



Boston Center for Refugee Health & Human Rights
at Boston Medical Center

CARING FOR TORTURE SURVIVORS



CARING FOR SURVIVORS

Caring For Torture Survivors Free Online Course

This is a free, internet-based course for individuals from a variety of backgrounds who want to learn about caring for and working with survivors of torture. Participants will learn about the health consequences of torture, uprooting, and other human rights violations. Participants will also learn how to approach survivors of torture and related trauma, and recognize clinical signs and symptoms in order to screen, treat, and support individuals at risk.

Frequently Asked Questions:

Where can I take the course?

This is an online course. You can take the course by clicking on the link above that says take course here. The course will open in a new window.

How much does it cost to take the course?

The Caring for Survivors Course is free.

Who can take the course?

Anyone can take the course, but we recommend it especially for health professionals, lawyers, trainees, and human rights advocates who want to learn about caring for survivors of torture and refugee trauma.

Will I get a certificate of completion?

At this time we do not offer a certificate of completion upon taking the course. We provide this course for your information to access at any time.

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INTRODUCTION: OBJECTIVES

“Caring for Refugees and Survivors of Torture” is an internet-based introductory human rights course for health professionals (i.e. physicians, nurses, social and public health workers, psychologists), lawyers, trainees, and human rights advocates who want to learn about caring for survivors of torture and refugee trauma.

The course covers four basic areas: the epidemiology of torture; background information on human rights and torture; legal considerations specific to asylum seekers, asylees, and refugees; and methods for holistically caring for survivors of torture. In the case examples, health professionals from the Boston Center for Refugee Health and Human Rights will demonstrate approaches to treating and supporting these groups. The course also offers links to legal and clinical documents and other helpful resources.

Participants will learn about the medical and public health consequences of torture, uprooting, and other human rights violations. They will also learn how to approach this client/patient population, recognize clinical signs and symptoms, and then screen, treat, and support individuals at risk.

Learning Objectives:

- To understand the scope, magnitude, and implications of human rights violations
- To recognize signs and symptoms of torture and related trauma
- To learn how to sensitively approach, screen, treat and support these clients/patients
- To become aware of resources available for this client/patient population

INTRODUCTION: EPIDEMIOLOGY

Prevalence of Refugees and Survivors of Torture

According to information provided by the United Nations High Commissioner for Refugees, a total of 67 million people had been forcibly displaced by the end of 2007(1). 16 million of them qualify as refugees, of whom 11.4 million fall under the UNHCR's mandate while some 4.6 million Palestinian refugees fall under the responsibility of the United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA). The number of internally displaced persons (IDPs) is estimated at 51 million worldwide. 26 million were displaced as a result of armed conflict; the UNHCR currently provides protection or assistance either directly or indirectly to 13.7 million of them.

An estimated 3 million refugees lived throughout the world in 1978, but the number increased rapidly to 16 million in 2007 (1). The largest number of refugees ever recorded, 18.2 million, was documented in 1993. According to data compiled from several treatment centers, 5-35% of refugees are survivors of torture (3).

The number of refugees has artificially decreased since 1993 because more people are forced to remain confined within the borders of their own countries (1-2). However, this was reversed in 2006 when numbers started going up again, especially due to surges in recent years from Afghanistan and Iraq (1). The UNHCR reported that more than 23 countries had IDPs at the end of 2007 compared to less than 5 countries at the end of 1975 (1). Neighboring countries often deny access to fleeing refugees because these countries fear economic, social, and/or political instability (2). Displacing large segments of the population serves at least three different purposes for those who force the migration: use as human shields during a conflict, providing a potential source of supporters, and preventing rivals from recruiting supporters (2).

Very few refugees, IDPs, and asylees ever return to their country of origin. For instance, in 2007 approximately 731,000 out of 9.9 million refugees (from end of 2006) repatriated on a voluntary basis (UNHCR 2006 citation). More worrisome is the fact that hundreds of thousands of refugees are forced to return to their countries of origin. For instance, after the genocide in Rwanda, the Democratic Republic of Congo forced 700,000 Rwandans back into their country, though the conditions in this country were unsafe for them (2).

In the United States, most refugees and asylum seekers/asylees come from Sub-Saharan Africa, the Middle East, Asia, Eastern Europe, and Latin America (3). As for the location of resettlement, refugee groups usually prefer particular geographic areas. For instance, Southeast Asian refugees initially resettled in California more than any other state from 1983-2005. During the same period, more non-Southeast Asians resettled in New York than any other state (4). In 2005, the largest number of Southeast Asian refugees came to Florida, where the majority of arrivals entered from Cuba, followed by California and Minnesota, the destinations of a large influx of Hmong refugees from Laos (4). In Texas, refugees from Cuba made up the largest proportion, while 66 percent of Washington arrivals came from the former Soviet Union (4).

Two separate surveys conducted in the United States found that 5-10% of all foreign-born patients seen in large urban medical centers suffered some form of torture in their countries of origin (5-6). Providers working in these health care facilities have long recognized that they and other refugee service providers are ill-prepared for the task of caring for refugees and survivors of torture (7-8).

Prevalence of Torture and Forced Disappearances

According to the 1999 Amnesty International Report, systematic torture and ill-treatment occurs in 102 countries (9). Similarly, UN data show that the problems of torture, uprooting, and ill-treatment are widespread, particularly in Africa, Asia, and Eastern Europe (10). Although political, ethnic, and religious persecution is rare in North America and Western Europe, other forms of ill treatment—such as police brutality, prisoner abuse, and the death penalty—are still prevalent (9).

Through the Working Group on Enforced or Involuntary Disappearances, the UN is currently investigating more than 41,000 cases of disappeared people (11). As of 1996, the highest number of cases came from Algeria, Argentina, Colombia, Guatemala, the Russian Federation, and Thailand (11). Since its creation in 1980, the Working Group has transmitted 51,763 individual cases to governments in all regions of the world. Over the past five years, the Working Group clarified the fate or whereabouts of only 2,702 disappeared persons (11).

Related Links:

[United Nations. Question of Enforced or Involuntary Disappearances.](#) 75 th Plenary Meeting, New York, NY, December 17,1991.

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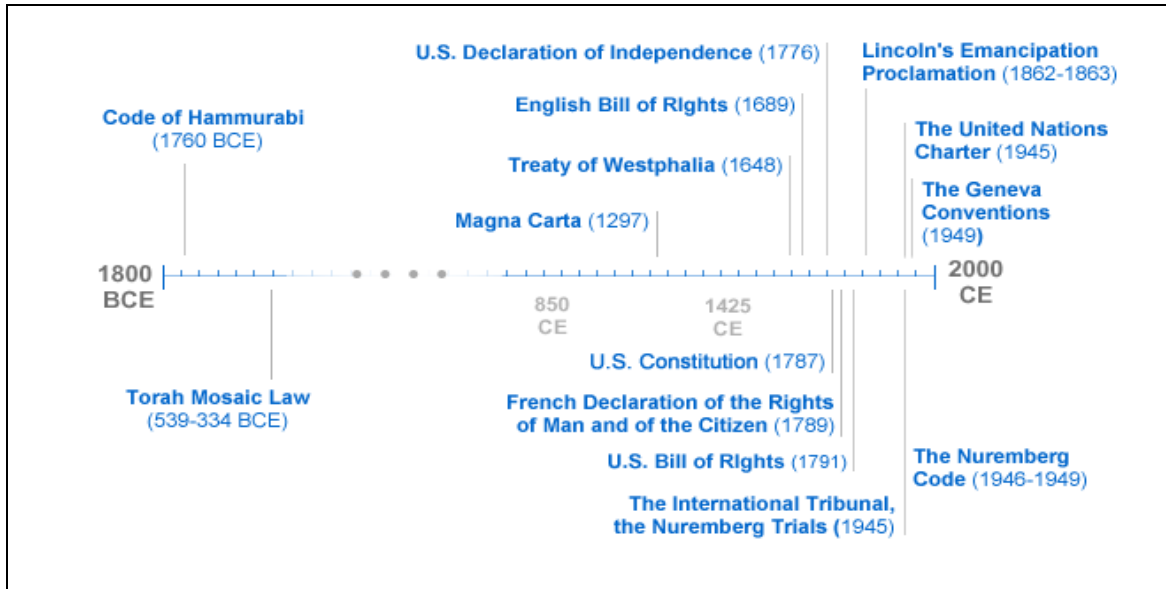
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HISTORICAL BACKGROUND: HUMAN RIGHTS TIMELINE



Although the modern human rights movement is only 60 years old, humans have been concerned about basic rights and freedoms for thousands of years (1-2). For instance, though the Romans asserted that the city-state did not protect non-Roman citizens, they believed that non-Roman citizens were entitled to certain rights that the state should not violate (1).

Human rights have continuously evolved throughout history. Until the Renaissance period, human rights were called 'natural rights' due to their intrinsic relation to natural law. Rights were considered duties to kings or other sources of authority, such as the Church. The concept of rights gradually changed when feudalism declined in Europe and scientific discoveries undermined support for human servitude. Philosophers introduced the concepts of life, liberty, and equality into mainstream society as the ideological basis of the French and American Revolutions. During the Enlightenment period, human rights were referred to as the "Rights of Man" in an effort to separate them from the concept of natural law. During World War II, people recognized that "Rights of Man" discriminated against women, so the term "human rights" was coined (1-3).

The meaning of torture has also changed throughout history from being a legal and public act (form of punishment) before the 18th century to an unacceptable and arbitrary act carried out in secrecy (2).

The following documents, treaties, organizations, and events are considered milestones in the history of human rights.

Code of Hammurabi, circa 1760 B.C.E

During Hammurabi's reign, a single code was consolidated from different Mesopotamian and Sumerian regulations that dealt with aspects of trade, labor, property, family, and slavery (4). Click [here](#) to view the Code of Hammurabi.

Torah Mosaic Law, circa 539-334 B.C.E.

The books of the Torah establish rights in terms of duties. Click [here](#) to view basic information about the Torah.

Magna Carta, 1297 C.E.

This document subjected King John to the rule of law and protected the rights of nobles and the church (5). Click [here](#) to view the Magna Carta.

Treaty of Westphalia, 1648

This treaty of 1648 sealed Europe's thirty-year war between Spain and the Roman Catholic Church on one side, and France and Germany on the other side. The treaty established the concept of national sovereignty by freeing state rulers from the Catholic Church's jurisdiction. Some attribute the treaty to the thoughts of Richelieu, Chief Minister of Louis XIII, king of France (1, 6). Click [here](#) to view the Treaty of Westphalia.

English Bill of Rights, 1689

The 1689 English Bill of Rights is one of the most important documents of British constitutional law. It forbids monarchs from suspending some civil and political rights without Parliament approval. The enactment of the English Bill of Rights came as a direct consequence of the struggle for power between the royal family and the Parliament (7). Click [here](#) to view the English Bill of Rights.

United States Declaration of Independence, 1776

Click [here](#) to view the United States Declaration of Independence.

United States Constitution, 1787

Click [here](#) to view the Constitution.

French Declaration of the Rights of the Man and the Citizen, 1789

This declaration attacked the political and legal system of the French monarchy and defined the natural rights of men as being liberty, property, security, and the right to resist oppression (1).

Click [here](#) to view the French Declaration of the Rights of Man and the Citizen.

United States Bill of Rights, 1791

The first 10 Amendments of the US Constitution guarantee certain rights for all citizens, including those rights not specifically mentioned in the Constitution (8).

Click to [here](#) view the Bill of Rights.

Lincoln's Emancipation Proclamation, 1862-1863

Click [here](#) to view Abraham Lincoln's Emancipation Proclamation.

International Military Tribunal - The Nuremberg Trials, 1945

The Nuremberg Trials held at the end of World War II marked the birth of the modern human rights movement. During the Trials, a court charged individuals with crimes

against peace and humanity for the first time in history. In particular, the Trials prosecuted Nazi Germans responsible for atrocities committed during the war (9-10).

The legal framework for the Nuremberg Trials was drawn up in 1943 when Churchill, Roosevelt, and Stalin signed the Declaration of Moscow, which addressed the atrocities being committed by the Nazis and issued a warning to the German government that the Allies were ready to prosecute any individual responsible for war crimes. Later, representatives from the United States, the United Kingdom, Russia, and France signed the Control Council Law No. 10 in Berlin on December 20, 1945, which outlined the creation of a tribunal to prosecute war criminals (9).

The International Military Tribunal carried out 12 different trials under the mandate of Law No. 10; the Major German War Criminals' Trial and the Doctors' Trial are the two best known. Other trials prosecuted SS officials, politicians, financiers, and bankers (9, 11-12).

The Doctors' Trial left two long-lasting legacies for humanity and for medical ethics. The first one is the Nuremberg Code (see next document), a document that delimits the extent of human experimentation and sets forth voluntary informed understanding consent as the key element for human participation in any type of experimentation. The second one is a hard lesson for physicians to come to terms with: from the Nazi doctors' instrumental participation in the extermination of millions of human beings, we witness professionals from whom people expect only the most altruistic acts become perpetrators (9,11-12).

United Nations Charter, 1945

World leaders saw no framework in place at the end of World War II to prevent human rights atrocities from ever happening again. Thus, they envisioned a permanent organization dedicated to the protection and promotion of human rights. Representatives from 50 nations met in San Francisco with the purpose of creating the United Nations (UN) Charter, a framework to maintain peace and harmony among all nations and to promote the respect of human rights. On June 26, 1945, the Charter was signed and on October 15, 1945 came into effect with Poland as its 51st member (10, 13). Following the creation of the UN Charter, delegates from different nations, under the leadership of former first lady Eleanor Roosevelt, drafted a document that now constitutes the cornerstone of the modern human rights movement: the Universal Declaration of the Human Rights (UDHR). The General Assembly officially adopted the Declaration on December 10, 1948 (10, 13).

Because the Declaration lacked the power to bind nations, the UN drafted two enforceable covenants: the International Covenant on Economic, Social, and Cultural Rights and the International Covenant on Civil and Political Rights (10). These two covenants represent the ideological priorities of East and West, respectively. The first document protects all positive rights such as the right to work, education, health, and a safe environment. These rights are called positive because states have to take an active role in order to guarantee them. The second document protects all negative rights such as the right to life, liberty, and freedom of expression. These rights are labeled negative because states only have to respect or avoid invading them (3, 10).

Nuremberg Code: Permissible Medical Experiments, 1946-1949

Trials of War Criminals before the Nuremberg Military Tribunals under Control Council Law No. 10. Nuremberg, October 1946 - April 1949 (9).

The great weight of the evidence before us is to the effect that certain types of medical experiments on human beings, when kept within reasonably well-defined bounds, conform to the ethics of the medical profession generally. The protagonists of the practice of human experimentation justify their views on the basis that such experiments yield results for the good of society that are unprocurable by other methods or means of study. All agree, however, that certain basic principles must be observed in order to satisfy moral, ethical, and legal concepts:

- The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.
- The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs, or engages in the experiment. It is a personal duty and responsibility that may not be delegated to another with impunity.
- The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.
- The experiment should be so designed and based on the results of animal experimentation and an knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.
- The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.
- No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur except, perhaps, in those experiments where the experimental physicians also serve as subjects.
- The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.
- Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.

- The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.
- During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.
- During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, and in the exercise of good faith, superior skill, and careful judgment requires of him that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.
- Click [here](#) view the Moscow Declaration
- Click [here](#) to view the London Agreement
- Click [here](#) to view the transcription of the Nuremberg War Crimes Trial

The Geneva Conventions, 1949

These conventions were the first international law treaties governing the conduct of nations during wartime. They created provisions for the treatment of sick and wounded soldiers at sea and on land, prisoners of war, civilians, and non-combatants.

To view all four Geneva Conventions:

- Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field. Adopted on 12 August, 1949 by the Diplomatic Conference for the Establishment of International Conventions for the Protection of Victims of War, held in Geneva from 21 April to 12 August, 1949.
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Available at: <http://www.un-documents.net/gc-2.htm>
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Available at: <http://www.un-documents.net/gc-3.htm>
- Geneva Convention relative to the Protection of Civilian Persons in Time of War. Adopted on 12 August 1949 by the Diplomatic Conference for the Establishment of International Conventions for the Protection of Victims of War, held in Geneva from 21 April to 12 August, 1949.
Available at: <http://www.un-documents.net/gc-4.htm>

Related Links:

[UN CHARTER](#)

UDHR

International Covenant on Economic, Social, and Cultural Rights

International Covenant on Civil and Political Rights

Click [here](#) to view other important Human Rights Instruments.

