The Physical and Psychological Findings Following the Late Examination of Victims of Torture

Michael Peel, Gill Hinshelwood, Duncan Forrest

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Michael Peel MB.BS, MRCGP, MFOM is a senior medical examiner at the Medial Foundation.
Gill Hinshelwood  MB.BS is a senior physician and the co-ordinator of doctors team at the MF.
Duncan Forrest MB. ChB, FRCS is a senior physician at the MF.

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Introduction

The Medical Foundation for the Care of Victims of Torture was set up in 1986 by a group of clinicians and others working with victims of torture in the UK Medical Group of Amnesty International. Although the Medical Foundation is principally a human rights and therapeutic organization, there has been an increasing number of requests for doctors and other clinicians to produce medico-legal reports on asylum-seekers as part of their claims for refugee status. The Asylum Team at the Medical Foundation reviews all these requests from legal representatives, and about half of those referred are given appointments to see examining doctors. In some cases reports are not written, either because the doctor is not confident of the veracity of the story that he or she is asked to document, or because there is nothing on which to write an expert report. Some inconsistencies in the history are normal, particularly when the different stories are given to people with different professional backgrounds, such as doctors, lawyers, and immigration officials, over a long period of time. It should always be stressed that the absence of physical and psychological signs must never be used as evidence that torture has not occurred.

Of the 2,873 new patients accepted by the Medical Foundation in 1998, reports were written in 924 cases by 32 doctors at the Medical Foundation. This is an increase of 48% from 624 reports written in 1997. By the time an asylum-seeker sees a doctor at the Medical Foundation, he or she will have been released or will have escaped from detention in another country, travelled to the UK, obtained legal advice, and been referred. Patients will therefore have been tortured quite some time in the past. The median delay is about two years, although it is not uncommon to be asked to see individuals some six or eight years after they have been tortured. Many will have been detained and tortured on several occasions, and so may have several generations of scars. It is extremely rare to see someone less than six months after he or she was tortured, and this is what is meant by the "late examination".

The Medical Foundation is based in a relatively small building that is intended to be as reassuring as possible for victims of torture. The waiting room is on the ground floor, and most of the consulting rooms are on the first and second floors. The majority of patients are seen here, although a few are examined in UK Immigration Detention Centres, and occasionally in prisons. The majority of patients are seen with the help of one of the Medical Foundation team of interpreters. Most doctors introduce themselves and the interpreter in the waiting room, and show the patient to the consulting room. This gives the doctor a chance to observe unobtrusively how the patient rises from the chair and climbs the stairs. The consulting rooms have a desk against the wall so that the centre of the room is clear for the doctor and the patient; and, when used, the interpreter can form a triangle. Occasionally a doctor who is new to the Medical
Foundation will observe the consultation, but normally no other person is present at the consultation.

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 the victim 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 most 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 difficult.

The consultation starts with the doctor introducing him or herself and explaining the purposes of the interview. The interpreter, if present, will introduce him or herself as well, and say a few words about his or her independence and confidentiality. Doctors at the Medical Foundation come from a wide variety of medical backgrounds, and the exact form of the consultation will depend very much on his or her previous experience. Some start by discussing the past and social history of the patient, 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 patient means that any line of questioning can be deferred until he or she is ready to talk about it. Questions of detail about the circumstances of detention help to gain confidence in the authenticity of the history. These would include such questions as "How big was the cell?", "Was there any lighting?", and "How could you go to the toilet?" In obtaining information about methods of torture used, it is important to avoid leading questions, although it is often necessary to ask follow-up questions to elicit details that the client may consider either too embarrassing or too banal to mention. A medical history following detention may also be significant. For example, post-traumatic epilepsy might follow a severe head injury.

The examination generally follows the history taking. For each lesion, and for the overall pattern, the doctor must consider whether it was deliberately inflicted, or due to disease or accident, or self-inflicted. The consultation will often be spread over several visits. It may be appropriate to perform a general physical examination early on, and to ask intimate questions and perform a genital examination (if necessary) at a later visit when the doctor has gained the confidence of the patient. Alongside the documentation for medico-legal purposes, all patients are assessed for treatment either by the examining doctor or colleagues within the Medical Foundation, or following referral to the general medical practitioner.

**Physical examination**

The commonest finding following the late examination of victims of torture is scarring, though disturbances of walking, posture, and joint movement are equally important.
Most scars are non-specific, but some individual scars can be helpful in supporting a history of torture, as can the pattern of scarring. Scars of unusual shapes, in uncommon locations, and of diffuse spread all suggest a deliberate cause, especially when the patient supplies a plausible attribution. Very occasionally, the patient will have photographs of the acute lesions, and it 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 patient.

