GUIDELINES FOR THE EXAMINATION OF SURVIVORS OF TORTURE (SECOND EDITION)

Foreword

Advice on the documentation and assessment of the consequences of abuse and torture has long been needed to help doctors, particularly those with little or no experience of this arduous work, offer the most effective service they can to its victims. As a pathologist for forty years and patron of the Medical Foundation, I am very glad that these Guidelines are now in print to meet that need.

Much of the advice contained in this book concerns the provision of medical evidence to help substantiate (or evaluate) claims of ill-treatment and torture by those who are applying for asylum or sanctuary. In these circumstances a poor report can be worse than none. If a report is incorrect, badly presented or obviously biased, it will be counter-productive.

I have been involved in this work for a number of years, including missions for Amnesty International and I have examined many survivors of torture on behalf of the Medical Foundation. I have to say that I find these tasks much more arduous and upsetting than my usual profession of forensic pathology where I deal with criminal injuries and deaths. There is a cold-bloodedness and premeditation about the abuse of human rights that is even worse than the horrors of ordinary' homicide.

Perhaps child abuse comes nearer torture in its repugnance. Indeed, there is much in common between the medical examination of these two types of abuse. In child abuse, often the child is too young to describe what happened and the perpetrators have ready excuses of accident. Thus greater reliance has to be placed on objective findings rather than witnessed circumstances.

There is also a similarity between the medical examiner of abuse and the forensic pathologist. Both have to remain absolutely impartial and objective, avoiding any hint of bias, despite the highly emotive situation which quite naturally tends to colour the doctor's attitude. Evidence in a criminal court must remain strictly within what can be demonstrated and proven in order to be credible and useful. similarly the reports written by a doctor looking at evidence of torture must be equally unshakeable. There are all too many critics who want to seize on any chance to discredit the allegations of maltreatment. It is not worth even the slightest exaggeration or over--interpretation of the physical findings.

These Guidelines are very timely and potentially valuable. The doctors at the Medical Foundation are to be congratulated on producing such a concise, but comprehensive document.

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Introduction to the Second Edition

The first edition of this booklet was written to assist doctors starting to work (mostly as volunteers) within the Medical Foundation. There was therefore no mention of some of the details which workers in the organisation would be expected to be familiar with already because of their access to the already-established, though hard-won, practical set-up at the Foundation's premises. In the intervening years there has been a steady demand from other organisations for information to assist their doctors, some of them not having the benefit of many of the facilities which we enjoy. Because of this, the new edition has been expanded to include advice on the physical environment best calculated to put clients at ease and ensure that information gained is comprehensive, accurate and confidential. Also included is additional clinical information that has been gathered since the first edition was written.

The vast majority of the medico-legal reports written at the Foundation are at the request of the legal representatives of asylum seekers in order to document evidence of torture, and the text is written with this aspect of the work in mind. However, similar requests for a report on alleged torture may arise in cases where a torture victim is seeking reparation or where an alleged torturer is being brought to trial. Such cases require a higher standard of proof than an asylum claim but the same principles for writing a report apply.

Because of the nature of referral to the Foundation, it is very rare for a victim to be seen immediately after torture. Few are seen as soon as six months and more often it is two or even more than ten years since the last episode of detention. Consequently there is little information in this booklet about examination in the acute period where forensic evidence must be gathered with details of such elements as the torture environment, damage to clothing and incriminating secretions.

The primary function of the Medical Foundation is care, counselling and treatment of torture survivors and the writing of reports is a secondary though very important one. By no means all clients are asylum seekers requiring a report to substantiate allegations of torture which form part of their claim to asylum but their cases need documenting just as rigorously in order to make possible another function of the Foundation - that of documenting patterns of abuse in specific countries or regions in order that the Foundation's unique experience can be put into the public domain. This is regularly being done by the publishing of handbooks and papers.

Doctors, whether staff or volunteer, come to the work of the Foundation with a variety of skills and experience, either through working in different countries or cultures or with different medical and surgical expertise. None are full-time forensic specialists, but all have wide experience in various forms of trauma. We are grateful to all of those who have added to the information in this edition by their suggestions and hints, gained from the writing of almost 1,000 medico-legal reports each year.

SECTION 1

The physical after-effects of torture

Duncan Forrest FRCS

Introduction

Torture is inflicted in many different ways, some of them characteristic of a particular country or culture, others universal. In some situations the torturers do not pay any attention to hiding their work and inflict injury indiscriminately, often leaving gross scarring, fractures and paralyses. In other countries, the torturers are anxious not to leave tell-tale sequelae which could be used as evidence in court and have developed techniques which cause only transient bruising or physical disability. They confine their beating to the early days of detention so that bruises will have faded before the victim has to be produced in court. Psychological methods of torture may be just as damaging as physical yet leave no external mark at all. Nevertheless, in investigating alleged torture, even apparently featureless cases, a detailed history and careful physical examination can often reveal significant evidence or else explain the absence of overt residual signs. Complete absence of any physical or psychological signs must never be construed as proof that no torture took place.

Natural history of wounds

1. The appearance of recent bruising, oedema, abrasions and lacerations may give a good indication of the nature and date of the assault.
2. Often bruising accompanied by petechial haemorrhages reproduces the shape or nature of the weapon used, such as an imprint of a hand on the face.
3. Bite marks may show a characteristic shape, especially on the breast.
4. Bruising caused by blows from a truncheon or stick may show parallel lines ("tramlines")[1]. These may be from one to three centimetres apart depending on the thickness of the weapon and to a lesser extent, on the degree of force used.
5. Bruising may be extreme even after slight trauma in subjects who suffer from such conditions as sickle cell disease.
6. The appearance of lesions changes rapidly and eventually, usually within a few weeks, all signs disappear unless there has been a breach of the full thickness of the skin. There are some exceptions to this rule: in dark-skinned people, even superficial injury may result in permanent increase or decrease in pigmentation: occasionally, injury which caused no breach in the skin may leave subcutaneous fat necrosis, fibrosis or other changes in soft tissue or bone.
7. Abrasions, burns and full-thickness breaches of the skin initially become closed by a scab which falls off after about ten days.
8. In partial skin destruction, the damaged skin at first looks pink but within a few weeks the skin has fully regenerated, including appendages such as hair, and has regained normal appearance. In the case of full-thickness loss, however, the skin is repaired by scar tissue which is at first pink and vascular but gradually fades and after about a year is pale and has reached its permanent appearance.

9. There is no regeneration of hair in the scar of a full-thickness injury.
10. The more recent an injury, the easier it is to date it by the appearance of the wound. The colour of a bruise is not such a reliable indicator of age, even after a few days, as previously claimed[1].
11. The presence of infection makes dating of a wound even more uncertain. After six months it is usually impossible to estimate the date an of injury with any degree of accuracy.

Factors which affect the nature of a scar.

1. Sometimes, for a variety of reasons the scar remains unstable and may continue to itch and scab over intermittently for years.
2. In some cases, most often in dark-skinned subjects or after burns or other irritating forms of injury, the scar becomes hypertrophic. Keloids sometimes become established as soon as six weeks after injury.
3. Shrinkage of the scar varies, influenced particularly by the supervention of sepsis and the time taken for the wound to heal. A deep wound which has been grossly infected will form a scar which becomes puckered and sinks below the general skin surface.
4. Blows which would, when aimed at a well-padded area of the body, cause only transient bruising, will often, if falling on a bony point such as the shin, cause a full-thickness wound, leaving a permanent scar.
5. A blow from a blunt implement on a bony point, especially the skull, may leave a sharply-defined wound which looks incised, though when fresh its margins will show some degree of contusion. The resulting scar will finally be indistinguishable from one caused by a sharp weapon.
6. A blow which has left "tramline" bruising may occasionally, if severe, result in "tramline" scarring or changed pigmentation (Fig.1).
7. A superficial injury which would not leave a permanent scar may, if it becomes infected, become full-thickness, be delayed in healing and eventually form a permanent scar.
8. Some areas of the skin are more susceptible to scarring than others. The skin of the labia, scrotum and penis is notably resistant to scarring. The adjacent skin of the pubic area, however, scars easily.