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INTRODUCTION: DEFINITIONS

Systematic Violence

We define systematic violence as all human rights violations carried out purposefully and regularly by governments, state sanctioned groups, or individuals acting on the orders of political, religious, and/or ethnic groups against fellow human beings. Examples of systematic violence include crimes against humanity, persecution, disappearances, unlawful detentions, and ill treatment. Systematic violence thus affects well-defined groups, whole communities, and entire nations—some to the point of near extinction (1-7).

Victims of systematic violence can fall within several categories depending primarily on their place of relocation: refugees, asylum seekers/asylees, internally displaced people (IDP), disappeared people, and returnees. People who have endured physical, mental, and/or sexual torture fall under the category of survivors of torture (1-7).

Crimes Against Humanity

According to Law No. 10 of the International Military Tribunal, the Nuremberg Trials' crimes against humanity are defined as "atrocities and offenses including but not limited to murder, extermination, enslavement, deportation, imprisonment, torture, rape, or other inhumane acts committed against any civilian population, or persecution on political, racial, or religious grounds, whether or not in violation of the domestic laws of the country where perpetrated (8)."

Other related definitions

1. "Crimes Against Peace: Initiation of invasions of other countries and wars of aggression in violation of international laws and treaties, including but not limited to planning, preparation, initiation, or waging a war of aggression, or a war of violation of international treaties, agreements or assurances, or participation in a common plan or conspiracy for the accomplishment of any of the foregoing (1)."
2. "War Crimes: Atrocities or offenses against persons or property constituting violations of the laws or customs of war, including but not limited to, murder, ill treatment or deportation to slave labor or for any other purpose, of civilian population from occupied territory, murder or ill treatment of prisoners of war or persons on the seas, killing of hostages, plunder of public or private property, wanton destruction of cities, towns or villages, or devastation not justified by military necessity (8)."

Torture

According to the Convention Against Torture and Cruel, Inhuman or Degrading Treatment or Punishment, "torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.

It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions (11)." For instance, whipping with a bamboo cane is socially accepted in some countries of South East Asia, while in Western countries, it is considered torture. Common to most definitions of torture are three elements: intentionality, a power-defenseless relationship, and infliction of pain or suffering (9).

The World Medical Association Declaration of Tokyo defines "torture as the deliberate, systematic, or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason (12)."

Genocide

"Genocide means any of the following acts committed with the intent to destroy in whole or in part national, ethnic, racial, or religious groups, thus (a) killing members of the group; (b) causing serious bodily or mental harm to members of the group; (c) inflicting on the group conditions of life calculated to bring about its physical destruction; (d) imposing measures intended to prevent births within the group; or (e) forcibly transferring children of the group to another group (13)."

Refugees

"The term refugee shall apply to any person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, or membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country (14)."

Asylum Seekers/Asylees

The definition of asylum seeker may vary from country to country, depending on the laws of each country. However, in most countries, the terms asylum seeker/asylee and refugee differ only in the place where an individual asks for protection. An asylum seeker/asylee makes this request after arriving in the host country, while a refugee asks for and is granted protected status outside of the host country (15-19).

In the United States, another difference between asylum seekers and refugees exist. Asylum seekers can be detained by the immigration service and are not entitled to receive public benefits or a work permit until asylum is granted. Refugees, however, have all previous entitlements plus the right to apply for permanent residence and citizenship sometime after arriving in the country (17).

Internally Displaced People (IDP)

Although the term IDP does not have a formal definition, the UN High Commissioner for Refugees has suggested that it should denote "those persons who, as a result of persecution, armed conflict or violence, have been forced to abandon their homes and leave their usual place of residence, and who remain within the borders of their country (18)."

Disappeared Persons

The UN Working Group on Enforced or Involuntary Disappearances defines the term disappeared person as an individual who "is arrested, detained, abducted or otherwise deprived of his or her liberty by officials of different branches or levels of government, or by organized groups or private individuals acting on their behalf, or with the direct or indirect support, consent or acquiescence of the government. A refusal to disclose the fate or whereabouts of the person concerned, or a refusal to acknowledge the deprivation of his or her liberty would follow, thereby placing that person outside the protection of the law (19)."

Returnees

Returnees are refugees, asylum seekers/asylees, and IDP who are able to return to their places of residence. Only a small percentage of refugees, asylum seekers/recipients, and IDP gain returnee status, and if they do, it happens several years after their departure (20).

Related Links:

[World Medical Association](#)

[World Medical Association Recommendations Guiding Physicians in Biomedical Research Involving Human Subjects](#). Adopted by the 18th World Medical Assembly, Helsinki, Finland, June 1964.

[United Nations High Commissioner for Human Rights](#)

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INTRODUCTION: TYPES OF TORTURE

The aim of torture is to obtain information or a confession, to incriminate a third person, to take revenge, or to establish a reign of terror within a community by breaking the body and the mind of the victim. Perpetrators seldom kill their victims or leave permanent physical marks, as corpses and scars are powerful evidence during a criminal process (1-5).

Several techniques are practiced to keep physical marks at a minimum. One method involves hitting a victim with a blunt instrument or covering the skin with fabric to decrease the chances of producing lacerations. Another technique used to cover up transient physical lesions is to carry out most of the physical torture during the initial phases of detention, allowing enough time for lesions such as echhymosis and edema to resolve (3-5).

Classification of torture into physical, mental, and sexual categories, though helpful for discussion, is somewhat artificial since most victims often endured all of them simultaneously. Torture not only affects a victim's entire person, but also generally has long-lasting and devastating sequelae for his or her family and the community at large (1-8).

Summary: Most Common Types of Torture (1-11)

1. Blunt Trauma: crushing injuries, whipping, beatings
2. Penetrating Injuries: gunshots, shrapnel, stab wounds, slash cuts
3. Suspension
4. Burns: chemical and thermal, cold and heat
5. Asphyxiation: wet, dry, chemical
6. Electric Shocks
7. Forced Human Experimentation
8. Traumatic Removal of Tissue and Appendages: via either direct avulsion or explosion
9. Extreme Physical Conditions: forced body positions (prolonged constraint) and extreme heat/cold conditions
10. Sexual Torture: sexual humiliation, trauma to genitalia, rape
11. Mental Torture: direct threats, sensory deprivation, solitary confinement, mock execution, witnessing torture, uprooting

1. Blunt trauma

Blunt trauma can be divided into three categories: crushing injuries, whipping, and beatings (1-4). Fingers and genitalia are frequent targets for crushing injuries. Objects commonly used to crush victims include rifle butts, pliers, heavy rollers, or even the body weight of the perpetrators. Beatings are one of the two most common forms of torture, the other being threats (4, 2). Certain forms of beatings have received specific names. For instance "telefono" (the telephone) consists of hitting both ears simultaneously with the palms of the hands. Beating the soles of the feet with a solid object is called "falanga,"

which has the purpose of disabling the victim and preventing him or her from escaping (1, 5-7).

2. Penetrating Injuries

Penetrating injuries are produced by gunshot wounds, flying shrapnel from explosions, and stabbing—which includes slash and scratch cuts. Perpetrators typically shoot their victims in the lower limbs to prevent any possible escape (7). Objects used for stabbing include, but are not limited to needles, razor blades, knives, bayonets, and various sharp objects such as glass, scrap metal, and rods.

3. Suspension

Victims of torture may be suspended by their wrists or ankles for several hours or even days (4-5, 7). Frequently, victims are suspended as high as possible and then released suddenly, causing different forms of blunt trauma such as bruises, fractures, and dislocations. Perpetrators also suspend their victims transiently from the earlobes (4-5, 7). Male victims of torture may also endure a form of suspension in which heavy objects are hung from their genitalia.

Certain forms of suspension have received specific names. "La barra" (the rod), also called "the chicken" or "the wheel of Buddha," consists of tying down the wrists with the ankles while keeping the knees completely flexed. A rod is passed under the knees and in front of the elbows, and then the victim is suspended by lifting the rod (5, 7). "La bandera" (the flag) consists of tying down both wrists on the back of the victim and then suspending the person by the hands. "The Palestinian suspension" consists of suspending the victim with one hand facing forward and the other one facing backwards (7). Finally, "el quirofano" consists of leaving the upper half of the victim's body suspended in the air, while the victim is lying down and facing up (5).

4. Burns

Victims of torture may endure chemical, thermal, and electric burns. A wide variety of objects are used to inflict this type of injury: cigarettes, hot irons, gas torches, ice, hot liquids like water and oil, electricity from power outlets or stun guns, acids, and other caustic materials (1-11).

5. Asphyxiation

Perpetrators asphyxiate their victims by covering their faces with a plastic bag (dry asphyxiation or dry "submarino"), submerging their faces in fluids (wet asphyxiation or wet "submarino"), and by forcing their victims to inhale chemicals or dust. In general, filthy water, urine, or excrements are used to carry out the wet "submarino" (1-11).

6. Electric Shocks

Electric shocks are commonly used in South America and Africa. Sources of electric shocks include power outlets, portable generators, cattle probes, and stun guns (1-11). Electric probes are often placed on sensitive organs, such as earlobes and genitalia.

7. Forced Human Experimentation

During the Nuremberg Trials, physicians were indicted, tried, and convicted for committing crimes against humanity, including forced human experimentation. Although the Nuremberg Code prohibits forced human experimentation, health professionals continue to participate in such activities. Unfortunately, the participation of health professionals in torture goes beyond forced experimentation and includes engaging in torture or in its cover-up by giving false medical certificates (12).

8. Traumatic Removal of Tissue and Appendages

Earlobes, hair, and nails are often removed traumatically. In addition, an explosive wave may produce avulsion of soft tissues.

9. Extreme Physical Conditions

Victims of torture recount several different forms of extreme conditions. Many victims have endured detentions inside prison cells where a human being only fits squatting, as well as exposure to adverse climatic conditions without shading, water, or appropriate clothing. Others have been forced to remain standing or assume difficult postures for days without rest (1-11).

10. Sexual Torture

Sexual torture includes sexual humiliation (e.g. pejorative comments), trauma to genitalia (e.g. suspension of heavy objects from the genitalia, castration, instrumentation), and rape. The International Crime Tribunals for Rwanda and the former Yugoslavia charged rape as a war crime. Rape is used effectively to terrorize entire communities. In Rwanda and the former Yugoslavia, for instance, women were frequently raped in front of relatives or their communities, leaving them ostracized, repudiated by husbands and other relatives.

11. Mental Torture

Almost all victims of torture suffer some form of mental torture. Direct threats to him/her or to a relative are by far the most common form of torture. Other forms of mental torture include sensory deprivation, poor conditions during detention, mock executions, long interrogations, and being forced to torture another person, witness the torture of another person, or watch killings and rapes. Sensory deprivation includes detention in complete darkness, exposure to bright lights and constant noises, or sleep deprivation. Lack of food, potable water, toilet, bed, windows, aeration, medical care, and communication are examples of poor conditions during detention (1-11). Mental suffering unique to refugees include enduring battlefield conditions, uprooting, and life in a refugee camp (1-11).

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INTRODUCTION: THE NEED FOR PRIMARY PREVENTION

Over the past 50 years, non-governmental organizations (NGOs), government agencies, and the UN have concentrated their efforts on secondary and tertiary prevention of human rights violations, such as humanitarian assistance during refugee crises, rebuilding the infrastructure of countries torn apart by war, monitoring human rights conditions, and treatment of victims. Although NGOs are moving toward primary prevention, such work still remains a small percentage of the global effort. The Campaign to Ban the Use of Landmines is a clear example of this shift towards primary prevention (1). No single reason explains the emphasis on secondary and tertiary prevention, except for the fact that most of the developed nations have been relatively spared from genocide and other humanitarian crises.

Why should countries such as the United States, Canada, and those from Western Europe care about the primary prevention of human rights violations, if they are not directly affected by the problem? The first reason is the dignity of those hundreds of thousands of victims. The second reason is that no country is immune to the sequelae of torture, uprooting, persecution, and other related human rights violations. Even industrialized nations are vulnerable to a large influx of refugees escaping from a nation in turmoil, as Western Europe witnessed during the recent crisis in Bosnia and Kosovo. The third reason is the obligation of industrialized nations to assist poor countries under certain international covenants and treaties (2-3).

Another essential question that should be raised before considering primary prevention measures for human rights violations is whether they would be effective in controlling the problem. Although primary prevention has been efficacious in controlling infections and certain chronic illnesses, no proof exists that they may control the problem of human rights violations. Switching our efforts toward primary prevention raises many other questions: Should we concentrate on deterrence or promotion? Should countries known to violate human rights and to carry out torture and persecution suffer economic and political sanctions, or should they receive a preferential treatment with the hope that better socioeconomic conditions will improve the country's human rights conditions?

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LEGAL INFORMATION: OBJECTIVES

After completing this section, the reader should be able to:

Understand the asylum application process including eligibility and the standard for asylum

- Identify and understand the significance of relevant forms, governing agencies, and important documents and evidence, including expert witness testimony
- Understand the significance of the one year filing deadline and its implications to the alien as well as the terms 'defensive' versus 'affirmative' application
- Understand current asylum trends in the United States
- Understand the role of health professionals and expert witnesses in the asylum process

LEGAL INFORMATION: ASYLUM IN THE UNITED STATES

Who Can Apply for Asylum in the United States?

Any legal or illegal alien who enters the United States may request asylum (1-4). The following aliens, however, are permanently barred from asylum: criminals, terrorists, perpetrators of human rights crimes, individuals who have firmly resettled in a third country, and individuals who were previously denied asylum (5).

The Asylum Application Process

Immigration law in the USA is created by Congress and shaped by the courts. Immigration law is always administered by a federal agency, though the agency fulfilling this supervisory role changes. The Immigration and Naturalization Service (INS) was replaced by the Bureau of Citizenship and Immigration Services (BCIS). On March 1, 2003, BCIS transitioned into the Department of Homeland Security (DHS). The deputy secretary of DHS now directs the United States Citizenship and Immigration Services (USCIS) and Immigration and Customs Enforcement (ICE) in administering immigration law.

An alien may claim asylum with an asylum officer. To submit an *affirmative application* for asylum, the individual has to submit the application to the USCIS within one year from the date of arrival. Otherwise, the process defaults into removal or deportation proceedings. If the process reaches this stage, the individual may file a *defensive asylum claim* to avoid removal/deportation. The alien, however, has to demonstrate extraordinary circumstances that prevented him or her from filing a timely asylum claim at a merits hearing (1-4).

Aliens making an affirmative asylum application are seldom detained by the USCIS, except those who file an asylum claim at a port of entry without proper documents (*i.e.* entering the country with a false visa or passport). On the contrary, aliens filing defensive asylum claims are more likely to be detained until an immigration judge rules on the case (1-3).

If an alien has made his or her asylum application affirmatively, the case is referred first to an asylum officer who has the discretionary power to grant or deny the asylum claim. Usually, the asylum applicant has a single interview with the asylum officer who looks for evidence of past persecution or well-founded fear of persecution. If a case is denied by an asylum officer or is filed as a defensive asylum application, a USCIS judge hears the case (1, 4-6). An alien may appeal a USCIS judge's decision first to the USCIS Board of Appeals and then to a federal court of appeals (1, 4). Congress, however, has recently limited the role of the federal court system when immigration matters are at hand. For further information, please view the USCIS' Affirmative Asylum Procedures Manual (9).

