person requesting the report, generally the public prosecutor. When a detainee or a lawyer acting on his or her behalf requests a medical report, the report must be provided. Copies of all medical reports should be retained by the examining physician.[...]. Under no circumstances should a copy of the medical report be transferred to law enforcement officials[...]" (Istanbul Protocol, § 126).

III. WHAT SHOULD A PSYCHOLOGICAL EVALUATION REPORT INCLUDE?

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

Case information

(Annex IV, section I in the Istanbul Protocol)

(See also Istanbul Protocol, §§ 123-126)

- Exact date, time and duration of the interview/evaluation
- Name and identity of the interviewee
- Description of physical and visible characteristic (e.g. height, weight, eye and hair color, visible scars, age)
- Location, nature, address of the institution where the interview/evaluation is being conducted
- Context of the interview and content of the request such as: who informed, who requested the interview (name, position, affiliation of the requesting person/ authority/institution), by which documents, reason of this request.

Condition and circumstances of the interview/evaluation

- Name, position and affiliation of those accompanying the patient
- The condition of (and/or limitation on) privacy at any time during the interview/ evaluation; name, position and affiliation of those present during the interview and/or during the psychological evaluation, if there is anybody
- Circumstances of the patient at the time of the interview/evaluation (e.g. nature of any restrains on arrival or during the examination, demeanour of those accompanying the detainee or threatening statements or behaviour to the the patient)
- Circumstances of the interview/evaluation (e.g. any inappropriate conditions of the interview room, any threat , oppression to the examiner, any intervention from third parties, any time restriction, any difficulties and/or barriers during the interview/evaluation).

Informed consent

(If no informed consent, the reason should be documented appropriately).

Interviewer/Clinician

- Name, affiliation, position and qualification of the clinician who conducts the interview/evaluation.

Background information

(Annex IV, section IV in the Istanbul Protocol)

(See also Istanbul Protocol, § 136 and § 279)

- General information (age, occupation, education, family composition, etc.)
- Past medical history
- Review of prior medical evaluations of torture and ill-treatment
- Psychosocial history pre-arrest.

History of torture and ill-treatment

(Annex IV, section V in the Istanbul Protocol)

(See also chapter IV, sections E, F and G and § 276 in the Istanbul Protocol)

- Detailed record of the subject's story as given during the interview, including al-

leged methods of torture or ill-treatment, times when torture or ill-treatment is alleged to have occurred should be included
- Summary of detention and abuse, circumstances of arrest and detention, initial and subsequent places of detention (chronology, transportation and detention conditions), narrative account of ill-treatment and torture (with all details, in each place of detention), review of torture methods should be written.

Medical history, physical complaints, symptoms and findings

(See chapter V, sections B, C, D and E and § 281 in the Istanbul Protocol).

Psychological history/examination

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

- Methods of assessment
- Current psychological complaints (for more information see §§ 240-249; § 277, §§ 234-236 and § 254 in the Istanbul Protocol)
- Post-torture history (§ 278)
- Pre-torture history (§ 279, § 136)
- Past psychological/psychiatric history (§ 282)
- Substance use and abuse history (§ 283)
- Mental status examination (§ 284)
- Assessment of social functioning (§ 285)
- Psychological testing, neuro-psychological testing, etc. (see § 286, §§ 293-298 and chapter VI, section C1 in the Istanbul Protocol for indications and limitations).

Consultations

(Annex IV, section 11 – if applicable)

Interpretation of findings – clinical impressions

(Annex IV, section XII)

It should be formulated in accordance with the information given in the Istanbul Protocol (see §§ 142-144, §§ 157-160, § 236, § 253, § 255, § 277 and §§ 287-290) and summarized in the "Interpretation of the findings – clinical impression" in Part E in this guide.

The evaluation report should:

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

(See Annex IV, section XII.2 in the Istanbul Protocol)

(For more information, see also chapter IV, sections A, B, G and L; chapter VI, section C.3 (k) and § 162, § 236, § 253, § 255, § 277, § 289 and § 20 in the Istanbul Protocol.)

Conclusions and recommendations

Should include the following (see Annex IV, section 13 in the Istanbul Protocol):

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

Authorship

- Clinician's signature, date and place.

Relevant annexes

(See also chapter VI, section C.3 and section C.4(b) in the Istanbul Protcol.)

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International Rehabilitation Council for Torture Victims (IRCT)

The International Rehabilitation Council for Torture Victims (IRCT) is an independent international health professional organisation which promotes and supports the rehabilitation of torture survivors and works for the prevention of torture worldwide. The IRCT collaborates with rehabilitation centres and programmes throughout the world that are committed to eradicating torture and to assisting torture survivors and their families.

The IRCT works toward the vision of a world without torture. Specifically, we:

- raise awareness of the need for torture rehabilitation and encourage support for survivors;
- promote the establishment of treatment facilities around the world;
- work for the prevention of torture;
- fight impunity for torturers and work to ensure the rights of torture victims;
- document the problem of torture and collect results of research related to torture; and
- work to increase funding for rehabilitation centres, programmes and projects worldwide.

Recognised internationally for its work, the IRCT enjoys special consultative status with the Economic and Social Council of the United Nations and the UN Department of Public Information, and observer status with the Council of Europe and African Commission on Human and Peoples' Rights.

The IRCT network today embraces 142 member rehabilitation centres and programmes in 73 countries and territories around the globe, providing support and hope for torture survivors, and acting as a symbol of triumph over the terror of torture.

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ISBN 978-87-88882-40-7 (paperback)
ISBN 978-87-88882-42-1 (PDF)

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