"Innocent" scars

1. While examining an alleged torture victim it is essential to keep in mind the possibility that a scar may be "innocent", that is, from any cause other than torture.
2. Most scars which result from work, sport or natural accidents are found in the most exposed parts of the body such as the hands or over bony points such as the scalp, eyebrows, elbows, knees or shins.
3. The appearance of scars from accidental burns, whether dry from flame or hot metal or scalds from hot liquids or chemical agents, usually conforms to what would be expected from the history.

4. "Stretch marks" (striae) are of course commonest in women after pregnancy but are also often seen in dark skinned subjects, even the young, athletic and slim. They most often occur around the shoulder girdle, buttocks, hips and across the lower back. They run in roughly parallel wavy lines of fairly uniform length and width and are bilateral though not always symmetrical. They may, however, occasionally result from torture (see below).
5. Acne which has become infected may leave scars on the back as well as the face. They are usually very numerous, puckered and in random distribution. Infected insect bites may leave scars anywhere on the skin, not only on exposed surfaces.
6. Chickenpox is common in some areas such as northern Sri Lanka. The scars may resemble cigarette burns but their distribution is random.
7. Tribal markings are often deeply incised and are usually in parallel lines or patterns, bilaterally symmetrical on the face, trunk or arms.
8. Traditional healing as practised in many countries may leave scars by scarification with knives, razor blades or burning. It may be applied over a painful area on the trunk where the seat of disease is thought to reside and so there are usually a number of similar scars in a circumscribed area.
9. In some West African countries, skin is pinched up and then cut across with a razor blade to produce three or four short fine, parallel scars, usually in groups. This is used to introduce healing drugs or for counter-irritation of painful areas. (There is evidence that it may also be used in torture, see below) (Fig.2).
10. *Girpma*, a traditional remedy used by Kurds to "purify the blood" in infants, leaves a series of vertical parallel linear scars on the back close to the spine.
11. Some adherents of the Shia Islamic sect ritually flog themselves with whips or chains. They may show gross parallel linear scarring on the scalp and back.
12. Vaccination scars, often multiple and puckered, are found on the forearms, thighs and buttocks as well as the more usual deltoid area. BCG scars are single, usually on the deltoid but sometimes on the back of the elbow or buttock. These scars are usually depressed but may become keloid.
13. An operation scar is usually recognisable and its situation gives a clue to the organ that was involved, for instance a Caesarian scar, though some surgical procedures may be bizarre and the subject may not know what was done to him .
14. Women who have been subjected to female genital mutilation may present an appearance that could be confused with the results of torture.
15. Women who have had a traumatic vaginal delivery (which would be more common in poor countries) may show varying degrees of perineal damage, even including tears of the anal sphincter. These tears may never have been repaired.
16. Self-inflicted scars may be confusing. Their situation depends on whether the subject is right or left handed. The usual sites chosen are the wrists and forearms, trunk or back. They are often multiple but are usually fairly superficial.
17. Wounds may be inflicted by others at the behest of the subject in order to attain some political, social or legal objective. They may be in sites unreachable by the subject such as the back, but are unlikely to be very numerous.

Immediate effects of torture

Many of the appearances within a few days of torture are similar to those of any "innocent" trauma and are present for only a few days before they fade, leaving no trace. Authorities often counter accusations of torture by saying that the victim was injured while resisting arrest. There are some features, however, which may give a clue to the deliberate nature of the assault.

1. Bruising may be very widespread and in situations such as the face, back or soles of the feet which are areas which most often bear the brunt of deliberate blows.
2. Bruises may indicate the nature of the blows, such as the shape of a hand on the cheek or "tramline" linear bruising on the back after beating with batons or canes.
3. Deeper wounds may show a regular pattern, indicating that they were deliberately inflicted.
4. Circumferential weals round the wrists or ankles indicate restraint and perhaps suspension.
5. Wounds, fractures or dislocations or bleeding from the nose, ears or teeth which may be similar to accidental injuries may be convincingly explained if a detailed history can be obtained.
6. The psychological state of the victim is usually at its most disturbed in the immediate aftermath and though the victim may not be able to give a coherent account, his demeanour may be revealing.

Scars from torture

After the immediate effects have faded there are features which may make it possible to distinguish them from "innocent" ones.

1. Scars resulting from **beating or whipping** are often found on the back or buttocks, where they tend to be fine and linear, parallel or criss-cross (Fig.3). They will also be seen over bony points where they tend to be circular. If the victim's hands were free, he will often use his arms to protect the face, and scars will be found on the backs of the forearms and hands rather than the face. The type of implement used influences the nature of the scar. Truncheons and thick sticks (such as Indian *lathis*) usually leave no permanent scar unless very violent, when they leave wide linear scars or "tramlines" on soft parts[1] and circular scars over bony points, whereas thin canes such as rattans or whips made of leather, fan belts or electric cables are more likely to leave scars, usually sharply demarcated, fine and linear. Belts with metal buckles such as the Zairean *cordelette* leave a mixture of fine linear scars and circular or ragged, often keloid, scars where the skin has been ripped by the buckle or metal bosses. Rifle butts often leave ragged, puckered scars over bony points. It must be emphasised that even the most violent beating may leave no permanent trace. Often torturers use devices to avoid open wounds but not decreasing the pain, such as using sandbags or plastic tubing filled with sand or metal, beating over clothing or covering the back with towels.
2. **Beating on the soles of the feet** (*falaka, falanga, bastinado*) is used especially in Turkey but also throughout the Middle East, India and Sri Lanka. It causes immediate gross swelling and exquisite pain on walking, but, although striking late signs such as "smashing" of the ball of the foot or excessive dorsiflexion of the great toe can occur as reported from Denmark[2,3,4] and persistent evidence of changes on scintigraphy as reported from Turkey[5], we have

seldom been able to demonstrate these. There is usually deep tenderness on the ball and heel, but only occasionally thickening of the plantar fascia or deformity of the metatarsals or digits due to old fractures, or damage to the toenails. It is important to emphasise that gross findings are the exception rather than the rule. Many subjects, however, complain of pain on walking moderate distances for several years afterwards and characteristically suffer burning pain running up the legs in bed after a strenuous day, and may seek relief by walking on a cold floor or bathing the feet in cold water. If the beating has caused open wounds there may be residual scarring or pigmentation on the soles but these may be difficult to distinguish from natural injury in subjects who have been used to going barefoot.

3. **Kicks** usually produce more or less circular scars over the knee-caps, shins and ankles. Kicks to the trunk do not usually cause skin lesions except over bony points but may leave evidence of fractured ribs or ossified sub-periosteal haematomata. There may be a history of haematuria immediately after, or of ruptured liver or spleen which had required a laparotomy and will therefore show a surgical scar.

4. **Dragging along the ground** may produce parallel longitudinal scars along one side or the back of the body, characteristically involving those areas which would be most likely to come in contact with the ground. .

5. **Burns** from torture can usually be distinguished from accidental burns only by a convincing history. Indications that they may have been deliberately inflicted are if they are multiple in widely separated situations. Hot metal such as branding irons, heated iron bars or heated knives may leave a characteristic pattern (Fig.4). Acid or caustic burns may show the posture of the victim at the time (Fig.5). A burn on a woman's thigh or trunk in a situation which would not be exposed in normal life is persuasive evidence of torture, especially in one from a culture where modesty is required.

6. **Electrical burns** leave permanent scars only if the electrical energy has been delivered over a very limited area, such as in the South American technique of *picana* where shocks are delivered through pointed electrodes often in a target area such as the nipples, lips or ear lobes where fine white linear or puckered circular scars or groups of red, punctate marks may be found. Scars on the genitalia (a frequent site of electrical torture) are rare because the skin of the scrotum, penis or vulva does not scar easily. If there is a history of electricity having been passed through clips applied to the skin, there is more likelihood of permanent scarring and it may be of a characteristic shape (Fig.6).