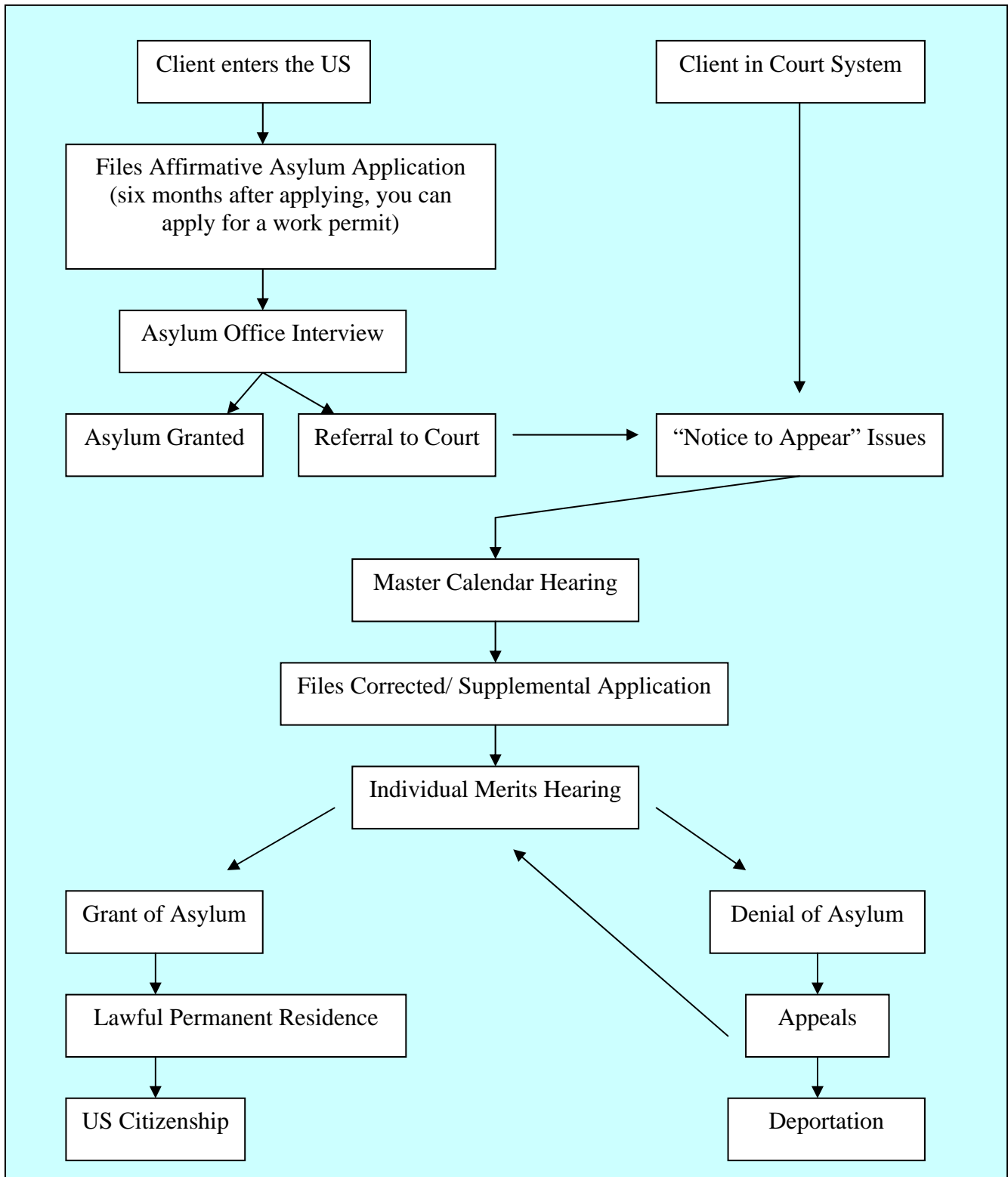
The process of applying for asylum is a complex one that requires filling out forms, gathering documents and evidence, and the assistance of an immigration attorney. The first two forms that asylum applicants need to complete are the USCIS form I-589 (Request for Asylum) and the EOIR-28 (Authorization to have an attorney representing

the asylum applicant during the asylum process) (4-7). Asylum applicants are encouraged to submit a sworn affidavit detailing their past persecution or explaining their fear of future persecution (5).

Other important documents are country condition reports issued by the US Department of State or a well-known non-governmental organization, such as Amnesty International or Human Rights Watch. Expert witnesses in international politics may write affidavits and/or testify before an immigration court to supplement the country conditions reports. Health professionals may also write medico-psychological affidavits and/or testify in front of an immigration court to provide an objective assessment of physical and mental marks of torture and persecution (4, 6).

Important Asylum Documents (4,8)
1. INS form I-589 (10/18/01 Or 7/3/03 versions are accepted)
2. Form authorizing the presence of an attorney
3. Asylum applicant's affidavit
4. Identification documents
5. Originals and official translations of all relevant documents (i.e. arrest warrants, threat letters, newspaper clips)
6. Expert and lay witness' affidavits
7. Reports of country conditions
8. Attorney's brief

The Asylum Process in the U.S.



Standard for Asylum

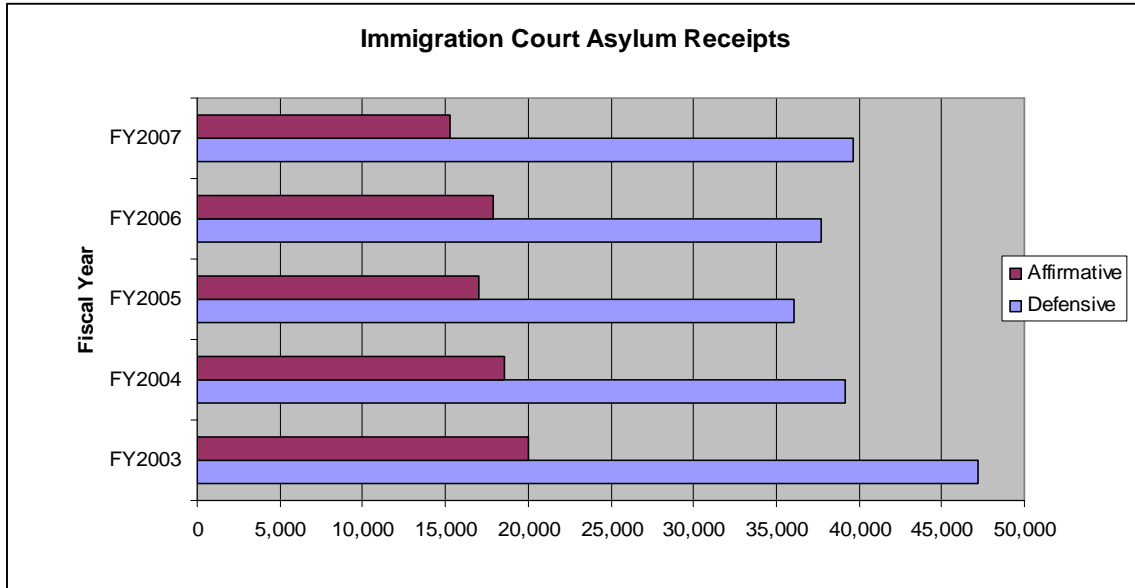
To obtain asylum, every alien has to prove "past persecution or a well-founded fear of persecution on account of race, religion, nationality, political opinion or membership in a particular social group (5)." Although the USCIS courts are administrative courts, they function similarly to the judicial courts with two exceptions. First, the asylum applicant carries the burden of proof, and second, the federal rules of evidence do not apply to these cases (8).

By persecution, the USCIS means "a threat to the life or freedom of, or the infliction of suffering or harm upon those who differ in a way regarded as offensive (5)." By fear of future persecution, the USCIS means "(1) the alien possesses a belief or characteristic that a persecutor seeks to overcome by means of punishment of some sort; (2) the persecutor is already aware, or could become aware, that the alien possesses this belief or characteristic; (3) the persecutor has the capability of punishing the alien; and (4) the persecutor has the inclination to punish the alien (5)."

Compared to the standard of proof necessary to obtain asylum, withholding of deportation has a higher standard of proof. The alien has to demonstrate that the chances of being persecuted if he or she were to return to his or her country of origin are more likely than not. In other words, the alien has to demonstrate that the risk of persecution is greater than 50% (4).

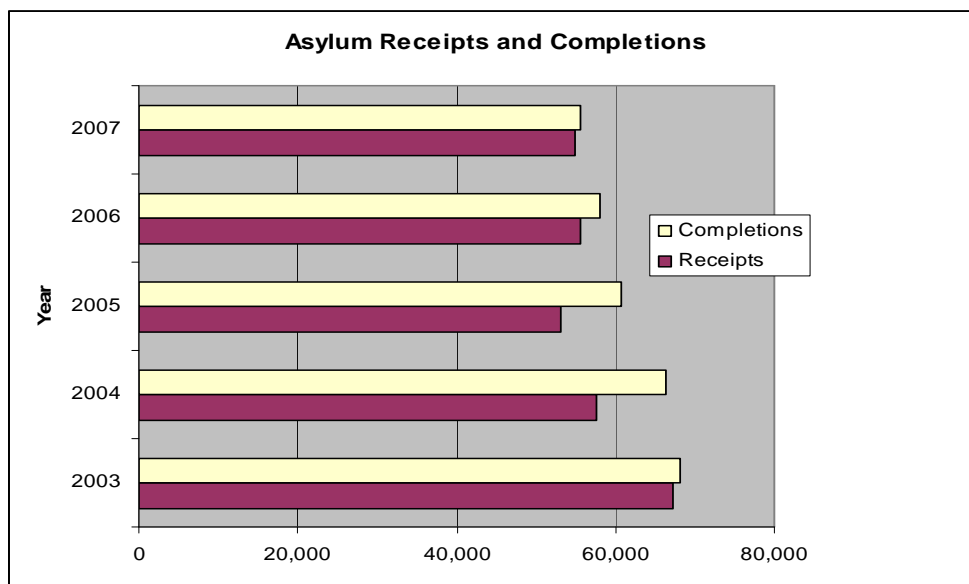
Asylum Statistics in the United States

After having been the second most common destination for new asylum-seekers in 2005 and 2006 (48,900 and 50,800 claims respectively), the United States of America became the main receiving country in 2007 (10). In 2007, a total of 54,957 asylum applications were submitted in the U.S. (11). According to the Executive Office of Immigration (EOIR), there are two ways that aliens may request asylum: "affirmatively," by completing an asylum application and filing it with a DHS Asylum Office; or "defensively," by requesting asylum before an immigration judge. Below are charts showing the number of asylum receipts in the U.S from 2003 to 2007, taken from the Statistical Yearbook from the EOIR and U.S. Department of Homeland Security (11).



	Affirmative	Defensive	Total
FY2003	47,221	20,047	67,268
FY2004	39,120	18,552	57,672
FY2005	36,095	17,065	53,160
FY2006	37,747	17,907	55,654
FY2007	39,629	15,328	54,957

According to the yearbook, asylum receipts and completions declined by 18 percent each year from 2003 to 2007, as outlined in the table below:



Nationality

In 2007, the 10 nationalities listed below accounted for 63 percent of all asylum grants, with China alone accounting for 35 percent of all asylum grants. A total of 148 nationalities were represented among cases granted asylum in FY 2007. During a five-year period, five nationalities were repeatedly represented among the top 10 nationalities granted asylum each year: China, Colombia, Albania, India, and Haiti (11).

Nationality	Cases	% of Total
China	4,540	35.45%
Colombia	683	5.33%
Haiti	587	4.58%
Albania	420	3.28%
India	357	2.79%
Ethiopia	349	2.73%
Guinea	324	2.53%
Venezuela	315	2.46%
Iraq	276	2.16%
Egypt	231	1.80%
All Others	4,725	36.89%
Total	12,807	100.00%

Immigration Courts: Convention Against Torture

In 1999, the Department of Justice implemented regulations regarding the United Nations Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (Convention Against Torture or CAT). Under these regulations, those in removal, deportation, or exclusion proceedings may claim that they “more likely than not” will be tortured if removed from the United States. This regulation provides jurisdiction to the immigration courts to hear these claims, and provides jurisdiction to hear appeals from the immigration courts’ decisions regarding CAT claims (11).

2007 Convention Against Torture Cases by Disposition

Granted			Denied	Other	Withdrawn	Abandoned	Total
Withholding	Referred	Total					
449	92	541	13,874	7,086	5,873	756	28,130

As shown in the table above, the immigration courts adjudicated 28,130 CAT applications during FY 2007. This table shows the number of granted, denied, other withdrawn and abandoned CAT cases. (A substantial number of closed cases are counted as “other” asylum completions, e.g., change of venue to another court. Further, in some instances, those with a pending asylum claim may be granted some other type of relief besides asylum, and this is also recorded as an “other” completion.) Overall, 541 CAT cases were granted asylum, which was only 1.9% of the total number of applications.

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LEGAL INFORMATION: ROLE OF HEALTH PROFESSIONALS

Preparing Your Client/Patient

Please use the asylum process manual and checklists provided here to help your clients/patients navigate the asylum process and prepare for their affirmative asylum interview or merits hearing. [Click here for the asylum process manual.](#)

Expert Witness

See Appendix A for a document and checklist provides specific information regarding what questions an expert witness might expect to be asked at a merits hearing. See Appendix B for a presentation on the United States Asylum Process: Expert Witness Preparation

Writing a Medical/Psychological Affidavit

Medical/psychological affidavits have evolved since the Denmark Amnesty International Medical Group developed one of the first guidelines during the 1970s (1). Nevertheless, the essential parts of a medical/psychological affidavit remain the same: identification of the patient; qualifications of the clinician; history, physical, and mental exams; laboratory and radiographs; psychological instruments; opinions; and conclusions (1-4).

Recently, several well-known organizations from all over the world have drafted new guidelines on how to conduct an interview with a refugee or a survivor of torture and how to write an affidavit. The Istanbul Protocol was submitted to the United Nations High Commissioner for Human Rights in August 1999 (4). We encourage all readers who wish to learn how to conduct an interview and to write an affidavit to read the Protocol in its entirety. To order a copy, please contact [Physicians for Human Rights](#).

Related Links

To keep up to date with the USA's asylum law, see the [USCIS website](#).

To view the USCIS application forms for asylum and withholding of removal and their instructions, [click here](#).

To view country conditions reports:

- [US Department of State](#)
- [USCIS](#)
- [UN High Commissioner for Refugees](#)
- [Human Rights Watch](#)
- [Amnesty International](#)
- [Asylum Law](#)

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INTERVIEW CONSIDERATIONS: OBJECTIVES

We hope that the following information will aid you in sensitively conducting sessions such as physical and oral health exams and mental health interviews with survivors of torture through the following lessons:

- Learn the risk factors relating to a history of torture
- Learn to prepare for and conduct interviews and exams in a sensitive manner that considers the client's/patient's cultural background, current situation, and past traumatic experiences
- Understand the different types of interpreters and the roles they should play during interviews and exams
- Understand the potential for vicarious traumatization and learn how to recognize and cope with it

INTERVIEW CONSIDERATIONS: PLANNING AND PREPARATION

Before Approaching the Patient

In order to aid in the establishment of a fiduciary relationship with your client/patient, it is helpful to become aware of the risk factors related to a history of torture (see figure below). Learning about the political situation of the country where your client/patient is from, as well as the ethnic conflicts, geography, and main cultural values characteristic of his/her country of origin prior to the first meeting will help you to act sensitively and begin meeting his/her possible special needs from the very beginning. In addition, refugees and survivors of torture interpret this knowledge as a genuine interest in them, enhancing the development of a trust-based relationship (1).

Risk Factors for Torture *

1. Refugee or asylee status
2. Leader of an opposition organization
3. Relative of a victim who has suffered systematic violence
4. History of arrest or detention
5. Residence in flash point countries (i.e. Bosnia, Rwanda)
6. Prisoner of war
7. Immigrant from a country with a totalitarian or military regime
8. Member of a minority group (religious, ethnic, or political)
9. Past residence in a country experiencing civil war

* Adapted from Table 1. Historical Risk Factors for Torture. Weinstein HM, Dansky L, and Iacopino V. Torture and War Trauma Survivors in Primary Care Practice. West J Med 1996; 165: 112 – 118.

How to Approach the Patient

To avoid re-traumatization, any health or legal professional conducting an interview with a refugee or a survivor of torture should follow some basic guidelines (1). You should introduce yourself, explain the purpose of the interview, and delineate how the interview will progress. When interviewing a person who is detained or under arrest, you should explain how you became involved in the case (1-2). In addition, you should avoid having refugees and survivors of torture wait for an interview because it resembles the waiting period before an interrogation session (2).

Interviewers should make refugees and survivors of torture feel that they are in control during the interview. Therefore, allow refugees and survivors of torture to take breaks, decline answering questions, and stop the interview at any point. In addition, you should avoid rushing the patients or asking questions too fast because this may recreate an interrogation (2-3).