The whole body must be examined thoroughly; the patient may ignore small scars that he or she considers unimportant, and may be unaware of some scars on the less visible parts of the body. Small scars on the forehead and cheeks may have been caused by direct blows, but may also be the result of acne or chickenpox. Broken or missing teeth are often shown by asylum-seekers as evidence of assault, but the general oral hygiene usually makes this sign unhelpful. Scars on the ulnar surfaces of the arms or in the palms of the hands may be from defence wounds. Scars on the knees and the shins are often caused by being kicked by soldiers or policemen with heavy boots, but are usually indistinguishable from football injuries and other adolescent accidents. Relatively minor wounds, particularly of the lower legs, ankles, and feet, may leave lesions if they subsequently become infected because of poor hygiene in the cell.

Cigarette burns can be quite distinctive. Typical scars are 5-10 mm in diameter, with a depigmented centre and a hyperpigmented periphery. Some are larger and irregular in shape from the cigarette being rubbed in. Where the cigarette was not pressed in so firmly, it can leave a small non-specific area of hyperpigmentation. Burning with a hot metal rod or similar device commonly leaves sharply demarcated atrophic scars. Scars from hot water or, less commonly, caustic substances, leave a pattern of scarring and hyperpigmentation from which the flow of liquid is often quite clear. A single episode of scalding could of course be from a domestic accident, but when there is evidence of several episodes, it is much clearer that this is the result of torture.

Incisions may be caused by bayonets, often separated from the rifle, or by knives or broken bottles. Sometimes the scars remain narrow and clearly defined, but often it is difficult to distinguish them from scars caused by laceration, particularly if the victim did not receive medical attention after the injury. Regular patterns of small incisional scars in Africans are more likely to be tribal markings or caused by traditional healers, but sometimes such scars have been caused by torture.

Whipping can sometimes leave lines of hyperpigmentation, especially in darker skin. In those with Middle Eastern skin types, hyperpigmentation is commonly seen up to five years after the incident, but has usually faded within ten years. Classic tramline scarring is much rarer. Sometimes sharp objects such as pieces of razor blade are embedded in the whip, and they leave more identifiable patterns. Military belts with heavy buckles, such as the Zairian cordelette, may also leave regular scars. These lesions are rarely confused with striae. Striae are caused by sudden gain or loss of weight, so they are also seen in some former detainees. They tend to be irregular rather than linear, and have a well-recognized distribution. They are commoner in dark-skinned individuals.

Less regular patterns of hyperpigmentation are seen following abrasions, again particularly in darker skins. Tight ropes or handcuffs may leave marks around the
wrist, and marks following rope burns can be seen elsewhere on the body where the individual has been tied up or suspended. These are rarely pathognomonic individually, but the locations and distribution of the marks can support the history of torture. Fingernails and toenails can be extracted or crushed during torture, but the late appearance is usually indistinguishable from innocent trauma or infection.

Self-inflicted scars are seen from time to time, although the pattern and location usually allows them to be distinguished from scars of torture. Some asylum-seekers attribute lesions to their torture that are clearly from another source. Sometimes this is the result of misunderstanding, in that the individual believes that he or she did not have any scars before the torture, and therefore all the marks on his or her body must be from the torture. In other cases it is probably a deliberate exaggeration. This is difficult for the doctor to manage. However, the lesion must be documented together with the patient's attribution and the doctor's opinion, even if this might undermine the overall credibility of the patient. If the doctor believes from other lesions that the patient has been tortured, this should be stressed. More commonly, patients are very willing to point out scars that are not related to torture, and this can sometimes add to their credibility.

Falanga (beating on the soles of the feet) is a common method of torture, particularly around the Mediterranean and in the Middle East. Patients will usually describe painful, swollen feet for days or weeks after the torture. Some describe pain on walking several years later, often up the front of the lower leg, others may suffer from pain in the foot in bed at night. There may be some tenderness of the sole of the foot on palpation. However, the recognized syndromes of permanent damage to the foot probably occur only in those whose feet were beaten most severely. Slaps to the ear can sometimes damage the eardrum. However, the finding of tympanic scarring does not exclude childhood infections.

Palestinian hanging (suspension by the arms tied behind the back) can lead to neuropathy of the brachial plexus, especially if it has been prolonged. Sometimes there are residual signs of this, and if they are still present after two years, they will probably be permanent. Patients sometimes give a clear history of weakness and loss of specific movements after suspension, which then recovered over the subsequent weeks. Such a history in someone who has no understanding of the clinical processes involved can be very supportive of a history of torture. Usually there is a long-standing complaint of pain and tenderness in the muscles of the shoulder girdle, and limitation by pain of movements, especially rotation. Some of this may be psychosomatic, though there is usually a real organic element.