7. **Cigarette burns** leave circular scars whose appearance depends on the length of time the lighted cigarette has been in contact with the skin. If it has simply been touched to the skin, there may be little or no permanent scarring, or be indistinguishable from acne or an insect bite, but if contact has been prolonged and the cigarette has been actually stubbed out on the skin, then there is often a deep, puckered circular scar with a thin, silvery surface, a pigmented rim and sometimes a central papilla. The victim may be able to describe the manner in which the cigarette was applied. Deliberately inflicted cigarette burns are applied to a part of the body which was easily accessible to the interrogator, e.g. on the front of the thigh or back of the forearm or hand if the victim was seated strapped to a chair. The fact that they are often distributed in a regular pattern such as a line or rosette, makes them one of the few types of scar which can categorically be stated to have been deliberately inflicted (though they must be distinguished from innocent causes such as vaccination or ritual scars) (Fig.7).

8. **Stab Wounds**. Stabbing with a knife characteristically leaves a fairly clean 1-5cm linear scar. A bayonet, which has one sharp edge and one blunt one, may leave a slightly teardrop-shaped scar, sharply pointed at one end and rounded at the other. There may occasionally be evidence of underlying muscle or nerve injury. A pointed stick used to prod the victim may leave a 1cm circular scar rather like a cigarette burn.
9. **Razor Cuts**. In West Africa these have reportedly been used for torture as well as innocently for treatment (See Page 4). They may be used as a means for the prisoner to be identified in future arrests or simply as a painful torture. Chilli paste or other irritant is sometimes rubbed into the wounds to add to the pain and to impress upon the victim that he is being given "bad medicine" or poison (Fig.8).
10. **Finger and toe nails** are often crushed or removed with pliers, or pins or splinters pushed under them. The end result may be a thickened and distorted nail, not easy to distinguish from innocent trauma or infection, but sometimes the nail re-grows normally. Scars on the sides of the fingers may be evidence of rings having been torn off.
11. **Ligatures, handcuffs and shackles** do not always leave permanent scars. The history can give an indication as to the likelihood of scarring by the length of time applied, the nature and tightness of the device and the immediate damage to the skin or deeper tissues (Fig.9). Scars tend to be circumferential, giving good evidence of their nature, but may only be present over the bony points of the wrists or ankles. Occasionally, there are simply lines of depilation rather than actual scarring.
12. **Ear lobes** may be lacerated because ear rings have been torn off.

Postural and other injury

1. **Neurological damage** may be due to a penetrating wound, suspension/traction or compression. The neurological picture can often be explained by the described torture. There may be pain, often with a psychosomatic element, sensory change, weakness, wasting, or loss of deep reflexes. It should be possible to distinguish between cord, root, or peripheral nerve damage. There may be a history of sensory loss after trauma which has recovered but followed by wasting or weakness. Neurological deficit may result from the nutritional deficiency of long detention.
2. **Fractures and dislocations** may result from a wide variety of deliberate assaults including direct violence with heavy weapons, twisting of limbs or dropping from a height. Distinguishing them from accidental injuries depends on their nature being consistent with the history.
3. **Vascular damage** may result from compression or direct violence. A history of acute swelling or colour change may give a lead. Diminution or loss of peripheral pulses may be detected.
4. **Persistent pain and stiffness** in the neck, back, hips and knees is complained of by almost all torture victims. This is not always easy to explain and there is often a strong psycho-somatic element, but it could be due to repeated direct trauma, to desperate attempts at avoidance during torture, or adverse prison conditions in a cramped, damp cell. Characteristically there is tenderness over the cervical and lower thoracic or upper lumbar spines and muscles, and pain on movement in the neck, flexion of the back and all movements of the hips and knees. Physical examination may show loss of normal contour,

and x-rays of the cervical and thoraco-lumbar spine may reveal pathology such as ankylosing spondylitis, spondylolisthesis or narrowing of a disc space, though such pathology is most often due to causes other than torture.

5. **"Palestinian hanging"** (Fig.10) in which the whole body weight is supported from the wrists or arms tied behind the back with extended and internally rotated shoulder joints, often results in some degree of permanent damage to the shoulder girdle. Many victims faint after a few minutes, so do not know how long they have been suspended, probably only for a few minutes at a time, but often repeatedly. At first, the muscles around the shoulder protect the joint, but when they become fatigued, the whole weight of the body falls on the capsule and ligaments of the joint and the lower roots of the brachial plexus are stretched. One or both shoulder joints may dislocate. Physical signs, even some years later, are painful limitation of all shoulder movements, with the joint occasionally completely frozen. Occasionally there is recurrent dislocation. More commonly there is winging of the scapulae due to a lesion of the long thoracic nerve, which may be missed unless looked for. Stretch marks are occasionally seen in the skin over the anterior shoulder. They may be attributed to Palestinian hanging but stretch marks are sometimes seen in this location in dark-skinned subjects who have not been hung.

6. Suspension over a pole in the **"parrot's perch"** ("*pau de arrara*") may leave serious nerve damage or rupture of the cruciate ligaments of the knees (Fig.11).

7. **Forcible abduction of the hips**. *Cheera*, (tearing), *Manji*, (stretching) (Fig.12) is found in India and Pakistan. The victim is usually sat on the floor with a man behind him with a knee in his back and pulling the head back by the hair. The legs are then forcibly abducted to 180 degrees repeatedly or held for half an hour or more[6]. The victim sometimes describes a tearing sound followed by the appearance of gross haematomata in the groins where the adductors have been avulsed from their origins. The long-term result is pain and tenderness in the muscles round the hip joints, especially the adductors, and pain on walking. Running, squatting or sitting cross-legged may be impossible. Occasionally there are scars on the inner aspect of the thighs where kicks have been delivered and stretch marks have rarely been observed in the groins (a most unusual situation for them).

8. **The *Ghotna*** is a thick wooden pole, about 4 feet long and 4 inches in diameter, used in India as a pestle for grinding corn and spices. *Ghotnas* are kept in many police stations, (or there may be similar specially-made implements of wood, metal or stone, often very heavy), and used in several ways for torture: (1) Placed between the thighs and the knees then tied tightly together with ropes or cloths. This may lead to vascular damage. (2) The *ghotna* may be placed in the popliteal fossa and the knees forcibly flexed over it (Fig.13). (3) The most common method: with the subject lying supine, the *ghotna* is placed on the thighs or sometimes the back, two or more men stand on it as it is rolled up and down the thighs or back (Fig.14)[6]. This causes gross destruction of muscle, occasionally resulting in early death from renal failure due to crush injury[7,8] or later with permanent disability but no outward signs apart from abnormal tenderness in the muscles which have been traumatised. If the *ghotna* is rolled over bony points such as the iliac crest or shins, the skin may be rubbed off, leaving extensive scarring, but the torturers are usually careful to avoid this by confining their activities to soft tissue areas.