Initially, questions should be open-ended, allowing a narration of the trauma without many interruptions. This technique of open-ended questions builds empathy and trust between the victim and the interviewer. However, you should carefully redirect the

interview with another open-ended question if the client/patient wanders off the subject of interest.

Short answer questions, particularly those necessary to obtain details of the trauma (how did it happen, when did it happen, where did it happen, what part of the body was affected, and what object was used), should be left to the second part of the interview or to subsequent interviews if possible. You should remember that short answer questions may resemble an interrogation. Therefore, questioning should be done gently and tactfully to avoid re-traumatization (2).

Finally, during the physical exam, health professionals should explain to the patient every step of the examination beforehand to avoid re-traumatization. For instance, if you dim the lights of the exam room to visualize the retina with an ophthalmoscope without first warning the patient, he may re-live confinement in a dark cell. Similarly, if you pull the ear of the patient to visualize the middle ear, the patient may re-experience a moment when her captors forcefully pulled her ears.

Health professionals who evaluate a survivor of torture only for an asylum evaluation should make a reasonable effort to find another health professional who could provide long-term medical or psychological care (3).

The Setting

Refugees and survivors of torture should be interviewed and examined in a place that offers privacy. When asylum seekers are detained and the interview needs to take place in a detention center, interviewers should delay the interview if the person will be released soon and there are no time constraints. Otherwise, if absolute privacy cannot be assured, you should keep all sensitive questions for a follow-up interview. If no other interview can be arranged, you must document all the limitations present during the evaluation (4-6).

The interview setting should also be comfortable, have adequate lighting and no hidden objects, and be as un-cell-like as possible (5). When interviewing detainees, health providers should request from prison officials an exam room where a physical exam can be conducted (4-6).

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INTERVIEW CONSIDERATIONS: THE USE OF INTERPRETERS

Types of Interpreters and Their Pros and Cons

Health and legal professionals often need interpreters to communicate with refugees and survivors of torture. Interpreters can be classified in three different categories: relatives of the victim, acquaintances of the victim or fellow citizens volunteering at community-based programs, and professional interpreters. Health and legal professionals who conduct interviews with interpreters should know the pros and the cons of each type to minimize potential problems during the interview (1-2).

A benefit of having a relative as an interpreter is that he or she knows the client/patient well and may share the same cultural background. Relatives may also corroborate the presence or absence of symptoms, or add information relevant to the case. Nevertheless, refugees and survivors of torture often hide from relatives painful parts of their trauma in an attempt to shelter relatives from any unnecessary suffering. Clients/patients may also not disclose torture histories to family members because they feel ashamed, particularly if they have experienced sexual torture. Another challenge with having relatives as interpreters is that they may alter the patient's testimony, perhaps because they are too familiar with the story or they may feel ashamed of repeating the story (1-2).

Under no circumstances should children be used as interpreters for their relatives. We consider having children as interpreters not only unprofessional, but also unethical. Similarly, when children are the subjects of the interview, interpreters should be available for their parents or guardians, even if the children are able to speak the language of the interviewer.

As with relatives, acquaintances or fellow citizens are able to interpret not only the verbal, but also the cultural language of refugees and survivors of torture. However, a major problem commonly found with this kind of interpreter is distrust. The refugee or the torture survivor may either fear that the interpreter is a government agent of his or her country of origin who is collecting information or that the interpreter may not maintain confidentiality (2).

Professional interpreters offer an accurate interpretation of verbal language, though much of the culturally specific content may get lost if the interpreter is not acquainted with that particular culture. Other setbacks include the cost involved in hiring a professional interpreter and the lack of professional interpreters for certain languages (1-2).

Rules for Interpreters and Interviewers

Health and legal professionals should debrief interpreters prior to an interview, particularly if the interpreter is a relative, an acquaintance, or a fellow citizen. First of all, interviewers should obtain an assurance from the interpreter of confidentiality. Instructions should also be given directing interpreters to speak clearly, avoid drawing attention toward themselves during the interview, correct any mistakes, and avoid expanding or summarizing narratives (1-3). To prevent traumatization of the interpreter,

it is also important to debrief the interpreter after the interview, particularly if the testimony was intense.

Interviewers should also follow some simple rules to avoid confusing the interpreter. For instance, interviewers should avoid long statements or questions. Interviewers should give enough time for the interpreter to translate the question to the patient and then translate his or her answer back to the interviewer (1-3).

Instructions for Interpreters (3)

1. Speak loudly and use a clear voice
2. Avoid drawing attention to yourself
3. Correct all mistakes as soon as noted, informing both the patient and the interviewer
4. Request clarification if a statement was not clear, informing both the patient and the interviewer that you want to clarify a statement
5. Maintain confidentiality
6. Interpret word for word without summarizing or expanding

Instructions for the Interviewer When Using Interpreters (1-3)

1. Avoid long statements or questions
2. Give enough time for the interpreter to translate the question to the patient and his or her answer to the interviewer
3. Ask for clarification if the interpreter and patient have a long discussion and the answer to the question is short, such as a monosyllable (yes or no)
4. Avoid using sentences phrased in the third person (i.e. ask Mr. X if he is having pain)
5. If confidentiality cannot be assured, stop the interview until another interpreter can be found

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INTERVIEW CONSIDERATIONS: VICARIOUS TRAUMATIZATION

Health and legal professionals, as well as interpreters, who are involved in the care of refugees and survivors of torture, should prepare themselves for hearing difficult testimonies. Otherwise, providers can suffer anxiety, depression, and even symptoms that mimic posttraumatic stress disorder. Some other symptoms include disbelief, rejection, internalization, hopelessness, despair, nightmares, and other intrusions (1-2).

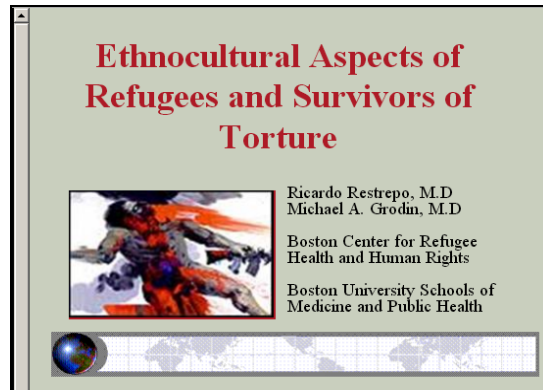
This phenomenon is called vicarious traumatization and can be avoided by having discussions with other colleagues about feelings and expectations that arise during or after interviews (1-2). For instance, Physicians for Human Rights offers to all providers who are beginning to work with survivors of torture a mentor who can offer assistance and advice.

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INTERVIEW CONSIDERATIONS: ETHNOCULTURAL PRESENTATION

Click [here](#) to open



CLINICIAN TRAINING: OVERVIEW

Much of the material covered in this section pertains specifically to specialized health care professionals, but may prove helpful to other professionals working with this population. Each of the Physical, Mental, and Oral Health sections cover types of torture, signs and symptoms, and guidelines for conducting safe and sensitive interviews and examinations with the client/patient. Vocational Rehabilitation addresses the issues involved in assisting clients/patients with the search for employment. No matter which specific service a provider may offer, it is imperative that s/he have a holistic understanding of the nature of the physical and psychological trauma associated with torture as well as the challenges torture survivors and asylum seekers may face during their efforts to re-establish themselves professionally and within communities.

CLINICIAN TRAINING: **IMPROVING TERTIARY RESPONSES TO TORTURE**

The Need to Train Health Professionals

Despite the growing number of survivors of torture, refugees, and people with related traumas (1-4), US health professionals learn little during their training about caring for this population. For example, two surveys suggest that only a minority of medical and public health schools teach about domestic and international human rights violations and the medical, mental health, social, and legal consequences of such violations (5-6). In addition, health professionals who work primarily in large urban centers have corroborated that they are ill-prepared for the task of caring for this population (7), which according to two different surveys compromises between 5 and 10% of all foreign clients/patients seen in these medical centers (8-9).

In our own experience at the Boston Center for Refugee Health and Human Rights, we found that 85% of refugees and asylum seekers who had a primary care physician and 60% of this client/patient population who had contact with some other health professional were never asked about human rights abuses. We also found that the mean time between arrival to the US and the first contact with a health professional aware of resources available for this client/patient population is 4.4 years, with a range of 2 months to 15 years. This lack of recognition of the needs of refugees and survivors of torture explains, in part, why a successful reintegration into society takes so long for most of these clients/patients. During the celebration of the 50th Anniversary of the Universal Declaration of Human Rights, the Consortium for Health and Human Rights called all health professionals-including medical, public health, and nursing schools-to increase global awareness of the relationship between health and human rights (10). The Consortium recognized that health professionals are in a unique position to advance the well-being of torture survivors, refugees, and clients/patients with related traumas because no other professionals have the opportunity to frequently encounter the medical, mental health, social, and legal needs of this patient population (10). Although efforts to train and educate healthcare providers have been underway since the end of the 1990s, the Consortium is well aware that more work is needed at a local, national, and international level (10-11).

The Need to Educate Clients/Patients About Their Symptoms

Several factors contribute to the alienation of refugees and survivors of torture. Among the most important are language barriers, cultural barriers, the lack of social support systems, and the incomplete understanding of the nature of these clients'/patients' psychological symptoms. As a result, refugees and survivors of torture struggle for years with a sense of insecurity and social estrangement that often lead to additional problems-including difficulties with work performance and feeling misunderstood, different, marked by trauma, and out of control (12-13).

Health care providers caring for this client/patient population should spend time explaining to clients/patients the nature of their symptoms, the natural history of depression, anxiety, and posttraumatic stress disorder, and the different forms of treatment available. Because of the cultural stigma associated with seeing a psychiatrist

or psychologist, this client/patient population mainly seeks care from primary care physicians (12-13). Therefore, primary care physicians should not disregard their part in this crucial step in the rehabilitation of refugees and survivors of torture.

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CLINICIAN TRAINING: VIDEO EXAMPLES OF CASES

Please note: our cases are streaming video files, encoded in Real Video format. In order to view these cases, you will need to [download Real Player](http://www.real.com/) (a free version of the program is available on their web site, <http://www.real.com/>). Click on either the images or the link "Click for the Video" to see the video.

Introduction

In this program, actors play the roles of survivors of torture. These actor's roles have been scripted. They do not represent any real events. They are fictionalized stories and are apolitical in nature. Interviews and examinations in these scenes are conducted by the staff of the Boston Center for Refugee Health and Human Rights. In each of the sections listed below, you can click on links provided for interviews and examinations for:

- Physical Health
- Mental Health
- Oral Health
- Vocational Rehabilitation

PHYSICAL HEALTH: OBJECTIVES

We hope that the following information, in combination with the Interview Considerations section, will aid you in sensitively conducting physical health exams with survivors of torture through the following lessons:

- Learn to assess and address holistically the unique needs of torture survivors
- Be familiar with common methods of torture and their corresponding sequelae
- Learn techniques to reduce the risk of retraumatization
- Learn how to gather a torture history for the purpose of composing an affidavit in support of an asylum claim

To view the physical health component of the UN-funded film produced by the Boston Center for Refugee Health and Human Rights, click on the link provided in the Physical Health section “Physical Health Interview.”

PHYSICAL HEALTH: OVERVIEW

In general, victims of human rights violations suffer many health problems (1-8). They may suffer from one category of conditions, such as Sickle Cell Anemia, that are prevalent in certain geographical areas, but are not related to socioeconomic conditions or to systematic violence.

Other illnesses affecting these individuals fall into a second category when they are related to the geographical area and poor socioeconomic conditions, yet still are unrelated to systematic violence. Malaria, for example, is prevalent in tropical swampy regions and is an even greater problem in poor populations that lack screens in their homes.

A third category of conditions, including malnutrition and gastroenteritis, are directly related to poor socioeconomic conditions and are exacerbated by systematic violence, particularly when large segments of the population are uprooted. For instance, the Somali and the Rwandan populations suffered from malnutrition and gastroenteritis prior to the outbreak of the civil war and the genocide. As hundreds of thousands of people were uprooted, however, the incidence of these two conditions exponentially increased and further strained the almost non-existent food and potable water supplies (3-7).

Finally, victims of systematic violence may experience health problems directly related to the process of uprooting, mistreatment, or torture. This fourth type of health issue can be divided into physical and mental health problems. Before discussing specific signs and symptoms of physical health problems resulting directly from systematic violence, let us first review some representative types of torture.

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PHYSICAL HEALTH: TYPES OF TORTURE

Blunt trauma

Blunt trauma can be divided into three categories: crushing injuries, whipping, and beatings (1-4).

Fingers and genitalia are frequent targets for crushing injuries. Objects commonly used include rifle butts, pliers, heavy rollers, or even the body weight of the perpetrators. Common sequelae of crushing injuries include fractures, dislocations, ankylosis, and deformed limbs.

Classic whip marks are easy to recognize by their appearance—multiple thongs or thin lines. When victims are often flogged with belts, wires, leather ropes, or bamboo canes, however, non-characteristic marks may be present. Whipping usually produces only transient and superficial marks that fade away within days. If permanent marks remain, they can appear as hyperpigmented macula or ill-defined scars.

Beatings are one of the two most common forms of torture, the other being threats (4, 2). Certain forms of beatings have received specific names. For instance “telefono” (the telephone) consists of hitting both ears simultaneously with the palms of the hands. Such trauma may cause hearing loss by rupturing the tympanic membranes. Beating the soles of the feet with a solid object is called “falanga,” which has the purpose of disabling the victim and preventing him or her from escaping. The resultant soft tissue swelling frequently may cause a compartmental syndrome serious enough to cause necrosis of the feet. Although perpetrators have their victims wear socks or footwear during “falanga” to prevent lacerations and permanent scarring, these foot coverings do not prevent the compartmental syndrome (1, 5-7).

Beatings may produce a wide range of physical marks. Some marks are transient, such as ecchymosis, that resolve within one or two weeks. Others are permanent, including scarring, fractures, or deformed limbs (1, 5-7). In general, the long-term external sequelae of beatings do not reflect the severity of a beating. For instance, a beating may cause acute renal failure from rhabdomyolysis, yet leave only small superficial scars or no permanent physical marks.



Crushing Injury

Comparative view of index fingers showing a deformity of the distal phalanx of the right finger caused by smashing with the butt of a rifle.



Whipping

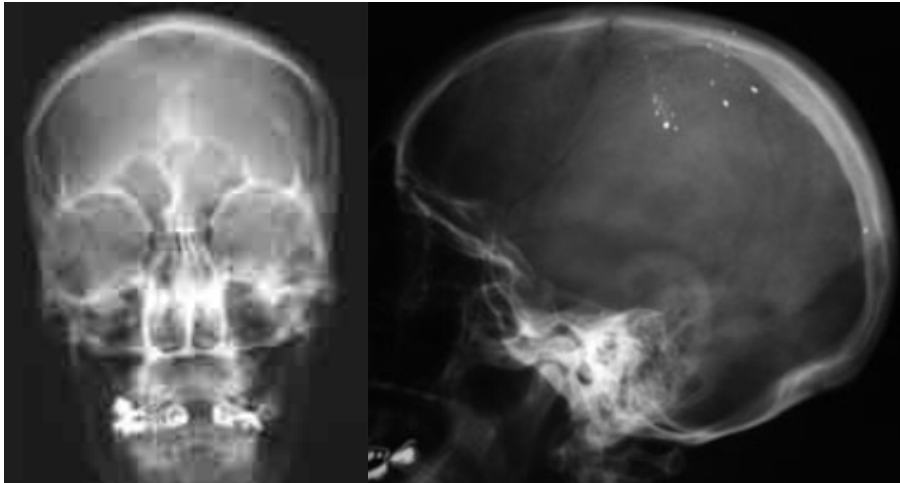
Whipping of a prisoner with a bamboo cane in Southeast Asia (Photo courtesy of Physicians for Human Rights)

Penetrating Injuries

Penetrating injuries are produced by gunshot wounds, flying shrapnel from explosions, and stabbing—which includes slash and scratch cuts.

Perpetrators typically shoot their victims in the lower limbs to prevent any possible escape (7). Most gunshot wounds cause serious injuries, such as palsy or fractures, and potentially life-threatening conditions like hemorrhages or perforation of a hollow viscera. Death may occur from bleeding or direct damage to a vital organ. Long-term complications include palsy, limb deformity, and organ dysfunction.