Almost all forms of torture include an element of sexual humiliation, but it is difficult to estimate the incidence of sexual assault as part of torture because it is under-reported. Although far fewer women than men are detained, those women who have been tortured in detention are extremely likely to have been raped or otherwise sexually abused. Vaginal rape and objects pushed into the vagina can cause immediate damage, but this heals in time, although HIV and other sexually transmitted diseases may persist, as might the fear of having contracted them. In women who have delivered babies, especially subsequent to the rape, there will be no discernible physical findings. If there has been no other torture, this can be very difficult to document, because the doctor's opinion will have to be based on the demeanour of the woman and her description of her psychological symptoms. Sexual abuse of males is probably much
less common, but there are currently no data on this. When there are conclusive physical
signs from other forms of torture, a man may not disclose sexual abuse, so it is
necessary to be particularly sensitive to this possibility during this part of the history
taking. Torturers often tell men when assaulting their genitalia that they will become
impotent, which may become a self-fulfilling prophecy. Most men are less distressed
once they have talked about their sexual abuse, and have been reassured about the
physical sequelae.\textsuperscript{12}

Urethral strictures and thickening of the distal urethra are sometimes found in men who
have had objects inserted into the penis, and there are few other causes of this. Scrotal
and penile wounds usually heal without a scar, so when scarring is found, it indicates
severe injury, such as may be caused by electric shocks delivered through crocodile
clips. Anal rape or objects pushed through the anus in either sex can sometimes lead to
scarring. Scarring from anal fissures is seen in a proportion of the general population,
but sometimes a doctor will see scarring in an unusual part of the anus, or scarring that
is larger than commonly seen following anal fissures.\textsuperscript{13}

**Psychological assessment**

Most asylum-seekers describe a range of psychological symptoms, although not always
from asking open questions. For example, they may not perceive their disrupted sleep
pattern as a medical problem. Psychosomatic symptoms are particularly common, but
most asylum-seekers believe them to be physical, and this must be documented. The
symptoms include sleep disturbances, particularly lying awake worrying, then waking
with nightmares when they do get to sleep.\textsuperscript{3} Sometimes it is difficult for them to
differentiate between a nightmare and an intrusive memory. Depression and anxiety are
common, and there may be a behaviour pattern to avoid stimuli that remind them of the
trauma. These are the symptoms of Post Traumatic Stress Disorder (PTSD)\textsuperscript{14}, but they
are described by others as the universal symptoms of loss and suffering.\textsuperscript{15} It is rarely
possible to establish the original stressor from the symptoms described by the patient.
The experience of seeking asylum is stressful even for those who have not been
tortured, and the thought of being returned to the country of origin makes the symptoms
worse.\textsuperscript{16} The patient's description of psychological symptoms should be listed, together
with a description of the individual's demeanour and, if they are available, independent
descriptions of behaviour. It cannot be said that they prove a story of torture, but they
can be supportive of it. Ultimately they are further pieces in the jigsaw picture of an
individual's history of abuse. This leads to the expert opinion on whether the symptoms
and signs are likely to have been caused in the way the patient describes.

**Writing the report**

The history should be written in as great detail as seems relevant, particularly focusing
on episodes of ill-treatment. It should be made clear that this is what the patient said,
while not implying that it must necessarily be true. When there are discrepancies with
other previous written statements, these should be resolved if possible by discussion.
The physical findings should be listed in a logical order and each given an attribution by
the patient. The examiner's opinion as to whether it is consistent, whether it agrees with
the patient's account, should also be added.

Since it is seldom possible to state categorically that lesions must have been caused by
torture in the manner described, the examiner should make an assessment of likelihood. Terms such as "compatible with" or "consistent with" can be used, meaning that the lesions could have been caused in the manner described by the patient, but that there are many other possible causes. The term "fully consistent with" is best used to mean lesions that are likely to have been caused in the manner described by the patient, and that there are few other possible causes. Very occasionally it is possible to say that the injuries could not have been caused by accident or disease.

Conclusions

Even many years after a person has been tortured, it can still be possible for a doctor to provide an expert opinion to support the history. Under the 1951 Refugee Convention, an asylum-seeker must demonstrate a reasonable fear of persecution to avoid being returned. In the UK, it is necessary to demonstrate only that there is "a reasonable degree of likelihood" that he or she has been tortured. This is quite possible when physical signs are present, if an assessment is made in the doctor's mind as to other possible causes of the lesions individually and collectively. Such documentation should also be valuable in supporting an allegation of torture when a higher standard of proof is required, such as in a criminal prosecution. It must always be stressed that the absence of conclusive physical signs, or of any physical and psychological signs and symptoms at all, does not disprove an allegation of torture.

References