Internal injury

1. **Blows to the head** by a heavy weapon such as a rifle butt may produce a traumatic cataract or retinal detachment, sensori-neural hearing loss, fractured nasal bones, septal deformity and anosmia, loss or loosening of teeth, lacerations of the tongue or mucosa of the cheeks. Punches or blows directly to the ears, slaps by the open hand or a wet towel may rupture eardrums or, very rarely, dislocate ossicles. A very severe blow can also produce a perilymph fistula - either by displacing the stapes or occasionally by rupturing the round window membrane - this is usually associated with vertigo and an initial severe or fluctuating deafness usually progressing to a total loss on the affected side. Otitis media may follow direct blows to the ears. None of this is specific to torture but depends on the history. If there has been a history of concussion, especially if repeated, epilepsy may supervene. Since the temporal lobe is the usual site of trauma, the subject may not necessarily say that he has had fits or blackouts but only complains of dizziness, poor memory or olfactory attacks, often followed by a headache. Here again the history is important because only if there is no record of previous attacks can the diagnosis of post-traumatic epilepsy be entertained. There may be evidence of loss of short-term memory, confusion or dementia, sequelae which are difficult to distinguish from the common psychological effects of stress and may require specialist consultation and perhaps further investigation with imaging techniques. They can seldom be proved to have been caused by deliberate violence, though their existence may fit in with details of the history.
2. **Vigorous shaking** has been shown to cause cerebral and retinal haemorrhage, sometimes fatal, (adult shaken syndrome)[9]. Survivors may be expected to show similar effects to the above.
3. **Fractures** are frequently badly treated or completely neglected in the context of torture and so may show gross mal-union or even non-union. The same may be the case in warfare or civilian life in undeveloped countries so minute details of the history become important in considering credibility.
4. Imprisonment in **complete darkness or exposure to bright lights** or the sun often leads to long-standing photophobia and lachrimation, though there is seldom any demonstrable pathology.
5. **Repeated ducking** under water to the point of drowning, ("*submarino*", "*chiffon*") may lead to persistent lung pathology such as emphysema, especially if the water used is contaminated, though any causative relationship would be difficult to prove. Where the ear drums have previously been ruptured or a pre-existing perforation exists, immersion may induce middle ear infection.
6. The presence of a **stress ulcer** may be suggested by epigastric tenderness. Peptic ulcers may also be caused by the forced ingestion of noxious substances or bad diet in prison.
7. **Swallowing of caustic or acid** may result in oesophageal stricture.
8. **Abdominal surgical scars** may confirm a history of splenectomy or nephrectomy following trauma.
9. **Renal trauma** may result in loin or suprapubic tenderness or haematuria. Frequency and dysuria are common but usually have a psycho-somatic element. It is unusual for urological investigation to reveal any pathology.
10. **Hernia or hydrocele** may or may not be post-traumatic.

11. **The vas deferens** may be palpably disrupted or, if there has been infection, thickening may be felt.

12. **A testis** that is smaller than its fellow, especially if normal sensation is reduced, is very suggestive of past trauma. Many male victims believe themselves to be impotent or sterile. This may be the result of actual trauma but more often results from psychological conditioning by the torturers who routinely threaten to destroy the victim's manhood by blows or electric shocks[10].

13. **Penile trauma** leaves scarring on the skin only if there has been gross violence, though the underlying corpora may be fractured, leaving palpable thickening. Hesitancy or dribbling micturition may indicate a urethral stricture.

14. **A meatal stenosis** is visible and a stricture of the anterior urethra may be palpable. These may result from insertion of foreign objects with or without electrical shocks and be followed by chronic infection. Such urinary trauma requires full specialist investigation.

15. **Rape or other sexual abuse** either vaginal or anal seldom leaves any long-term trace in the genital area because the skin in this area usually heals quickly. Immature girls and post-menopausal women are more vulnerable to local damage though they also usually heal quickly. Scars if present may be difficult to find. However, especially if penetration has been caused by very violent insertion of rigid objects such as bottles or truncheons, there may be obvious scars in the vulval or perianal skin or even gross destruction of the perineal musculature. These need to be distinguished by their location, shape or direction from scarring caused by traumatic childbirth or female genital mutilation. There may be scars on the trunk or thighs resulting from scratches during a struggle. The distinction between trauma and "natural" anal fissure or haemorrhoid is impossible to make unless the scarring is gross or in an unusual position. Fissures may have been induced by constipation as the result of prison conditions and continue to cause pain or bleeding long afterwards. In some countries an important complication of sexual abuse is the development of one or more sexually transmitted diseases.

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SECTION 2

The psychological assessment of torture victims

Francoise Hutton

Introduction

As part of a general examination, it is always important to assess the mental state of a patient. There is no set way of doing this. Some persons open up spontaneously during the interview and it is best to follow their lead. Others may be more reserved. It is essential initially to try and establish some trust by allaying fears about the purpose of the interview, and by showing an interest in helping rather than in intruding or testing. The physical examination may in fact help break the ice. An open general question about current mood, feelings or worries may then facilitate a response. This can be followed by focussing on specific difficulties that come up. The aim is to clarify quite carefully the feelings experienced and actual preoccupations without resorting to leading questions. It may also be of interest, provided it does not seem intrusive, to find out a little about the refugee's background in his/her country, not particularly to establish any fact relating to torture, but to have a better image of him or her as an individual.

Findings

While there is no psychological symptom or disease entity which is specific of torture, its victims often suffer from distressing psychological problems. These are important to assess, even though they may not always be linked with the experience of torture but often with loss, grief, current fears of repatriation or social problems.

Major mental disorder, such as schizophrenia, manic depressive illness or florid psychoses are quite rare in our patients, as they are in the rest of the population. Even when they are present, they are usually found to have nothing to do with the experience of ill treatment and to have existed beforehand. However there is a possibility that a traumatic experience may have made the condition worse.

Anxiety, depression, paranoid feelings, psychosomatic conditions are, on the other hand, quite common and tend to overlap.

Anxiety

There may be vague 'free floating" anxiety with general tension or more specific fears:-

of going out, of being in crowds, of seeing police or military uniforms.

of being indoors, afraid of footsteps or sudden noises.

Panic attacks are common.

Bad memories may intrude spontaneously, or there may be recurring nightmares.

Psychosomatic symptoms

Unexplained back or neck pains, headaches, muscular tension, heart throbbing, palpitations, chest pains, hyperventilation are all common. In many non-western cultures somatic expression of distress is very common and pain may be, for instance, an expression of tension or anger. Some refugees are also preoccupied with fears that their body has been seriously and permanently damaged by the violence they have experienced.

Sleep problems

Many patients have severe sleep disturbance. Questions about sleep and what disturbs it are very informative. Sleep-deprived people tend to function poorly; memory, concentration and cognitive skills are all impaired.

Depression is suggested by:

loss of interest and energy, feeling numb, dead.

poor concentration, poor memory (worse subjectively than objectively).

Severe insomnia, waking up in a terrible state in the early hours of the morning.

Feeling sad, crying a lot. Intense guilt. Pessimism about the future. Sense of life being pointless, or even unbearable.

There is a wide range of feelings from realistic unhappiness and sense of loss to real despair and suicidal feelings. It is therefore important to assess how disabling or even dangerous the depressive state may be.

Paranoid feelings

Some suspiciousness may be realistic given the circumstances, but some refugees feel that every one is trying to test them and trip them up, including the interviewer, or that people are watching them and talking about them all the time, for instance in our waiting room. Such paranoid feelings do not usually amount to a true psychotic state. Misinterpretations of reality tend to be transient and to occur mainly under stress. However, they may be quite disruptive socially, particularly in dealing with officials. Such states are often associated with depression, but not always.

Post-traumatic stress disorder (PTSD)

This concept is somewhat controversial because it implies a definite causal link between symptoms and experienced or witnessed trauma, although there is no form of psychiatric illness that can be said to be specific of trauma, let alone of torture. However PTSD is not a disease entity, but a syndrome with very definite features which are well described in the current DSM-IV (see appendix). The symptoms are not only aspects of a long standing anxiety state. They also indicate that an original traumatic event is being re-experienced, recurrently and intrusively, through dreams, flashbacks (often associated with dissociation).or intrusive memories. There is an avoidance of anything likely to bring back painful memories such as talking about them, and

there is also often a self- protective emotional numbing and withdrawal, as if to avoid painful feelings altogether. Yet patients may be on edge, on the alert, apt to startle and over-react to stimuli, and easily irritable. PTSD is only ever considered as a diagnosis if the symptoms have been persistent and disabling for at least three months and the subject has been under review for a prolonged period.

It is quite possible for some people to go through the most terrible ordeals without developing any symptoms of PTSD or other serious psychological symptoms beyond a natural increase of anxiety and perhaps an occasional nightmare.

Clients who have witnessed friends, relatives or even strangers (particularly children) being tortured are often more haunted by such memories than by what happened to themselves. There may also be terrible guilt when they know or suspect that a relative has been tortured because of their own escape from the country.