Objects used for stabbing include, but are not limited to, needles, razor blades, knives, bayonets, and various sharp objects such as glass, scrap metal, and rods. Forms of stab wounds include amputations of earlobes, fingers, and toes, and slash cuts (5). Stabbings may cause pain, bleeding, nerve damage, perforation of a hollow viscera, and infection. Death may occur from bleeding or septicemia from an infected wound or a ruptured hollow viscera. As with beatings, the long-term sequelae of a stab wound do not reflect the severity of the causal insult.



Flying Shrapnel
Anterior-posterior and lateral views of the skull showing metallic shrapnel from a projectile.



Stabbing: Slash Cut
Slash cuts of the interior aspect of the left arm.

Suspension

Victims of torture may be suspended by their wrists or ankles for several hours or even days (4-5, 7). Tightening ropes may compromise circulation to hands or feet. Some victims experience permanent neurological damage from nerve compression. Resulting scars from prolonged suspensions are easy to identify: bilateral scars or maculae around the wrists or ankles. Frequently, victims are suspended as high as possible and then released suddenly, causing different forms of blunt trauma such as bruises, fractures, and dislocations.

Perpetrators also suspend their victims transiently from the earlobes, which may cause their avulsion, or the hair, causing traumatic alopecia (4-5, 7). Male victims of torture

may also endure a form of suspension in which heavy objects are hung from their genitalia.

Certain forms of suspension have received specific names. "La barra" (the rod), is also called "the chicken" or "the wheel of Buddha," consists of tying down the wrists with the ankles while keeping the knees completely flexed. A rod is passed under the knees and in front of the elbows, and then the victim is suspended by lifting the rod (5, 7).

"La bandera" (the flag) consists of tying down both wrists on the back of the victim and then suspending the person by the hands. This type of suspension produces intense pain and as soon as muscular fatigue ensues, shoulders dislocate, damaging the brachial plexus.

"The Palestinian suspension" consists of suspending the victim with one hand facing forward and the other one facing backwards. As with "la bandera," this type of suspension produces intense pain and eventually produces shoulder dislocation and brachial plexus injury (7).

Finally, "el quirofano" consists of leaving the upper half of the victim's body suspended in the air, while the victim is laying down and facing up. "El quirofano" produces muscle spraining in the lumbar area (5).

Burns

Victims of torture may endure chemical, thermal, and electric burns. A wide variety of objects are used to inflict this type of injury: cigarettes, hot irons, gas torches, ice, hot liquids like water and oil, electricity from power outlets or stun guns, acids, and other caustic materials (1-11).

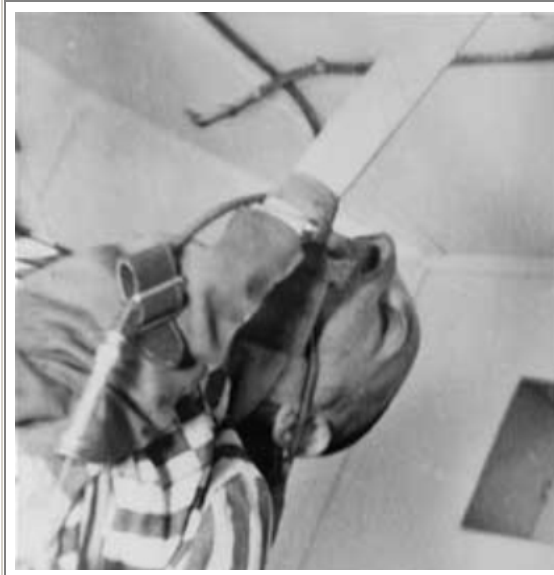


Burns

Anterior aspect of the right foot showing a flash-over burn from a grenade explosion.

Asphyxiation

Perpetrators asphyxiate their victims by covering their faces with a plastic bag (dry asphyxiation or dry "submarino"), submerging their faces in fluids (wet asphyxiation or wet "submarino"), and by forcing their victims to inhale chemicals or dust. In general, filthy water, urine, or excrements are used to carry out the wet "submarino" (1-11).



Asphyxiation

Asphyxiation of a prisoner during human experimentation at the Dachau Concentration camp during the Holocaust

Electric Shocks

Electric shocks are commonly used in South America and Africa. Sources of electric shocks include power outlets, portable generators, cattle probes, and stun guns (1-11). Electric probes are often placed on sensitive organs, such as earlobes and genitalia. Long-term physical marks from electric shocks are typically discrete and minor, although some victims may experience a permanent seizure disorder. In contrast, the immediate complications of electric shocks are potentially lethal: tonic-clonic seizures and cardiac arrhythmias.

Forced Human Experimentation

During the Nuremberg Trials, physicians were indicted, tried, and convicted for committing crimes against humanity, including forced human experimentation. Although the Nuremberg Code prohibits forced human experimentation, health professionals continue to participate in such activities. Unfortunately, the participation of health professionals in torture goes beyond forced experimentation and includes engaging in torture or in its cover-up by giving false medical certificates (12).

Traumatic Removal of Tissue and Appendages

Earlobes, hair, and nails are often removed traumatically. In addition, an explosive wave may produce avulsion of soft tissues.

Extreme Physical Conditions

Victims of torture recount several different forms of extreme conditions. Many victims have endured detention inside prison cells where a human being only fits squatting, as well as exposure to adverse climatic conditions without shading, water, or appropriate clothing. Others have been forced to remain standing or assume difficult postures for days without rest (1-11).

Sexual Torture

Sexual torture includes sexual humiliation (e.g. pejorative comments), trauma to genitalia (e.g. suspension of heavy objects from the genitalia, castration, instrumentation), and rape.

The International Crime Tribunals for Rwanda and the former Yugoslavia charged rape as a war crime. Rape is used effectively to terrorize entire communities. In Rwanda and the former Yugoslavia, for instance, women were frequently raped in front of relatives or their communities, leaving them ostracized, repudiated by husbands and other relatives.

Sexual torture produces long-lasting mental and physical sequelae. In rape cases, these include unwanted pregnancy and sexual transmitted diseases.

Mental Torture

Almost all victims of torture suffer some form of mental torture. Direct threats to him/her or to a relative are by far the most common form of torture. Other forms of mental torture include sensory deprivation, poor conditions during detention, mock executions, long interrogations, and being forced to torture another person, witness the torture of another person, or watch killings and rapes. Sensory deprivation includes detention in complete darkness, exposure to bright lights and constant noises, or sleep deprivation. Lack of food, potable water, toilet, bed, windows, aeration, medical care, and communication are examples of poor conditions during detention (1-11).

Mental suffering unique to refugees include enduring battlefield conditions, uprooting, and life in a refugee camp (1-11).

Summary: Most Common Types of Torture (1-11)

1. Blunt Trauma: crushing injuries, whipping, beatings
2. Penetrating Injuries: gunshots, shrapnel, stab wounds, slash cuts

3. Suspension
4. Burns: chemical and thermal, cold and heat
5. Asphyxiation: wet, dry, chemical
6. Electric Shocks
7. Forced Human Experimentation
8. Traumatic Removal of Tissue and Appendages: via either direct avulsion or explosion
9. Extreme Physical Conditions: forced body positions (prolonged constrain) and extreme heat/cold conditions
10. Sexual Torture: sexual humiliation, trauma to genitalia, rape
11. Mental Torture: direct threats, sensory deprivation, solitary confinement, mock execution, witnessing torture, uprooting

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PHYSICAL HEALTH: TORTURE-RELATED PHYSICAL SIGNS AND SYMPTOMS

Clinical Signs (1-12)

Form of Torture	Affected Organ/System	Acute Sequelae	Chronic Sequelae
Blunt Trauma <ul style="list-style-type: none"> • Crushing Injuries • Whipping • Beatings 	Skin and Appendages	-Edema -Lacerations -Ecchymosis	Scars
	Musculo-skeletal	-Dislocations -Fractures -Rhabdomyolysis -Closed Compartment Syndrome	-Ankylosis -Limb Deformity -Chronic Myalgias -Chronic Fasciitis
	Neurological	-Brain Concussion: loss of consciousness -Intracranial Bleeding -Skull Fracture	-Organic Brain Syndrome -Chronic Headaches -Post Concussion Syndrome -Reflex Sympathetic Dystrophy
	Genitourinary/Renal	-Acute Renal Failure -Hematuria -Hematocele	
	Respiratory	-Aspiration Pneumonia	

	Ears, Nose, Throat, Eyes	<ul style="list-style-type: none"> -Conjunctivitis -Iritis -Decreased Visual Acuity -Anterior Chamber Bleeding and Collapse -Dislocation of the Lens -Retinal Detachment and Hemorrhages -Strabismus -Tympanic Rupture and -Erythema -Hearing Loss -Otitis Media and Externa -Vocal Cord Palsy -Cricoid Bone Fracture 	<ul style="list-style-type: none"> -Tympanic Rupture -Blindness or Decreased -Visual Acuity -Permanent Hearing Loss -Vocal Cord Palsy
	Oral and Dental	<ul style="list-style-type: none"> -Bleeding -Tooth Avulsion and/or -Fracture -Mandibular Fracture and/or Dislocation 	<ul style="list-style-type: none"> Edentulous - Temporomandibular Joint Syndrome
Penetrating Injuries <ul style="list-style-type: none"> • Gunshot Wounds • Stab Wounds • Slash Cuts 	Skin and Appendages	<ul style="list-style-type: none"> -Edema -Lacerations -Echymosis -Infections: cellulitis, abscesses, sepsis 	<ul style="list-style-type: none"> -Scars
	Musculo-skeletal	<ul style="list-style-type: none"> -Fractures 	<ul style="list-style-type: none"> -Limb Deformity
	Neurological	<ul style="list-style-type: none"> -Peripheral Nerve - Damage: palsy or anesthesia -Spinal Cord Injury: paraplegia or quadriplegia -Brain Damage -Seizures -Intracranial Bleeding 	<ul style="list-style-type: none"> -Peripheral Nerve Damage: palsy or anesthesia -Spinal Cord Injury: paraplegia or quadriplegia -Brain Damage -Seizures
	Vascular	<ul style="list-style-type: none"> -Massive Bleeding - Death 	<ul style="list-style-type: none"> -Amputation from Necrosis

		-Limb Necrosis	
	Gastrointestinal	-Peritonitis	-Fistulas -Malnutrition
	Genitourinary/Renal	-Hematuria -Acute Renal Failure	
	Respiratory	-Pneumothorax and - Tension Pneumothorax -Hemothorax -Empyema	-Broncho-pleural Fistulas
	Ears, Nose, Throat, Eyes	-Anterior Chamber Collapse -Endophthalmitis	-Blindness
Electric Shocks	Skin	-1st, 2nd, or 3rd Degree Burns	-Scars
	Musculo-skeletal	-Muscle Sprains -Intramuscular Hematomas -Fractures -Rhabdomyolysis	
	Neurological	-Seizures	-Seizures
	Cardiovascular	-Arrhythmias	
	Genitourinary/Renal	-Acute Renal Failure - Rhabdo	
	Respiratory	-Apnea	
Suspension	Skin and Appendages	-Edema -Echymosis -Lacerations -Loosening of the Galea	-Scars -Alopecia -Disfigurement
	Musculo-skeletal		-Fibrositis, particularly of the shoulders and neck

	Neurological	-Peripheral Nerve Damage: palsy or loss of sensation	-Peripheral Nerve Damage: palsy or loss of sensation
	Vascular	-Necrosis	-Amputations
	Genitourinary	-Penile Fracture -Hematocele -Ecchymosis	-Erectile Dysfunction -Testicular Atrophy
Burns <ul style="list-style-type: none"> • Thermal • Chemical 	Skin and Appendages	-Blisters -Infections: cellulitis, sepsis	-Scars -Contracture over Joint Areas -Disfigurement
	Metabolic	-Dehydration -Electrolyte Imbalance -Malnutrition	
	Genitourinary/Renal	-Acute Renal Failure	
	Ears, Nose, Throat, Eyes	-Conjunctivitis -Iritis -Corneal Burns	-Blindness
Asphyxiation <ul style="list-style-type: none"> • Dry Submarine • Wet Submarine • Chemical 	Neurological	-Seizures -Anoxia/Hypoxia	-Organic Brain Damage
	Respiratory	-Aspiration Pneumonia -Angioedema -Burn of the Upper Airway Tract	
Sexual Torture	Genitourinary	-Sexual Transmitted Diseases -Unwanted Pregnancy -Mutilation of External Genitalia Hematocele	-Erectile Dysfunction -Sexual Transmitted Diseases Dyspareunia

		-Genital Lacerations and/or Abrasions	
		-Hematuria -Ecchymosis	

Clinical Symptoms (1-12)

Form of Torture	Affected Organ/System	Acute	Chronic	
Blunt Trauma <ul style="list-style-type: none"> • Crushing Injuries • Whipping • Beatings 	Skin and Appendages	Bleeding Purulent Drainage of Wounds Pain Swelling Loss of hair	-Nail Atrophy or thickening -Permanent hair loss	
	Penetrating Injuries <ul style="list-style-type: none"> • Gunshot Wounds • Stab Wounds • Slash Cuts 	Musculo-skeletal	-Pain -Swelling -Muscle Spasm -Decrease Range of Motion -Crepitation -Deformity	-Chronic Pain -Decrease Range of Motion -Deformity
		Neurological	-Palsy -Anesthesia, Paresthesia, and Dysesthesia -Memory Deficit -Loss of Consciousness -Changes in Mental Status -Incontinence -Seizures -Shivers/Tremors	-Palsy -Anesthesia -Chronic - Headaches -Memory Deficit Vertigo/Dizziness -Chronic Seizures
	Electric Shocks Suspension Burns <ul style="list-style-type: none"> • Thermal • Chemical 	Cardiovascular	-Palpitations	-Palpitations

<p>Asphyxiation</p> <ul style="list-style-type: none"> • Dry Submersion • Wet Submersion • Chemical <p>Sexual Torture</p>		<ul style="list-style-type: none"> -Chest Pain -Bleeding 	
	Gastrointestinal	<ul style="list-style-type: none"> -Nausea and Vomiting -Hematemesis -Bright Red per Rectum -Melenas -Abdominal Pain -Changes in Bowel Habits: diarrhea and constipation -Tenesmus -Fecal Incontinence 	<ul style="list-style-type: none"> -Changes in Bowel Habits: diarrhea and constipation -Soiling
	Genitourinary/Renal	<ul style="list-style-type: none"> -Urinary Frequency -Urinary Hesitancy -Dysuria -Decrease Urine Flow -Urinary Retention -Hematuria -Vaginal Bleed and Discharge -Tenesmus 	<ul style="list-style-type: none"> -Dysuria -Urinary Hesitancy
	Respiratory	<ul style="list-style-type: none"> -Shortness of Breath -Cough -Pleuritic Pain 	<ul style="list-style-type: none"> -Shortness of Breath -Cough
	Ears, Nose, Throat, Eyes	<ul style="list-style-type: none"> -Decrease Hearing -Earache -Ear discharge -Tinnitus -Epistaxis -Anosmia -Dysphagia -Hoarseness 	<ul style="list-style-type: none"> -Permanent Hearing Loss -Anosmia -Tinnitus -Permanent Hoarseness -Chronic Dysphagia
	Oral and Dental	<ul style="list-style-type: none"> -Pain -Swelling -Bleeding -Decrease Range of Motion and Crepitation of the Temporomandibular 	<ul style="list-style-type: none"> -Chronic Temporomandibular Joint Pain

		Joints	
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1. Shrestha NM and Sharma B. Torture and Torture Victims – A Manual for Medical Professionals. Center for Victims of Torture, Katmandu, Nepal, 1995.
2. Mcivor RJ and Turner SW. Assessment and Treatment Approaches for Survivors of Torture. *British J. Psychiatry* 1995;166: 705 – 711.
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11. American College of Physicians. The Role of the Physician and the Medical Profession in the Prevention of International Torture and in the Treatment of its Survivors. *Ann Int Med* 1995;122: 607 – 613.
12. Annas GJ and Grodin MA. *The Nazi Doctors and the Nuremberg Code - Human Rights and Human Experimentation*. Oxford University Press, New York, NY; 1992.

PHYSICAL HEALTH: PHYSICAL HEALTH INTERVIEW

What you are about to see is an interview involving a physician and survivor of torture. The purpose of this interview is to complete the process of gathering information from the patient in order to compose an affidavit. You may need to alter your interview and physical exam techniques depending on your client's stage of recovery and on the purpose and function of the interview. The corresponding bullet points listed below the video link explain the material shown in the film clips and supplement it with guidance more applicable to initial meetings. For convenience, only male pronouns will be used in the following text corresponding to the male patient in the film. Above all, you want to avoid re-traumatization via interrogation-like techniques—as well as physical contact and use of routine medical instruments—that simulate your client's torture experience. You generally want to go very slowly and preface everything you do with a thorough explanation. The necessitation of an affidavit for an asylum hearing may call for a more expedited evaluation. It is best to use interpreters who are culturally sensitive and medically trained.

[Click for the Video](#)



Interview

Getting Settled

- Aim to make the exam room as non-threatening as possible so your patient is not reminded of his past confinement.
 - Use a large room when possible. Windows, culturally appropriate artifacts, flowers, and art can help create a safe and reassuring environment. Through décor, you can personalize the interview room and communicate that you are familiar with the region of the world from which he came.

- Limit the number of instruments and medical paraphernalia that are visible to the patient, as these may remind him of objects used during his torture experience.
- Refraining from wearing a white lab coat makes the encounter more personable.
- Do not bring groups of medical students into the exam room.
- Greet your patient in a culturally sensitive manner.
 - You may want to do research or ask the interpreter to find out what will be appropriate for this patient.

Beginning the Exam

- Introduce yourself, give your credentials, and explain your role at the treatment center in which you work.
- Clarify your patient's demographic information.
 - How does your patient spell and pronounce his name? How would he like to be addressed?
 - Obtain his contact information.
- Ask how your patient got to the treatment center. Did he have trouble getting to the office? Explain to him where he is.
- Set the overall agenda for obtaining the necessary information for writing an affidavit. Depending upon the patient, this may take several appointments. Carefully describe how long this exam session will be and what it will entail.
- Inform your patient that you will be taking notes during the exams for documentation purposes. Explain what the notes will be used for and maintain eye contact throughout the exam.
- Explain the principle of confidentiality to your client, as many clients may be unfamiliar with this concept.
 - Assure your client that nothing will be used or reported outside of the exam room without his expressed written permission. This includes any communication with his referring lawyer, if this was the nature of your patient's referral.
 - Explain to him that you will be writing an affidavit for his asylum hearing, that he will have an opportunity to review it, and that it will not be sent to his lawyer without his consent. Your patient and his lawyer together will decide if the affidavit you write will be used in court. Set some ground rules, as refugees and survivors of torture have often experienced a lack of control in their past environments.
 - Give your patient a sense of control, telling him that he can stop the exam at any time and refrain from answering any questions. You may stop the exam as well if you feel things are too emotionally charged. Often survivors of torture have trouble tolerating physical contact, particularly genital or rectal exams if they have experienced sexual trauma.

Pre-Torture Social and Work Histories

- Ask about his life before the torture occurred.
 - Childhood and family life
 - Education and work life
 - Has he been married and does he have children?
 - What is his experience with religion, cultural traditions, and/or political organizations?
 - Clarify if other family members have also been persecuted.

Current Social and Work History

- What is your patient's current living situation, including access to food, clothing, and shelter?
- What is his level of social functioning (daily activities, occupation, social networks, recreational activities)?

Medical History

- Take a routine medical history (family history, hospitalizations, childhood diseases, allergies, medications, traditional medical practices, alcohol, stimulants, depressants, tobacco, diet, illness, and pain complaints)
 - Inquire about his existing medical and mental health records.
- Specific releases for these records may be needed so that you have a complete medical history when writing your patient's affidavit.
- Trauma history (stresses, lack of healthy family support networks, abuse, domestic violence, childhood trauma)

Gathering Torture History

- Proceed very carefully and judiciously.
- Phrase your questions in a way that regularizes and normalizes your patient's experiences with torture so he does not feel alienated or ashamed.
- It is often helpful to conduct your interview in a chronological fashion.
- It is important to find out where, when, and how the torture occurred for documentation purposes. Clarify the context in which torture occurred and why he was persecuted. Ask him to describe the circumstances of his arrest and where he was taken.
 - If your patient was imprisoned, why and how did this happen?
 - What did his cell or detention center look like? How many people were in his cell? Did your patient endure hard labor in detention?
 - Did he have access to water, food, a toilet, warmth, medical care, legal representation, and human rights advocacy?
 - While imprisoned, was your patient able to sleep well and communicate with his family?

- Slowly ask him to describe what happened. Specific areas of concern will include:
 - Was he threatened?
 - Was your patient beaten, suspended, shaken, restrained, shackled, burned, crushed, shocked, or exposed? Did he experience head trauma, as this may affect how well he remembers past events?
 - Ask him to describe his acute wounds and healing process, and any medical treatment he might have received for his wounds.
 - Was your patient forced to accuse others or to confess to things he did or did not do?
 - Was he forced to watch or participate in mock executions or the torture of others?
 - Obtain a history of sexual violence and rape very slowly and compassionately. You may want to wait until you have gained rapport with your patient before asking about sexual trauma.
 - Note that events related to sexual trauma, as well as being forced to give information that could hurt another or one's family, can be particularly difficult to talk about.
 - Why and how was your patient released?
 - From what did your patient derive the will to survive and the strength to endure?
 - How did these experiences immediately affect your patient?
 - Inquire about chronic sequelae of torture.
 - Give reassurances whenever possible

Physical Exam

- Be cognizant that the physical exam will be difficult for your patient and may likely cause him to feel very vulnerable. It is therefore important that you preface everything you do with a thorough explanation. Describe what the instruments are before using them. Remind your patient that he can stop the exam whenever he feels uncomfortable. Be reassuring and compassionate at all times. As you proceed, consider whether his narrative is consistent with the physical findings.
- Be attuned to body language.
- Blood pressure cuffs and otoscopes can simulate torture instruments.
- Conduct genital, rectal, and pelvic exams slowly and carefully, preferably deferring them until later appointments because these exams can be very traumatizing if patients have been raped. Keep in mind that many women have not seen a speculum before.
- Be aware that many survivors of torture have somatic complaints, meaning they have no organic origin.
- Document all non-torture lesions.
- Document all scars and deformities, especially those on the limbs.
- Perform careful neurological and abdominal exams, as headaches and abdominal pain are common in survivors of torture.

- Exam the soles of the feet, though falanga does not usually leave chronic scars.
- Primary care physicians should conduct mental health screenings:
 - Formal diagnostic tools, in certain instances may be of value, however these screening tests are generally not culturally validated.
 - Assess your patient's appearance, eye contact, attitude, motor activity, affect, mood, speech, thought processes, thought content (hallucinations, delusions, judgment), insight, orientation, and cognition. Note that cultural variations in how patients present mental disorders must be taken into account.
 - Many survivors of torture are affected emotionally by their experience. In order to create a treatment plan, assess the need for medication, and write an affidavit, it is important to evaluate the presence of psychiatric symptoms and their impact on functioning. For example, using Western nomenclature according to the Istanbul Protocol, patients may present with major depression, post-traumatic stress disorder, somatic complaints, substance abuse, neuropsychological impairments, psychosis, bipolar disorders, enduring personality change, generalized anxiety disorder, panic disorder, acute stress disorder, somatoform disorders, and phobias. Click [here](#) to find a complete DSM IV description of these disorders.
 - Allow the patient to get dressed in privacy and ask him to open the door when he is ready for you to return. Be prompt in returning, as waiting can trigger anxiety.

Reflection

- What is your impression of the consistency and veracity of the interview and physical findings, keeping in mind that some inconsistency is expected due to the nature of torture and its physical and psychological effects on people?
- You should come to some diagnostic impression after the first interview and devise a treatment plan accordingly.

Ending the Interview

- Leave time to ask your patient if he has any remaining questions or wants to talk about additional topics.
- Clarify what the next step will be, when your patient's next appointment will be, and what will happen during this next meeting.
- You may want to give your patient a business card with your contact information. Inform him of your availability and the protocol he should follow if an after-hours emergency arises.
- Educate your patient about your treatment center and the services it offers.
 - The Boston Center for Refugee Health and Human Rights offers health education, treatment, and referrals to medical specialists and social support services.
 - Sign a release for your patient's information so you may dialogue with other providers and his lawyer.

- Walk out of the exam room with your patient.

PHYSICAL HEALTH: ADDITIONAL RESOURCES

Crosby, S.S., Mohan, S., Di Loreto, C., Spiegel, J.H. (2009). Head and neck sequelae of torture. *The Laryngoscope*, 120(2), 414-419. Available at:
<http://onlinelibrary.wiley.com/doi/10.1002/lary.20731/abstract;jsessionid=59224EF1C6B1DEE58891417907E28A82.d04t04>

MENTAL HEALTH: OBJECTIVES

We hope that the information contained in this section, in combination with the Interview Considerations page, will help you to achieve the following learning objectives:

- 1) To understand the various types of mental torture, as well as recognize the mental component of physical torture.
- 2) To recognize and understand the range of mental health issues faced by individuals and communities as a result of torture.
- 3) To learn how to sensitively hold mental health sessions with survivors of torture.

MENTAL HEALTH: OVERVIEW

Victims of human rights violations may experience mental health issues directly related to torture, mistreatment, and uprooting. Issues relating to mental health do not just affect the individual, but families and communities as well. By considering their client's potential mental health issues beforehand, caregivers can provide assistance and treatment based on consideration of the client's mental as well as physical condition.

One helpful tool for understanding the refugee experience is the Triple Trauma Paradigm, which organizes common traumas into three phases: Pre-Flight, Flight, and Post-Flight (1). Along with the primary mistreatment and torture, a refugee/asylee must cope with the disruption of everyday activities and resources, like school, work, personal property, social position, access to health care, transportation, and cultural cohesion. Physically leaving one's home and country constitutes a number of risks, leaving the individual feeling disoriented, uncertain, and vulnerable to further trauma. Once the refugee arrives in his or her country of refuge, they must cope with their past experiences as well as the stresses of acclimating to a new culture, finding housing and work, and in many cases, coping with the uncertainties relating to the asylum process.

Mental symptoms for individuals include post-traumatic stress disorder and depression, but families and communities may exhibit signs of damage as well. These may manifest as constriction of social networks, distrust in communities and authority figures, and individual and community-wide censorship. Families may experience a loss of social and cultural support, social withdrawal, marital or intergenerational conflict, interruption of parental functioning, low tolerance for negative emotions, silence about the traumatic experiences, parent/child role reversal, and extraordinary pressure on children to succeed (1).

Almost all victims of torture suffer some form of mental torture. Direct threats to him/her or to a relative are by far the most common form of torture. Other forms of mental torture include sensory deprivation, poor conditions during detention, mock executions, long interrogations, and being forced to torture another person, witness the torture of another person, or watch killings and rapes. Sensory deprivation includes detention in complete darkness, exposure to bright lights and constant noises, or sleep deprivation. Lack of

food, potable water, toilet, bed, windows, aeration, medical care, and communication are examples of poor conditions during detention (2-11).

Mental suffering unique to refugees include enduring battlefield conditions, uprooting, and life in a refugee camp (2-11). See page 40 of this manual for a list of types of torture.

References

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TORTURE-RELATED MENTAL HEALTH SIGNS AND SYMPTOMS

Risk Factors for Psychological Sequelae *

1. Female
2. Length of imprisonment
3. Previous history of psychological trauma
4. Mental preparedness
5. Personality traits
6. Torture

* Adapted from In: Basoglu M (Ed.). *Torture and Its Consequences - Current Treatment Approaches*. Cambridge University Press: Cambridge, UK, 1992.

Many survivors of torture are affected emotionally by their torture experiences. In order to create a treatment plan, assess the need for medication, and write an affidavit, it is important to evaluate the presence of psychiatric symptoms and their impact on functioning. For example, using Western nomenclature according to the *Istanbul Protocol*, clients may present with posttraumatic stress disorder, major depression, somatic complaints, substance abuse, neuropsychological impairments, psychosis, bipolar disorders, enduring personality change, generalized anxiety disorder, panic disorder, acute stress disorder, somatoform disorders, and phobias. Note that formal diagnostic tools are generally not culturally validated and that cultural variations in how clients present mental disorders must be taken into account.

Posttraumatic Stress Disorder (PTSD)

PTSD can be acute, chronic, or delayed and has 5 diagnostic criteria according to the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) IV (1):

1. The first criterion and key element for the diagnosis is exposure to an event outside the usual human experience, such as combat experience, a major natural catastrophe, or torture.
2. The second criterion is presence of symptoms for at least a month.
3. The third criterion is re-experiencing the initial event in at least one of the following forms:

- Recurrent and intrusive recollections of the trauma. For example, an African patient described how the voices of his captors were present all day and all night, no matter if he was working or resting, happy or sad.
- Recurrent distressing dreams about the trauma.
- Acting/feeling as if the events were recurring (i.e. hallucinations, flashbacks, and illusions). For instance, an Algerian man recounts seeing his captors beating him during an interrogation and consequently trying to protect his head from the imaginary blows. He has noticed that the smell of urine triggers the flashbacks since this smell was strongly present in the interrogation room of his past.
- Emotional and physical distress when exposed to cues that symbolize or initiate the remembrance of the trauma. A patient from Sub-Saharan Africa, for example, becomes very anxious every time he has to take an elevator because it reminds him of the narrow cell in which he was imprisoned for several months.

4. The fourth criterion is persistent avoidance of stimuli associated with the traumatic event in at least three of the following forms:

- Avoidance of thoughts or feelings that may arouse memories from the trauma. For instance, a female patient can no longer remember intimate moments with her husband because she immediately remembers being gang raped.
- Avoidance of activities or situations that resemble the trauma. An African male patient, for example, has experienced sexual dysfunction since tortured because every time he tries to have intercourse with his wife he remembers being raped and his captors saying "you are no longer a man."
- Inability to recall an important aspect of the traumatic event. For instance, a female patient recalled all the details of her detention, except for the period of time when she was raped.
- Diminished interest in daily activities
- Detachment and estrangement
- Restricted range of affect expressed as inability to love or be loved
- Sense of foreshortened future

5. The fifth criterion is persistent state of increased arousal manifested in at least two of the following ways:

- Difficulty falling or staying asleep
- Irritability
- Difficulties concentrating
- Hyper-vigilance
- Exaggerated startle response. A patient from Central America, for example, who received multiple threats by phone cannot control jumping whenever she hears a phone ringing.

Major Depression

According to the DSM IV, at least five of the following criteria should be present in the absence of organic brain damage, a medical condition such as hypothyroidism, or other psychiatric problem (1):

1. Anhedonia
2. Decreased interest in all or almost all daily activities
3. Insomnia or somnolence
4. Psychomotor agitation or retardation
5. Sadness
6. Feeling worthlessness or inappropriate guilt
7. Suicidal ideas
8. No evidence

Depression and PTSD have some symptoms in common such as insomnia, decreased interest in daily activities, and sense of foreshortened future.

Reference

1. American Psychiatric Association. Diagnostic and Statistical Manual on Mental Disorders, 4th edition. Washington , DC, 1994.

MENTAL HEALTH INTERVIEW

Introduction

What you are about to see is an initial interview involving a mental health professional and survivor of torture. You may need to alter your interview techniques depending on your client's stage of recovery and the purpose and function of the interview. The corresponding bullet points listed below the video explain and supplement the material shown in the film clip. For convenience, only feminine pronouns will be used in the following text corresponding to the female patient in the film. Above all, you want to avoid re-traumatization via interrogation-like techniques and other methods that simulate your client's torture experience. You generally want to go very slowly; however, the necessitation of an affidavit for an asylum hearing may call for a more formal and structured interview style. It is best to use interpreters who are culturally sensitive and medically trained.

Interview, by Dr. Michael Grodin and Dr. Lin Piwowarczyk

[Click here for video](#)



Getting Settled

- Conduct the interview in an open area so your client is not reminded of her possible past confinement.
 - Windows, culturally appropriate artifacts, flowers, and art can help create a safe and reassuring environment. Through décor, you can personalize the interview room and communicate that you are familiar with the region of the world from which she came.
- Meet your client in the waiting area or at the door and direct her to a chair where the interview will take place.