Victims of rape

They may have any of the problems listed above or none. In addition, like other victims of sexual abuse, they may feel dirty, ashamed, afraid of men, and may suffer from sexual dysfunction in their marriage which does not always resolve itself if they have a baby. They may also worry about AIDS to the extent of requesting an HIV test.

In some cultures, nudity carries much shame and being stripped naked can leave terrible humiliation behind. Similarly, in such cultures, insulting obscenities can make women feel profoundly degraded. Such experiences are often impossible to share with relatives or with anyone and may only come out if the client feels very safe with another woman.

Male rape also carries terrible humiliation and shame. It is often denied and only admitted later. Men do not always find it easier to talk about this to another man if they feel that they have lost something of their manhood.

Observations

Since all feelings described are inevitably subjective, one has to try and form some opinion of the subject's personality. Is he someone who tends to exaggerate his problems or to minimise them? Is he trying to make a specific impression? Is he reticent because of genuine difficulties such as fear or shame, or is he deliberately evasive? A few objective observations may be helpful, although much doubt may remain.

Anxiety may show physically by tremor, sweating, tachycardia, and visible muscular tension.

Rapid eye movements while unresponsive to questions is sometimes seen as a subject relives a particularly traumatic experience.

Very depressed subjects often look ill. They may appear to have lost weight and look wasted. They may be slowed down, vague, clearly unable to concentrate on questions. This may contrast with a history of good academic or professional achievement. Others may be agitated, tearful or angry.

Sometimes the possibility of brain damage has to be considered especially after a history of blows to the head. There might be peripheral localising signs, but this is quite rare. A

cognitive assessment tends to be difficult with language and cultural problems and with little knowledge of previous functioning. However, it is possible to test roughly orientation and short term memory, to find out whether a name or a picture is remembered after a few minutes. Sometimes an informant is available to say, for instance, that the subject cannot go out alone and gets lost even on a familiar route. Without imaging techniques it can be difficult to distinguish organic impairment from functional loss of concentration and vagueness due to severe depression or anxiety.

Inappropriate agitation and anger are also often noticeable in paranoid patients (sometimes already in the waiting room) They are very apt to misunderstand what is said to them in the interview in some persecutory way. Cultural barriers and current emotional factors have to be kept in mind as they well be the main cause of such behaviour.

Evaluation

It is not easy to know how much of what is described or observed may be linked with an experience of ill treatment such as torture or rape.

Very often, subjects appear to be mainly preoccupied with "the ordeal of being a refugee", with current social problems, realistic feelings of loss, or anxiety about the outcome of an application or an appeal. Such problems may well be enough to account for their state of mind. Yet sometimes depression and anxiety may persist, or even worsen, once the practical problems have been resolved.

The diagnosis of PTSD has both psychiatric and legal recognition and is widely used in personal injury claims. But the problem, with torture victims is that the existence of the original trauma is in some doubt, and it is not possible to conclude retrospectively from symptoms that the alleged traumatic episode has definitely taken place. Unfortunately, the most specific symptoms of PTSD (intrusive memories, nightmares which repeat the event experienced) are subjective and easy to learn about. Signs that can be easily observed, such as hyper-arousal or lack of emotional responsiveness are much less specific, and they could also be faked. Occasionally, there may be more or less reliable witness accounts of refugees causing concern in their hostel by screaming or shouting in the night during their nightmares, or having alarming dissociative episodes during flash-backs, but such objective evidence is rare.

However, similar objections can be raised against most psychiatric or psychological medico-legal findings and yet lawyers often take them into account.

Conclusion

Perhaps the main point of the psychological assessment is to convey in simple language a fairly clear picture of the patient's state of mind, with emphasis on the aspects which seem "more likely than not" to be related to an experience of persecution. Whether one uses the concept of PTSD or not is debatable, but detailed evidence of the patient's continued suffering, both subjective and, whenever possible, based on observation, is likely to be relevant, in spite of scientific limitations

A definite diagnosis (for instance of clinical depression) can sometimes be made but a psychiatric diagnosis is often not at all appropriate and it can be unhelpful to "medicalise"

refugees too much, especially as cultural factors tend to limit the exactitude of psychiatric examination. .

Some comment may need to be included in the report as to whether the refugee's state of mind seems to be mainly affected by current stresses or by his past experiences, or is an interplay of all these factors which cannot be disentangled.

Finally, if the report indicates serious concern about the psychological state of the refugee, some suggestion or decision should be made concerning possible treatment, referral or follow up and it should be mentioned in the report. In that context, it may be appropriate, in some cases, to point out risks of serious breakdown or suicide if the refugee is submitted to too much on-going stress.

SECTION 3

Guide to writing medical reports on survivors of torture

Edited by Duncan Forrest

The role of the medical expert

1. Although examination of patients is essentially the same whether they are seen for medico-legal purposes or have simply come for advice in a normal consultation, there are differences in the way they are referred and seen. Though medico-legal reports are basically the same, reports after torture are different in some respects. These guidelines describe these differences and highlight points which the doctor preparing a medical report on an alleged torture victim should bear in mind.

2. If a report is required for a criminal case such as in the prosecution of an alleged torturer, the level of proof is "beyond reasonable doubt". If it is for a civil trial such as torture victim seeking redress, the level of proof is lower – "on a balance of probabilities". For an asylum application – in the United Kingdom at least – the level of proof as determined in the House of Lords in the case of Sivakumaran, is lower still – "a reasonable degree of likelihood". Whereas in a criminal case there may often be a need for additional proof provided by imaging, biopsy or laboratory tests, (though in many instances these will not produce any additional information), in an asylum case clinical examination alone will usually suffice. Nevertheless, whatever the object of the report, the history-taking and clinical examination must be rigorous. The doctor should always bear in mind while preparing a report that it may be necessary to defend any statements under cross-examination in court. Though this section relates mainly to asylum reports, much of the advice is equally relevant to other circumstances.

3. Cases referred for medical examination are selected by legal representatives who consider that there may be medical evidence to support an allegation of torture. The legal representative, who represents his client's interests instructs the doctor who is, therefore, in the position of an expert witness. The doctor is asked to prepare a medical report outlining what, *if any,* injuries have been suffered as a result of torture, the role of other pre-existing or coincidental factors, and some form of prognosis. The role of the expert witness, as defined by the court, is to give objective, impartial advice based upon his clinical and professional experience.

4. The doctor should be aware that the solicitor is instructed to represent his client's best interests and will be concerned to present such evidence as will assist him in advancing his case. The solicitor is under no obligation to inform the doctor of any facts that he knows which are adverse to his client's case. The doctor must not assume that the solicitor has related all the material facts. The onus is upon the doctor to discover and report upon any material features which he considers relevant, even if they may be adverse to the case of the party instructing him. The solicitor does, of course, run the risk of his medical expert having no credibility at all if that expert has not taken into account material features relating to the history and he may decide not to submit the report to the court.

5. The medical report should be factual, detailed and carefully worded. It is important to be aware how easily medical evidence and jargon can be challenged and the doctor should avoid making assertions that could not be defended in court. Since the report will be read mainly by non-medical officials, abstruse medical terms should be avoided, or if they must be used, they should be defined. Descriptive terms, such as *falaka*, should also be defined.
6. The examination should ideally be done by a doctor with knowledge of the prison conditions and torture methods in use in the particular region, and their common after-effects.
7. All relevant sources of information, e.g. Immigration Service or Home Office interview record or the subject's self-completed questionnaire for his claim to asylum, legal representatives' deposition, caseworker's report, findings by other doctors, which are available should be perused before proceeding to the medical examination. A list of these sources should be recorded in the report so that the reader will be able to judge how the report relates to them. Rarely the subject will have photographs of the acute lesions, and these can be very helpful in giving an opinion on the cause of the late signs. However, before citing such photographs in an expert report, it is essential to be certain of the date of the photographs, and that they really are of that subject.

The environment of the interview

1. Many torture survivors have had bad experiences with doctors who in their home country may be unsympathetic employees of an oppressive state or even complicit in torture. They may therefore be apprehensive about being interviewed by a doctor and it is important to begin by putting them at their ease and giving a full explanation of one's role and independent status.
2. Subjects' fears that details obtained at the interview will be seen by possibly hostile agencies must be dispelled by reassurances that any information will be treated as strictly confidential and that the report will be given only to the subject's solicitor. The interviewer must seek written permission to show the report to any third party such as the general practitioner or social worker.
3. It is helpful to greet the subject in the waiting room, observe his general demeanour and watch him unobtrusively as he rises to his feet, walks and climbs the stairs to the consulting room..
4. The consulting room should be furnished informally and comfortably. Rather than conducting an interview across a desk, it is preferable for the doctor to sit directly facing the interviewee, with the interpreter, if present, completing a triangular setting.
5. The environment is not as easy to arrange when a client is being interviewed in a prison or detention centre. If possible it is better not to accept a legal interview room which is usually very small with no facilities for examination, but to insist on a medical room with a couch and good lighting. However, it may be better to produce a limited report and note the constraints if the alternative means a further delay or to take a history on the first visit and arrange a further appointment to conduct the physical examination in more suitable surroundings.
6. Unless there is a good reason to the contrary, female patients are seen by female doctors and with female interpreters. This is because there is frequently a history of rape that she may be unwilling to discuss in front of males, and this history is not always known at the start of the

interview. It is also necessary for the patient to expose all her body in stages to the doctor, and many female asylum-seekers are uncomfortable to do this in front of a male doctor. For men, particularly those who have been sexually assaulted in detention, the situation can be much more complex. In general they should be seen by a male doctor, although occasionally men prefer to talk about sexual abuse in front of a female interpreter, because describing it in front of a male of their own cultural background is too humiliating.

7. The Medical Foundation has established a large panel of interpreters from many countries. They all have expertise in medical terminology and have been trained in the ethics of this specialised profession. In other organisations it is not always easy to provide suitable interpreters but every attempt must be made, not just to obtain someone who is familiar with the language (remembering that many languages have dialects which may make understanding difficult) but also of a compatible ethnic, religious and political background. He is not the subject's advocate and must be free of bias or prejudice and make sure that he translates the questions and answers accurately without a personal slant. If the subject expresses doubts or fears about the credentials or competence of the interpreter the interview must be postponed until his doubts are allayed or a more sympathetic interpreter is found. It is not a good idea to use a relative or friend of the subject, though they can sometimes be valuable sources of additional information.

8. The consultation starts with the doctor introducing himself and explaining the purposes of the interview. The interpreter, if present, will introduce himself as well, and say a few words about his independence and confidentiality.

9. The doctor should establish eye contact with the subject and questions should be directed at him rather than the interpreter. Say to the subject " What happened to you?" rather than to the interpreter "What happened to him?" It is important to avoid a situation which sometimes arises in which a *tête-a-tête* develops between the subject and interpreter or else the interviewer and interpreter and the third person is left out. Though the interviewer may not understand the language being used, it is important for him to keep watching the subject because much can be gleaned by observing his demeanour as he speaks.

History

1. As is normal medical practice, a full medical history should be taken, including relevant family and social history and previous medical and psychiatric history before proceeding to examination. The history and the subject's demeanour as he gives it may reveal much more about a subject's experience of torture than does the physical examination.

2. Doctors at the Medical Foundation come from a wide variety of medical backgrounds, and the exact form of consultation depends very much on their personal preferences. Some start by discussing the past and social history of the subject, to put the experiences of detention and torture in context. Others open by asking questions about the current physical and psychological state. The third option is to start by asking directly "when was the first time that you had problems with the authorities in [your country]?". This then structures the consultation in the same form as the final report. All three sets of information need to be sought, and generally it does not matter in which order. However, sensitivity to the reactions of the subject means that any line of questioning can be deferred until he is ready to talk about it.

3. It is important, as far as possible, to avoid asking leading questions, where the form of words or even the tone of voice may suggest a certain answer. Nevertheless, it is impossible to learn everything important without steering the conversation at some stage. This can be done by a question such as "Can you tell me what happened in March 1997?" Avoid list questions. If the correct answer is not on the list, the subject may give a wrong answer or else become confused. The subject may be inhibited by a number of factors: he may consider some facts not worth mentioning because they are taken for granted in his culture; he may have forgotten details; some items may be part of a cultural taboo; some symptoms may not seem relevant to him, for instance, hyperventilation; often the memory of torture, especially if it involves sexual abuse, may be so painful that the subject cannot bring himself to speak about it.

4. As is common in any medical consultation, the subject may be unable to give a detailed account at a first interview. He may have been blindfolded, confused and partially or completely unconscious during or after torture. There may have been many detentions spread over a number of years. Some time may have elapsed since the events, and there may be psychological sequelae. It is normal for an interviewee to be nervous, unsure and confused. It is most unusual for subjects to recall in exact detail all dates and aspects of repeated detentions. He may be reluctant to disclose details which he fears may implicate relatives back home. For these and other reasons it is sometimes valuable to build up a history over more than one session, saving the more intimate details for a subsequent session. In any case, a sitting of more than one and a half hours is likely to exhaust the subject as well as the interpreter and doctor.

5. The subject may be in a highly complex emotional state. This may make giving a history a severe ordeal for the subject who relives experiences which are often extremely distressing. For this and other reasons, it may be wise not to stick too rigidly to the convention of taking the history before the examination, but to elicit some aspects of the history while the physical examination is taking place.

6. Consistency and credibility are continuously assessed as the interview and examination proceed. In coming to a conclusion, the doctor must make a series of judgments, assessing the subject's demeanour as well as the history and physical signs. Allowance may have to be made for psychological factors that disturb the subject's demeanour, for instance, if he has a flattened affect or is unable to maintain his concentration or his responses are illogical and he finds difficulty in giving a coherent account.

7. Details of detentions include:

   Prison conditions: Poor prison conditions are noted, including any withholding of food and drink or forcing contaminated food or drink; withholding toilet and washing facilities; withholding or provision of medical treatment; confinement in total darkness with intermittent exposure to bright light, in extreme heat or cold, in small or unacceptably crowded cells, or where the floor is wet, infested or covered in excrement. The motive in seeking these details is partly to aid the assessment of credibility, but mainly for its relevance to physical or psychological ill-effects. It need only to be sufficiently detailed to meet these aims.

   Psychological torture: Testimony is recorded of details such as solitary confinement; sensory deprivation; mock executions; provocations, insults and threats during torture; enforced witnessing of the torture, rape or execution of family members or others.

Physical torture: Information is recorded on the frequency, timing and duration of any torture sessions, number and profession of assailants, e.g. police, soldiers, security guards or prison officers, and whether a doctor was involved.

8. The record of the torture itself includes:

   Type of weapons used, parts of the body attacked, posture adopted, physical restraints, suspension and the use of blindfolds, hoods or "Apollo" helmets, etc. Often the subject will mime the postures and nature of the attacks, giving a vivid picture and adding greatly to credibility.

   The immediate effects: whether the subject could see his assailants and the weapons they used; whether he became confused or disorientated or partially or completely unconscious; whether unconsciousness was thought to be due to blows to the head, extreme pain or exhaustion; whether protective strategies such as hyperventilation were used; whether he could walk unaided at the end of the torture session or was dragged back to his cell.

   The after-effects: the presence of bruising, blistering, bleeding, open wounds or other injuries immediately after abuse; the length of time taken for healing and whether wounds became infected; other physical symptoms such as vomiting, haematuria, internal pain, loss of function or sensation, dizziness or disturbance of sight or hearing; whether or not any medical assistance was offered at once or after release and the presence or absence of permanent after-effects, physical or mental.

   The subject's emotional reactions during and after torture and any religious or doctrinal beliefs that helped him to survive.

9. Many torture survivors have suffered repeated detentions and there may be several generations of scars. It is not always possible for the subject to remember during which detention each separate injury was inflicted.