- The interview should not begin until you and your client are seated comfortably at eye level.

Beginning the Interview

Introduce yourself, give your credentials, and explain your role at the treatment center in which you work. You may want to give your client a business card with your contact information.

Clarify your patient's demographic information. How does your patient spell and pronounce her name? How would she like to be addressed? Obtain her contact information. Ask if your client had trouble getting to the office and explain where she is. Carefully describe how long the interview session will be and what it will entail.

It is helpful to not take notes during the initial interview so that you can establish a therapeutic alliance, make eye contact, and listen carefully. If you do take notes, maintain eye contact and explain to your client what they are for and how they will be used.

- Explain the principle of confidentiality to your client, as many clients may be unfamiliar with this concept.
 - Assure your client that nothing will be used or reported outside of the interview room without her expressed written permission. This includes any communication with her referring lawyer, if this was the nature of your client's referral.
 - If the interview is being conducted so you can prepare an affidavit for your client's asylum hearing, it is important to explain to her that at some point an affidavit will be written, that she will have an opportunity to review it, and that it will not be sent to her lawyer without her consent. Your client and her lawyer together will decide if the affidavit you write will be used in court.
- Set some ground rules, as refugees and survivors of torture have often experienced a lack of control in their past environments.
 - Give your client a sense of control, telling her that she can stop the interview at any time and refrain from answering any questions. You may stop the interview as well if you feel things are too emotionally charged.
- Educate your client about your treatment center and the services it offers.

Gathering Pre-Torture Social & Work Histories

[Click here for video](#)



- Start the interview by focusing on your patient's strengths and her life before the torture occurred.
 - Childhood and family life
 - Education and work life
- Has she been married and does she have children?
- What is her experience with religion, cultural traditions, and/or political organizations?
- Clarify if other family members have also been persecuted.

Gathering Torture History

[Click here for video](#)



- Proceed very carefully and judiciously.
- Phrase your questions in a way that regularizes and normalizes your client's experiences with torture so she does not feel alienated or ashamed.
- It is often helpful to conduct your interview in a chronological fashion.
- It is important to find out where, when, and how the torture occurred for documentation purposes. Clarify the context in which torture occurred and why she was persecuted. Ask her to describe the circumstances of her arrest and where she was taken.
 - If your client was imprisoned, why and how did this happen?
 - What did her cell or detention center look like? How many people were housed in the cell? Did she have access to water, food, a toilet, warmth, medical care, legal representation, and human rights advocacy?
 - While imprisoned, was your client able to sleep well and communicate with her family?
 - Slowly ask her to describe what happened. Specific areas of concern will include:
 - Was she threatened?
 - Was your patient beaten, suspended, shaken, restrained, shackled, burned, crushed, shocked, or exposed? Did she experience head trauma, as this may affect how well she remembers past events?
 - Was your client forced to accuse others or to confess to things she did or did not do?
 - Was she forced to watch or participate in mock executions or the torture of others?
 - Obtain a history of sexual violence and rape very slowly and compassionately.

- Note that events related to sexual trauma, as well as being forced to give information that could hurt another or one's family, can be particularly difficult to talk about.
- Why and how was your client released?
- From what did your patient derive the will to survive and the strength to endure?
- How did these experiences immediately affect your patient?

Give reassurances whenever possible.

Current Social and Work Histories

- Why and how did your client come to live near your treatment center?
- What is your client's current living situation, including access to food, clothing, and shelter?
- What is her level of social functioning (daily activities, occupation, social networks, recreational activities)?

Medical, Psychological, and Trauma Histories

- Inquire about prior medical and mental health treatment and records.
 - Specific releases for these records may be needed so that you have a complete medical history when writing your client's affidavit.
- Medical and psychological history
 - Medical problems, hospitalizations, Western and traditional medicines, allergies, diet
 - Drug history (alcohol, stimulants, depressants, tobacco)
- Trauma history (stresses, lack of healthy family support networks, abuse, domestic violence, childhood trauma)

Assessing Mental Health Status

- Formal diagnostic tools in certain instances may be of value; however, these screening tests are generally not culturally validated.
- Assess your client's appearance, eye contact, attitude, motor activity, affect, mood, speech, thought processes, thought content (hallucinations, delusions, judgment), insight, orientation, and cognition. Note that cultural variations in how clients present mental disorders must be taken into account.
- Many survivors of torture are affected emotionally by their experience. In order to create a treatment plan, assess the need for medication, and write an affidavit, it is important to evaluate the presence of psychiatric symptoms and their impact on functioning. For example, using Western nomenclature according to the Istanbul Protocol, clients may present with major depression, post-traumatic stress disorder, somatic complaints, substance abuse, neuropsychological impairments, psychosis, bipolar disorders, enduring personality change, generalized anxiety disorder, panic disorder, acute stress disorder, somatoform disorders, and phobias.

Reflection

- What is your impression of the consistency and veracity of the interview, keeping in mind that some inconsistency is expected due to the nature of torture and its physical and psychological effects on people?
- You should come to some diagnostic impression after the first interview and devise a treatment plan accordingly.

Ending the Interview

[Click here for video](#)



- Give timely notice before concluding the interview so your client can ask any remaining questions or talk about additional topics.
- Clarify what the next step will be, when your client's next appointment will be, and what will happen during this next meeting.
- Inform her of your availability and the protocol she should follow if an after-hours emergency arises.
- Offer referral services if needed.
- Sign a release for your client's information.
- Hand your client a written follow-up appointment slip.
- Walk out of the interview room with your patient.

MENTAL HEALTH: OTHER RESOURCES

[National Capacity Building Project, the Center for Victims of Torture. "Healing the Hurt: A Guide for Developing Services for Torture Survivors." 2005.](#)

ORAL HEALTH: OBJECTIVES

We hope that the following information will aid you in sensitively conducting oral health exams with survivors of torture through the following lessons:

- Identify oral health issues and barriers to accessing dental care particular to survivors of torture
- Understand the significance of addressing the oral health needs of torture survivors within a holistic model of health care
- Learn techniques to reduce the risk of retraumatization
- Be familiar with common methods of torture and their corresponding sequelae

ORAL HEALTH: OVERVIEW

Within a holistic model of health care it is important to address the unique oral health needs of torture survivors. Many survivors have experienced trauma to the mouth during the context of torture resulting in discomfort or pain. In addition, many torture survivors come from countries where access to oral health care and prevention is minimal or non-existent. Finally, torture survivors face innumerable barriers to accessing oral health services in the United States. See page 40 in this manual for definitions of types of torture.

ORAL HEALTH: TORTURE-RELATED PHYSICAL SIGNS AND SYMPTOMS

Clinical Signs (1-12)

Form of Torture	Affected Organ/System	Acute Sequelae	Chronic Sequelae
<ul style="list-style-type: none"> • Blunt Trauma Crushing Injuries Whipping Beatings 	Oral and Dental	Bleeding Tooth Avulsion and/or Fracture Mandibular Fracture and/or Dislocation	Edentulous Temporomandibular Joint Syndrome

Clinical Symptoms (1-12)

Form of Torture	Affected Organ/System	Acute	Chronic
Blunt Trauma Crushing Injuries Whipping Beatings Penetrating Injuries Gunshot Wounds Stab Wounds Slash Cuts Electric Shocks Suspension Burns Thermal Chemical Asphyxiation Dry Submarino Wet Submarino Chemical	Oral and Dental	Pain Swelling Bleeding Decrease Range of Motion and Crepitation of the Temporomandibular Joints	Chronic Temporomandibular Joint Pain

References

1. Shrestha NM and Sharma B. Torture and Torture Victims – A Manual for Medical Professionals. Center for Victims of Torture, Katmandu, Nepal, 1995.
2. Mcivor RJ and Turner SW. Assessment and Treatment Approaches for Survivors of Torture. *British J. Psychiatry* 1995;166: 705 – 711.
3. Forrest D. The Physical After-Effects of Torture. *Forensic Science International* 1995; 76: 77 – 84.
4. Petersen HD and Rasmussen OV. Medical Appraisal of Allegations of Torture and the Involvement of Doctors in Torture. *Forensic Science International* 1992; 53: 97 – 116.
5. Rasmussen OV. Medical Aspects of Torture. *Danish Medical Bulletin* 1990; 37(Supplement 1): 1 – 88.
6. Goldfeld AE, Mollica RF, Pesavento BH, Stephen VF. The Physical and Psychological Sequelae of Torture – Symptomatology and Diagnosis. *JAMA* 1988; 259(18): 2725 – 2729.
7. Skylv G. Physical Sequelae of Torture. In: Basoglu M (Ed.). *Torture and Its Consequences – Current Treatment Approaches*. Cambridge University Press: Cambridge, UK, 1992. p 39 – 53.
8. Sommer F, Vesti P, Kastup M and Genefke IK. Psychosocial Consequences of Torture: Current Knowledge and Evidence. In: Basoglu M (Ed.). *Torture and Its Consequences – Current Treatment Approaches*. Cambridge University Press: Cambridge, UK, 1992. p 56 – 68.
9. Weinstein HM, Dansky L, and Iacopino V. Torture and War Trauma Survivors in Primary Care Practice. *West J Med* 1996; 165: 112 – 118.
10. Iacopino V, Ozkalipci O, Schlar C. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol). Available at: <http://www.phrusa.org/research/torture/index.html> [Accessed 05/11/01].
11. American College of Physicians. The Role of the Physician and the Medical Profession in the Prevention of International Torture and in the Treatment of its Survivors. *Ann Int Med* 1995;122: 607 – 613.
12. Annas GJ and Grodin MA. *The Nazi Doctors and the Nuremberg Code - Human Rights and Human Experimentation*. Oxford University Press, New York, NY; 1992.

ORAL HEALTH: ORAL HEALTH EXAM

Introduction

What you are about to see is an oral screening involving a dental hygienist and survivor of torture. The corresponding bullet points explain and supplement the material shown in the film clips. For convenience, only male pronouns will be used in the following text corresponding to the male patient in the film. Above all, you want to avoid re-traumatization via interrogation-like techniques—as well as physical contact and use of routine oral instruments—that simulate your client’s torture experience. It is best to proceed slowly and to use interpreters who are culturally sensitive and medically trained.

Interview, by Harpreet Singh, RDH, MS

[Click for the Video](#)



Beginning the Exam

- A dental screening can be conducted in a dental or non-dental setting. The examination environment should be welcoming, non-traumatizing, and un-cell-like, with all examination implements and instruments in view.
- Start by introducing yourself. Inform the client how he was referred to you and then tell him what you will be doing today.
 - Explain to your client that you will look into his mouth to examine his oral health status and then will help him find a dentist that will be able to treat him.
- Clarify your patient’s demographic information.
- How does your patient spell and pronounce his name? How would he like to be addressed?

Obtain his contact information

- Is he experiencing any pain in his mouth today?
- How would he describe the health of his teeth and gums?
- Has he ever been to the dentist, and if so, when was his last visit?
- Ask about his brushing habits. What does he use to clean his teeth and how often does he do so?
- Has he experienced any trauma or torture in his face or mouth? If he was imprisoned in the past, was he able to clean his teeth during that time? What were his eating habits while imprisoned?
- Inform him that you will now perform a brief examination of his neck, mouth, and teeth.

Assessing Oral Health Status

- Begin by doing an extra-oral exam, looking at the lips, neck, and jaw for any abnormalities.
- Inspect the entire dentition systematically, proceeding from tooth to tooth. Begin with the teeth in the right upper jaw and continue towards the left upper jaw. Then examine the teeth in the lower jaw from left to right.
- Examine the mouth for:
 - Loose teeth, missing teeth, broken teeth and root tips
 - Presence of restorations (fillings) and broken or missing fillings
 - Signs of poor oral hygiene and oral malodor
 - Tooth pain, sensitivity to temperature change and pressure, and inability to chew in comfort

Patient Education and Referral

- Discuss your findings with the patient in simple terms and inform him of his treatment options.
- Educate your patient about oral hygiene and do a demonstration of proper brushing and flossing.
- Tell him to where you will be referring him for dental services and help him set up an appointment.
- Ensure that you have answered all of his questions.

References

1. Shrestha NM and Sharma B. Torture and Torture Victims – A Manual for Medical Professionals. Center for Victims of Torture, Katmandu, Nepal, 1995.
2. Mcivor RJ and Turner SW. Assessment and Treatment Approaches for Survivors of Torture. *British J. Psychiatry* 1995;166: 705 – 711.
3. Forrest D. The Physical After-Effects of Torture. *Forensic Science International* 1995; 76: 77 – 84.
4. Petersen HD and Rasmussen OV. Medical Appraisal of Allegations of Torture and the Involvement of Doctors in Torture. *Forensic Science International* 1992; 53: 97 – 116.
5. Rasmussen OV. Medical Aspects of Torture. *Danish Medical Bulletin* 1990; 37(Supplement 1): 1 – 88.

6. Goldfeld AE, Mollica RF, Pesavento BH, Stephen VF. The Physical and Psychological Sequelae of Torture – Symptomatology and Diagnosis. JAMA 1988; 259(18): 2725 – 2729.
7. Skylv G. Physical Sequelae of Torture. In: Basoglu M (Ed.). Torture and Its Consequences – Current Treatment Approaches. Cambridge University Press: Cambridge, UK, 1992. p 39 – 53.
8. Sommer F, Vesti P, Kastup M and Genefke IK. Psychosocial Consequences of Torture: Current Knowledge and Evidence. In: Basoglu M (Ed.). Torture and Its Consequences – Current Treatment Approaches. Cambridge University Press: Cambridge, UK, 1992. p 56 – 68.
9. Weinstein HM, Dansky L, and Iacopino V. Torture and War Trauma Survivors in Primary Care Practice. West J Med 1996; 165: 112 – 118.
10. Iacopino V, Ozkalipci O, Schlar C. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol). Available at: <http://physiciansforhumanrights.org/library/istanbul-protocol.html>
11. American College of Physicians. The Role of the Physician and the Medical Profession in the Prevention of International Torture and in the Treatment of its Survivors. Ann Int Med 1995;122: 607 – 613.
12. Annas GJ and Grodin MA. The Nazi Doctors and the Nuremberg Code - Human Rights and Human Experimentation. Oxford University Press, New York, NY; 1992.

ORAL HEALTH: OTHER RESOURCES

The Oral Health Status of Survivors of Torture

K.M. Lituri¹, H. Singh¹, M.M. Henshaw¹, L. Piwowarczyk², M. Grodin³, S. Crosby²
1 Boston University School of Dental Medicine, MA, USA, 2 Boston University School of Medicine, MA, USA, 3 Boston University School of Public Health

VOCATIONAL REHABILITATION: OBJECTIVES

We hope that with the following information, in combination with the Interview Considerations section, you will accomplish the following learning objectives:

Be able to explain vocational rehabilitation services

Be able to **identify unique considerations of providing vocational rehabilitation services to torture survivors and with cultural competency**

- Be able to give examples of assessment questions to use during initial appointments
- Be able to summarize ways to prepare someone for being rejected from a job

To view the vocational rehabilitation component of the UN-funded film produced by the Boston Center for Refugee Health and Human Rights, click on the link on page 86.

VOCATIONAL REHABILITATION: OVERVIEW

We hope that the following information, in combination with the Interview Considerations page, will aid you in sensitively conducting an initial vocational rehabilitation meeting with survivors of torture. To view the vocational rehabilitation segment of the UN-funded film produced by the Boston Center for Refugee Health and Human Rights, click on the link above. For further information on providing vocational rehabilitation services to refugees and survivors of torture, see the manual provided below. You can also view a webinar, moderated by the [Center for Victims of Torture](#) and a Job Readiness Guidebook in the “Additional Resources” section of this course.

VOCATIONAL REHABILITATION: INTERVIEW

Introduction

Survivors of torture and trauma often experience unique barriers and challenges to choosing, getting, and keeping gainful employment. You, as a vocational rehabilitation specialist, should work toward the following objectives with clients: vocational integration, establishment of trust, selection of appropriate employment, employer education, facilitation of safety, and monitoring of progress. The film you are about to see depicts a vocational rehabilitation specialist and a survivor of torture who are beginning the job search process. Make every effort to avoid re-traumatization via interrogation-like techniques. It is best to proceed slowly and to use interpreters who are culturally sensitive. The corresponding bullet points explain and supplement the material shown in the film. For convenience, only feminine pronouns will be used in the following text corresponding to the female client in the film.