10. The history should be checked against any other documents which are available. Discrepancies of fact are noted and explanations sought from the subject, allowing time for thought and ordering of the memory. Minor variations often occur in the telling even by normal subjects and are more likely by confused or forgetful subjects; they do not necessarily detract from and indeed may add to credibility.

11. Suspicion may arise that the story is fabricated or embellished. It is often possible to explore this possibility by asking more detailed questions, especially about the way in which specific weapons were used and the immediate effects such as bruising, cuts, blisters etc. and how long the wounds took to heal. The answers to such questioning could not have been previously rehearsed and their accuracy can be assessed in relation to long-term evidence such as scarring or loss of function.

12. It is important to try to distinguish between the subject who is embellishing his story with each retelling, and the one who genuinely recalls and recounts more details each time.

13. Any discrepancies in the history should be discussed with the subject who should be given time to reflect and recall the correct sequence of events. It is worth stressing that precise recall of dates and places is impossible where multiple episodes of torture have occurred or where the subject has suffered severe emotionally-mediated memory disturbance.

14. If the true history cannot be satisfactorily established, if there is lingering doubt about credibility, or if the subject has difficulty in speaking about his experiences, a second appointment may be advisable. Often the history becomes clearer after an interval. Or a caseworker may be asked to interview the subject. Details can then be discussed with the caseworker or legal representative before the report is written.

Past history

1. The social history is relevant only in so far as it may have affected health and mental functioning. Though the political activities may be of interest, they do not add to the medical picture and have no place in the final report. Conversely, level of education, what contact sports were played at school and what work was undertaken subsequently are all important.
2. The subject's record of past injuries and serious illnesses, both physical and psychological has an important bearing on the present situation and should be recorded in detail as should previous habits of eating, sleeping and exercise.
3. For women who claim to have been sexually assaulted it is important to obtain a reproductive history to include whether she was a virgin at the time and if not whether she had borne children and if the births were straightforward. The history of contraceptive use at the time of rape must be obtained, for example, if an intra-uterine coil was in place it would prevent conception whereas oral contraceptive, once discontinued, would not. If the woman says she conceived through rape, the date of delivery of the child must be recorded as well as the birth weight (to assess prematurity). If she miscarried, it is worth getting a history of the event since miscarriages in the first trimester are different in clinical pattern from those in the second trimester. Men who allege sexual assault should also be asked about their previous and subsequent sexual history.

Present condition

1. The subject is questioned and details recorded about his present general physical and psychological condition, especially in relation to the pre-detention state, and including changes in weight, appetite, energy and general well-being. Special emphasis is placed on physical symptoms attributed to detention, ill-treatment or torture.
2. Detailed questioning should include items such as: distance the subject can walk before suffering pain or breathlessness; whether he can run; whether he can lift weights; in subjects where religion or custom require it, whether he can kneel, squat or sit cross-legged.
3. In both males and females who allege sexual assault it is important to discover if there is evidence of sexually transmitted disease.
4. Symptoms suggestive of psychological stress, such as sleep disorder, nightmares, loss of concentration, hypervigilence, mood changes, panic attacks, asthma, hyperventilation, indigestion or susceptibility to external stimuli such as sudden noises or the sight of uniforms, should be recorded.
5. Many subjects will include complaints that the doctor may think irrelevant but they should nevertheless be recorded. Subjects will often be socially isolated, uncertain of their future

and grieving for lost or missing family members and so may focus on these concerns rather than on scars and physical pains.

6. Enquiries should be made concerning previous medical examinations and especially hospital investigations. If possible such reports should be obtained.

Examination

1. The examination should follow the routine which the examiner is used to, but with special emphasis on any areas of the body which the history suggests were the sites of abuse.
2. The whole skin surface should be examined for abrasions or scars, bruises, lacerations and palpated for tenderness and the presence of subcutaneous nodules of fat necrosis or periosteal thickening or evidence of old fractures. A good light and magnifying glass are essential in order to detect faint scars which may sometimes be brought out by rubbing the skin to induce hyperaemia.
3. Every scar and other surface lesion detected must be measured and recorded. It is sometimes helpful to illustrate scars, etc. on an outline diagram or photograph.
4. When there is a history of beating about the head, special attention must be paid to the ears, eyes, nose and inside of the cheeks as well as broken or missing teeth. Scars on the scalp are often difficult to discover if the hair is thick. They are best identified by palpation rather than vision.
5. Especially where there is a history of suspension, all abnormalities or limitation of movement of joints and neurological changes such as weakness, sensory change or wasting should be searched for.
6. Winging of the scapulae occurs occasionally after “Palestinian hanging”. It is easily missed and should be looked for by asking the subject to press against the wall with arms extended forward.
7. If the subject gives a history of having been subjected to abnormal posture, musculo-skeletal pain is often elicited when an attempt is made to passively impose that posture.
8. When rape or sexual abuse is alleged a close inspection of the genital and anal area is obviously indicated but it may be impossible, especially at a first interview and it may have to be deferred until confidence is gained and perhaps an interviewer and interpreter of appropriate gender arranged for. Except when there has been violent attack there is likely to be no visible evidence. Except in acute cases colposcopy or proctoscopy are not usually indicated. They are likely to be unnaturally painful and emotionally damaging and therefore unacceptable without general anaesthetic. The decision to examine a woman who alleges rape should be taken on individual circumstances. A woman who has since delivered a child vaginally or a woman who is extremely modest may both, for different reasons, sometimes be left unexamined. In other cases, inspection of the vulva is indicated and only sometimes, internal vaginal examination. If the woman is pregnant with a rapist's child, the pregnancy must be accurately dated, probably by ultrasound.
9. Throughout the interview and examination the subject's emotional response and mental state should be observed closely. Abnormalities often include loss of affect or garrulous or tearful behaviour, hyperalertness, lack of concentration or heightened response to sudden movement, touching, noise or bright light. In this way, both an assessment of credibility and

an estimate of the psychological after-effects of torture can be made. It is best simply to describe the mood and behaviour rather than to apply a psychological diagnostic label such as “post-traumatic stress disorder” though awareness of the criteria is important (see appendix).

Interpretation

1. In writing the report, the objective listing of positive findings under the heading “on examination” should precede and be separate from the section of “interpretation” in which the subject's explanation and the examiner's interpretation is listed for each lesion.
2. Most lesions are not specific and could have as easily have been caused by accident or other “innocent” cause. It is essential to make allowance for this in making an assessment of the cause.
3. Though individual lesions may not be specific, their significance increases if there are numerous lesions grouped in suggestive patterns.
4. Very occasionally, the appearance is at odds with the description given, in which case it is essential to state this.
5. If torture could have been the cause, it is appropriate to state that the appearance is “consistent” with the subject's explanation, but describing other ways that it could have been caused.
6. Less often, the appearance can be stated as being “fully consistent”with the description of torture, although other explanations could still be possible.
7. In these cases, it is helpful to indicate the train of thought that has led to the conclusion and reasons for believing other explanations to be unlikely, for instance, “though the scar fits the explanation that it was caused by a blow from a truncheon, it could have been caused by a farm implement. Its situation probably rules out a self-inflicted injury”.
8. Occasionally, the lesion can be described as so “typical” or “characteristic” of the alleged torture technique that it would be very unlikely to have any other cause. The great significance of this should be emphasised.
9. There are only a few instances in which the physical traces could not have been caused in any way but by the torture described. In such cases, it is essential to state why the possibility of a natural explanation cannot be entertained.
10. If applicable, it is helpful to indicate that the techniques as described are used in the region in which the torture was alleged, that their use is well-documented and that they are known to produce such characteristic lesions.
11. The subject may attribute some scars to childhood or other accidents. These should be detailed, together with the subject's explanations. Distinguishing them from those scars which are attributed to torture shows that the subject is not trying to exaggerate his torture and thus may add to his credibility.
12. Scars which appear in patterns or in certain parts of the body may have been caused by tribal rituals, traditional remedies, stretch marks or disease or be self-inflicted. It is important to recognise these alternatives in order to make an informed assessment of possible causes other than torture.