[Click here for video](#)



VOCATIONAL REHABILITATION: OTHER RESOURCES

Piwowarczyk, L., Clark, G., Caballes, N. “Vocational Considerations in Immigrants” (2007). In: Walker, P. & E. Barnett (Eds.) *Immigrant Medicine*. Saunders Elsevier: Philadelphia, 699-701.

Piwowarczyk, et al. “Vocational Rehabilitation of Torture Survivors.” BCRHHR. Boston, MA: 2004. (funded by the Office of Refugee Resettlement)
Provided in Appendix C.

Simon, et al. “Job Kit Guidebook.” BCRHHR. Boston, MA: 2008.
Will be available: www.bcrhhr.org; Contact info.bcrhhr@bmc.org for distribution.

Vocational Rehabilitation with Torture Survivors Webinar, moderated by The [Center for Victims of Torture](#). [Click here to view Webinar](#)

CONCLUSION

We hope that you have found “Caring for Refugees and Survivors of Torture” to be a valuable introductory tool towards integrating human rights considerations into your work with survivors of torture and refugee trauma. We encourage you to continue your research in this area and to keep up to date with international and domestic events that impact the legal and material situations of refugees.

Upon completion of the course, you should have achieved the following objectives:

- Understand the scope, magnitude, and implications of human rights violations
- Be familiar with common methods of torture and how to recognize physical, mental, and oral signs and symptoms of torture and related trauma
- Understand the various types of mental torture, as well as recognize the mental component of physical torture, and recognize and understand the range of mental health issues faced by individuals and communities as a result of torture
- Learn the risk factors relating to a history of torture
- Learn to assess and address holistically the unique needs of torture survivors
- Become aware of resources available for this client/patient population
- Understand the asylum application process including eligibility and the standard for asylum
- Identify and understand the significance of relevant forms, governing agencies, and important documents and evidence, including the role of health professionals and expert witness testimony
- Understand the significance of the one year filing deadline and its implications to the alien as well as the terms ‘defensive’ versus ‘affirmative’ application
- Understand current asylum trends in the United States
- Learn to prepare for and conduct interviews and exams in a sensitive manner that considers the client’s/patient’s cultural background, current situation, and past traumatic experiences
- Understand the different types of interpreters and the roles they should play during interviews and exams
- Understand the potential for vicarious traumatization and learn how to recognize and cope with it
- Learn techniques to reduce the risk of retraumatization
- Learn how to gather a torture history for the purpose of composing an affidavit in support of an asylum claim
- Understand vocational rehabilitation services and be able to identify unique considerations of providing vocational rehabilitation services to torture survivors and with cultural competency

We welcome any feedback or additions to our resource lists. Please direct all course-related correspondence to info.bcrhr@bmc.org.

ADDITIONAL RESOURCES

Blumhofer, Rebecca D., Neha Shah, Michael A. Grodin, Sondra S. Crosby. ["Clinical Issues in Caring for Former Chattel Slaves."](#) .

[Cultural and Linguistic Competence. Systems of Care.](#) Retrieved 2/09/09.

Grodin, Michael A., Linda A. Piwowarczyk, Derek Fulker, Alexander R. Bazazi, Robert B. Saper. ["Treating Survivors of Torture and Refugee Trauma: A Preliminary Case Series Using Qigong and T'ai Chi."](#) The Journal of Alternative and Complementary Medicine. September 1, 2008, 14 (7): 801-806.

Piwowarczyk, Linda A., Terence M. Keane. ["Impact of September 11 on Refugees and Those Seeking Asylum."](#) Transcultural Pyschiatry 2007; 44; 566.

Piwowarczyk, Linda, Terence M. Keane, Alisa Lincoln. ["Hunger: The Silent Epidemic Among Asylum Seekers and Resettled Refugees."](#) International Migration, Vol. 46 (1). Blackwell Publishing Ltd., Oxford: 2008.

[Torture Journal. International Rehabilitation Council for Torture Victims. Retrieved 2/09/09.](#)

APPENDIX A

Boston Center for Refugee Health and Human Rights Expert Witness Checklist

Prepared by Dr. Michael A. Grodin and Linsey Ben-Ami

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Before the Hearing:

What to Do:

- ⌚ Make sure you have spoken with the client's lawyer about the case and about the types of questions you might be asked by all parties. To prepare, the lawyer will ask you many questions that he/she may ask you in court.
- ⌚ Be sure to ask the lawyer what the line of questioning will be and if there are any specific problems that might arise during your testimony.
- ⌚ Be certain you know the correct date, time, and place for which the hearing has been scheduled. It is sometimes possible to testify by phone if it is cleared with the judge. The lawyer must do this in advance.
- ⌚ Review the client's case file to make sure that it is accurate and complete. Do not bring originals or photocopies of the file with you to the court or the court may enter it as evidence into the court record. You may bring your evaluation with you.
- ⌚ Refresh your memory concerning the specifics of the patient's case.
- ⌚ Dress professionally. Avoid flashy colors and wear minimal jewelry.
- ⌚ Arrive at least an hour before you are scheduled to testify. Ask the lawyer to try to schedule your testimony for a specific time if the judge will agree. Otherwise be prepared to take off the entire morning or afternoon. If there is not enough time to hear the entire case, the hearing will be scheduled to continue on another day and you will be asked to come to testify then.
- ⌚ Use the toilet, stretch your muscles, and breathe deeply several times before the hearing begins. This will help make you more comfortable and will improve your body language.
- ⌚ If possible, before the trial starts, walk into the courtroom and see where the witness chair is located and the path you need to take to get to it. This will make it easier to walk there directly and help make you feel more comfortable.

During the Hearing:

Body Language:

Remember that messages are also conveyed by *nonverbal* language (e.g. tone of voice, facial expression, hand gestures, body position and eye contact).

- ⌚ Sit up straight.
- ⌚ Keep your hands on your lap and away from your mouth.
- ⌚ Keep both feet on the ground. Do not cross your legs.
- ⌚ Look directly at the questioning lawyer or the judge. Remember to make eye contact.

Speaking:

- ⌚ Tell the truth, the whole truth and nothing but the truth, otherwise you might hurt the client's case.
- ⌚ Speak accurately, concisely, and honestly.
- ⌚ Speak loudly and clearly and a little slower than usual. Using shorter sentences will make it easier for everyone to understand.
- ⌚ When someone asks you a question, wait until they finish the entire question, and then take a deep breath before responding. This will make sure you hear the entire question and give you some time to think before you respond.
- ⌚ If you do not understand the question, ask the lawyer to repeat it for you.
- ⌚ When you don't remember the answer to a question, say that you don't remember- don't try to make something up! You may also ask the judge if it is acceptable to look at the client's evaluation to help refresh your memory.
- ⌚ If you don't know the answer, say you don't know.
- ⌚ If you make a mistake, admit it and correct it. If you recall something you couldn't remember earlier or recall something differently than you had earlier, correct yourself. Nobody is going to hold it against you if you make a mistake, but they will hold it against you if they think you are lying.
- ⌚ Do not speak outside of your area of qualification.
- ⌚ Do not speculate or answer questions such as "What was _____ thinking when she attended the protest?"
- ⌚ Never memorize your testimony. Know your facts, but memorizing will make you look rehearsed during your testimony and you will not be able to handle questions asked out of order.
- ⌚ Show respect to everyone in the courtroom. If you need to ask the judge a question, look at the judge and say "Your Honor." Wait until the judge gives you permission to speak before you ask the question. Refer to the lawyers as "Sir" or "Madam."

- ⌚ Be polite, professional, and appropriate. Act the same way whether it is the client's lawyer or the government's lawyer asking you questions. Do not get defensive.
- ⌚ If you need to take a break, it is OK to ask the judge for a recess.
- ⌚ Do not write personal notes or they may become evidence included in the court record.
- ⌚ Do not supply anything beyond the affidavit already submitted to the court unless you have consulted with both the client and the client's attorney.

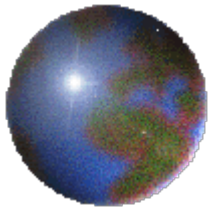
Keep in Mind:

- ⌚ This is an adversarial process. The government's lawyer is supposed to ask difficult questions. She is not there to be nice, but to do her job. Do not take it personally and do not get angry.

APPENDIX B

United States Asylum Process: Expert Witness Preparation

United States Asylum Process: Expert Witness Preparation



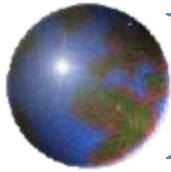
Michael A. Grodin, MD

Professor of Health Law, Bioethics, Human Rights and Psychiatry

Co-director, Boston Center for Refugee Health and Human Rights

Linsey Ben-Ami

Research Assistant, Boston Center for Refugee Health and Human Rights

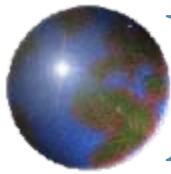


Definition of an Expert Witness

- An **expert witness** is a witness, who by virtue of education, or profession, or experience, is believed to have special subject matter knowledge beyond that of the average person sufficient that others rely on him for his opinions.

– From “Free Definition”. Available at:

<http://www.free-definition.com/Expert-witness.html>



United States Asylum Process

Client enters the US

Client in Court System

Files Affirmative Asylum Application

(Six months after applying you can apply for a work permit)

Asylum Office Interview

Asylum Granted

Referral to Court

“Notice to Appear” Issues

Master Calendar Hearing

Files Corrected/ Supplemental Application

Individual Merits Hearing

Grant of Asylum

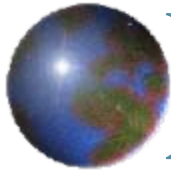
Lawful Permanent Residence

US Citizenship

Denial of Asylum

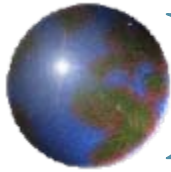
Appeals

Deportation



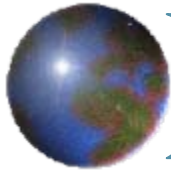
Asylum: Elements

- “Well Founded Fear” of “Persecution”
- Based on following factor(s)
 - Race
 - Religion
 - Nationality
 - Political Opinion
 - Membership in a Particular Social Group
- Government *is* persecutor or cannot control persecutors – unable or unwilling to protect



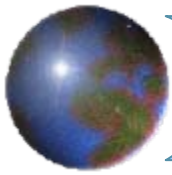
Additional Requirements

- Cannot safely return to any part of the country of origin
- No firm resettlement in another country
- Cannot have persecuted others
- Cannot have been convicted of certain crimes
- At Attorney General's discretion (terrorism, etc.)



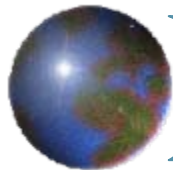
Merits Hearing: Trial Logistics

- JFK Federal Building
- Other cases may be scheduled at the same time
- Cases begin at either 9:00 a.m. or 1:00 p.m.
- Trial lasts 1-3 hours, may be continued
- You may only be allowed in the courtroom during your testimony



JFK Building

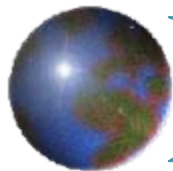




Getting to the Courtroom

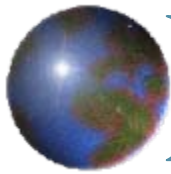


The courtroom is on the third floor. When you step off the elevator, there will be signs directing you to the courtroom.



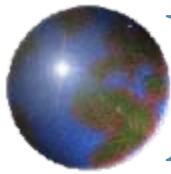
Approaching the Courtroom





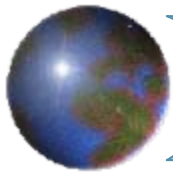
Entrance to the Waiting Room





Entrance to the Waiting Room

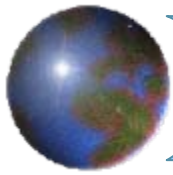




Sign-in Window



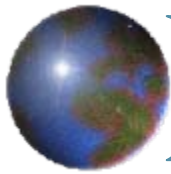
When you arrive, talk to the Immigration Court officials at the sign-in window.



In the Waiting Room



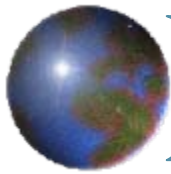
Be prepared to spend a considerable amount of time in the waiting room. Others waiting with you might be upset or emotional. It is not uncommon to see people waiting who are handcuffed or shackled.



Courtroom (seen from the doorway)

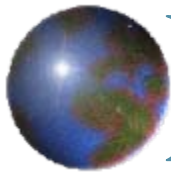


This is an example of one of the courtrooms ¹⁴



Courtroom (from the back)



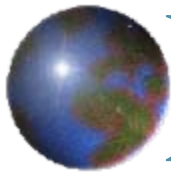


Seats in the Courtroom



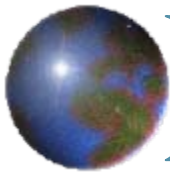
You will sit here
until called to
testify





View of the Judge's Bench



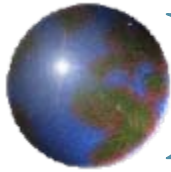


Testifying



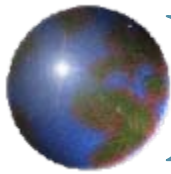
This is where you
will sit when you
testify





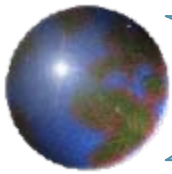
Merits Hearing: Trial Procedure

- Trial begins with review of Master Calendar proceedings
- Review of exhibits in record
- Review of exhibits submitted with trial brief
- Applicant will testify first



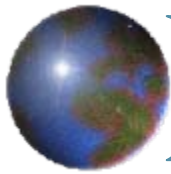
Establishing Professional Credentials

- At the beginning of your testimony the client's lawyer will ask several questions about your professional background and experience
- After this questioning the client's lawyer will state "For the record I am asking the Court to qualify this witness as an expert in assessing _____."



General Questions You Might Be Asked by the Client's Lawyer

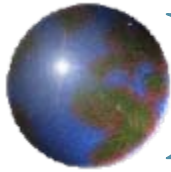
- Questions about expertise:
 - Have you ever served as an expert witness?
 - Do you have a specialty in your practice?
 - How much experience do you have with refugees and asylum seekers?
 - Where did you learn this?



Questions the Lawyer Might Ask (cont.)

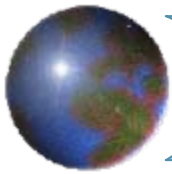
■ Questions about the patient:

- Have you seen _____ as a patient in your practice?
- Approximately how many times have you seen _____?
- Did she discuss with you the events of her life in (country X)?
- Did she tell you about what happened in _____?
- Did she tell you about how she was treated at the time of her arrest, imprisonment, etc?
- Did she tell you why she came to the United States?
- Did she tell you what has happened to her since entering the US?



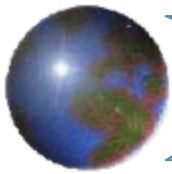
Questions the Lawyer Might Ask (cont.)

- Have you prescribed medication for _____?
- Do you envision further treatment for _____?
- Did you find _____ to be credible?
- Did _____ discuss what would happen if she returned to (country X)?



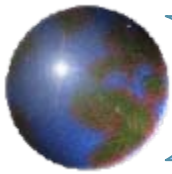
Possible Questions for Mental Health Professionals

- Are you familiar with the symptoms of PTSD?
- Are you familiar with the symptoms of clinical depression?
- Did _____ appear to have symptoms of PTSD?
 - What are they?
- Did _____ appear to have symptoms of depression?
 - What are they?



Possible Questions for Mental Health Professionals

- Is it your opinion _____ would experience further psychological harm if she returned to (country X)?
- Everyone who has been tortured has PTSD/MDD. Why doesn't the patient show any symptoms?



General Questions You Might Be Asked by the Government's Lawyer

- How can you make a judgment based on spending only 4 hours with the patient?
- You have already spent 25 hours with the patient, so how can you serve as a neutral source of information?
- How do you know the patient is not malingering?
- Have you ever refused to write an affidavit for an applicant or served as a government witness?