13. All participants in the asylum process inevitably need to make some estimate of the applicant's credibility. The examining doctor is not excluded from this process of assessment and should have credibility in mind throughout his history-taking and examination and have made some assessment of it in his own mind by the end. He is assisted by having all possible documents, especially those recording previous medical examinations, at his disposal.

14. Accurate dating of scars is virtually impossible unless they are very recent. Examination may be made many months or years after the alleged torture, and so it is not usually possible to state categorically whether or not the age of the scars coincides with the dates given in the history, except to say whether or not they are compatible.

15. In many cases, there are few or no physical signs, since only injuries which cause full thickness destruction of the skin leave scars. Bruises and abrasions nearly always disappear without trace, occasional exceptions being subcutaneous fat necrosis or, in deeply pigmented races, hyperpigmentation or depigmentation of an area of skin. It is important to point out that lack of scars is to be expected if the victim states that there were no open wounds immediately after torture.

16. Abnormal psychological responses may indicate a state of severe stress. This is seldom referable specifically to torture. Sometimes the account of nightmares, daytime flashbacks etc. includes details e.g. of pursuit, capture, beating or confinement which accurately re-enact events given in the history. Though this may appear to lend support to the credibility of the history and the causal relationship of the torture to the present psychological state, it is important to consider the possibility that the connection may be false.

17. Many subjects, especially from African countries, tend to "somatise" their psychological state, producing symptoms which cannot be explained on physical examination or investigation.

18. If the balance of the medical evidence does not support torture, or there is significant inconsistency, the doctor should state this in the report and consult with the legal representative. If a report does not appear to support the allegation of torture, the legal representative will probably not submit it in support of the claim for asylum. It may be necessary to refuse to submit a report, though in such a case a report, including the doctor's reservations, should be completed and placed on file for possible future reference.

Further investigation

1. Though it is usually possible to detect long-term effects of serious injury by the usual observation and palpation of a thorough physical examination, there are occasions when more evidence may be obtainable by a clinician skilled in a certain aspect of pathology. In such cases a second opinion by a specialist colleague can be invaluable.

2. On other occasions special investigations may be indicated. These include; x-ray and other imaging techniques such as ultrasound, scintigraphy or CT or MRI scanning; electromyography; rarely, punch biopsy at the site of alleged electrical injury. Such investigations should not be undertaken unless there is a real possibility of a positive result. Negative findings do not rule out the possibility of torture but may appear to do so if included in a report.

3. To be of use photographs need to be of high quality and not all lesions are easily depicted. It is helpful to have a general shot indicating the areas of the body involved, followed by close up shots. In close-ups there should always be a ruler included to give an idea of scale and in the case of limbs, an indication of left or right.

Opinion

1. The purpose of the medical report, commissioned by the subject's legal representative, is to provide supporting evidence for an assertion of torture. The doctor is asked to give his opinion as to whether the available medical evidence supports the subject's allegation of torture or other ill-treatment. However, the doctor must give an objective, unbiased opinion to the court. It is no part of the doctor's function to give an opinion as to overall credibility of the case, though it is quite in order to express an opinion as to whether the medical evidence supports the allegation of torture.
2. The doctor's opinion is reached by taking into account the subject's medical history, amplified by reference to as many other documents as are available, together with signs elicited by physical examination and, if available, special investigations, with the interpretation of these signs by the subject and the doctor. Reaching a definite diagnosis, just as in other clinical work, may be difficult or impossible. If signs are confusing or no clear decision can be made, it may be helpful to call for a second opinion by a psychiatrist, neurologist, or other specialist.
3. When no scars are detected, it is essential to emphasise in the report that their absence does not vitiate a claim of torture, unless the description given of the nature or severity of the injury is such that scarring or deformity would have been inevitable. In most cases it is possible to decide whether the history is sufficiently suggestive of torture as practised in the region to explain the absence of signs.
4. It can seldom be proved that the commonly-reported pains in the joints, neck and back, thought to follow beating and certain postural techniques are necessarily the result of torture. However, it is possible to state that such symptoms and signs would be most unusual in a young, healthy adult, that they could be explained by a history of serious physical abuse, or by specific forms of suspension such as “Palestinian hanging” or that they could be accounted for by long incarceration in cramped, damp, cold conditions. Many elements are evaluated and summated, some of them positive, others negative or indeterminate, before a final opinion is reached.
5. In deciding on the wording of the report, the doctor should test and assess the validity of his views by considering whether he would be prepared to be cross-examined on them under oath as an expert witness.
6. In giving an opinion it is helpful, if relevant, to mention the factors which may have inhibited the subject in giving a full and accurate history at his original interview. Inconsistencies in a history should be thoroughly checked and, if necessary, the legal representative consulted to clear up any misunderstandings in the history-taking which may have arisen through causes such as mis-translation. It is important to realise that a history with gaps or inconsistencies does not necessarily invalidate a claim that the subject did indeed suffer ill-treatment.

7. An asylum applicant who has given false evidence in other aspects of his asylum application may still have suffered the ill-treatment described. Untruthfulness does not rule out torture.
8. When histories are taken from several refugees from the same country or region, their accounts of torture are often very similar. This may be because police and interrogators have a limited and repetitive repertoire of torture methods. If appropriate, it is valuable to note in the report that the history is consistent with known techniques for that region (sometimes detailed in reports from independent bodies such as Amnesty International or the Medical Foundation).
9. Since the psychological effects recorded are rarely specific to torture it is often appropriate to add a sentence such as:- "He exhibits severe psychological evidence of stress/anxiety/depression as shown by symptoms X, Y and Z. These are not specific to torture but have probably also have been contributed to by the trauma of bereavement, exile and his present circumstances".
10. A subject may have been receiving ongoing treatment or counselling at the Medical Foundation or elsewhere for some time before a report is requested. In such a case, an extra heading, such as "**Response to Ongoing Treatment**", may be included in the report, giving a description of the applicant's progress and new details of history which have come to light in successive interviews. This may add greatly to the applicant's credibility.
11. If, after a medical report has been submitted, new evidence arises which could affect the doctor's opinion, it may be possible to offer a re-examination and furnish a supplementary report. This can be most useful if it amplifies previous statements or adds new information.

Further reading

1. United Nations. Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment (the Istanbul Protocol). (In press but also online at: www.phrusa.org)
2. Human Rights Centre, University of Essex. Colchester. The Torture Reporting Handbook. 2000. ISBN 1 874635 28 5. (Also online at: www2.essex.ac.uk/human_rights_centre/)

APPENDIX

POST TRAUMATIC STRESS DISORDER AS DEFINED IN DSM-IV

A. The person has been exposed to a traumatic event in which both of the following were

B. present:

I) The person experienced, witnessed. or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

2) The person's response involved intense fear, helplessness, or horror. *Note*: In children. this may be expressed instead by disorganised or agitated behaviour.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. *Note*: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

2) Recurrent distressing dreams of the event. *Note*: In young children, there may be frightening dreams without recognisable content.

3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, aud dissociative flashback episodes, including those that occur on awakening or when intoxicated) *Note*: In young children, trauma-specific re-enactment may occur.

4) Intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.

5) Physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not pres-ent before the trauma), as indicated by three (or more) of the following:

I) Efforts to avoid thoughts, feelings, or conversations associated with the trauma.

2) Efforts to avoid activities, places,. or people that arouse recollections of the trauma.

3) Inability to recall an important aspect of the trauma.

4) Markedly diminished interest or participation in significant activities.

5) Feeling of detachment or estrangement from others.

6) Restricted range of affect (e.g. unable to have loving feelings).

7) Sense of a foreshortened future (e.g. does not expect to have a career, marriage, children, or a nor-mal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1) Difficulty falling or staying asleep.

2) Irritability or outbursts of anger.

3) Difficulty concentrating.

4) Hypervigilance.

5) Exaggerated startle response.

E. Duration of the disturbance (symptoms in B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.