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

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I. INTRODUCTION

Torture is defined in this Manual according to the United Nations Convention Against Torture, 1984:

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 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.1

Torture is a profound concern for the world community. Its purpose is to deliberately destroy not only the physical and emotional well-being of individuals but also, in some instances, the dignity and will of entire communities. It concerns all members of the human family because it impugns the very meaning of our existence and our hopes for a brighter future.[2]

Although international human rights and humanitarian law consistently prohibit torture under any circumstance (see Section II), torture and ill treatment are practiced in more than half of the world's countries.[3,4] The striking disparity between the absolute prohibition of torture and its prevalence in the world today demonstrates the need for States to identify and implement effective measures to protect individuals from torture and ill treatment. This Manual was developed to enable States to address one of the most fundamental concerns in protecting individuals from torture – effective documentation. Such documentation brings evidence of torture and ill treatment to light so that perpetrators may be held accountable for their actions and the interests of justice may be served. The documentation methods contained in this Manual also apply to other contexts including, human rights investigations and monitoring, political asylum evaluations, the defense of individuals who “confess” to crimes during torture, and needs assessments for the care of torture victims, among others. In the case of health professionals who are coerced to neglect, misrepresent or falsify evidence of torture, the Manual also provides an international point of reference for health professionals and adjudicators alike.

During the past two decades, much has been learned about torture and its consequences, but no international guidelines for documentation were available prior to the development of this Manual. The Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol) is intended to serve as international guidelines for the assessment of persons who allege torture and ill treatment, for investigating cases of alleged torture, and for reporting such findings to the judiciary and any other investigative body. The Manual includes Principles on the Effective Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (see Appendix I). These Principles outline minimum standards for State adherence to ensure the effective documentation of torture.[5] The guidelines contained in the Manual are not presented as a fixed protocol. Rather, they represent an elaboration of the minimum standards contained in the Principles and should be applied in accordance with a reasonable assessment of available resources.

The Manual and Principles are the result of three years of analysis, research and drafting undertaken by more than 75 experts in law, health and human rights representing 40 organizations or institutions from 15 countries. The conceptualization and preparation of this Manual was a collaborative effort between forensic doctors, physicians, psychologists, human rights monitors and lawyers working in Chile, Costa Rica, Denmark, England, France, Gaza, Germany, India, Israel, the Netherlands, South Africa, Sri Lanka, Switzerland, Turkey, and the United States.

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[1] The Board of Trustees for the United Nations Voluntary Fund for the Victims of Torture has recently decided that for purposes of its work, it will use the UN Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

[2] Iacopino V. Treatment of survivors of political torture: commentary. The Journal of Ambulatory Care Management. 1998; 21(2):5-13.

[3] Amnesty International. Report 1999. London: AIP, June 16 1999.

[4] Ba_o_lu M. Prevention of torture and care of survivors: an integrated approach. JAMA 1993;270:606-611.

[5] The Principles on the Effective Documentation of Torture and Cruel, Inhuman and Degrading Treatment or

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II. RELEVANT INTERNATIONAL LEGAL STANDARDS

The right to be free from torture is firmly established under international law. The Universal Declaration of Human Rights, International Covenant on Civil and Political Rights, and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment all expressly prohibit torture. Regional instruments similarly establish the right to be free from torture. The American Convention on Human Rights, the African [Banjul] Charter on Human and Peoples' Rights, and the [European] Convention for the Protection of Human Rights and Fundamental Freedoms all contain express prohibitions of torture.

A. International Humanitarian Law

The international treaties governing armed conflicts are known as international humanitarian law (IHL) or the "law of war." The prohibition of torture in IHL is only a small - but important - part of the wider protection these treaties provide for all victims of war. The four Geneva Conventions of 1949 have been ratified by 188 States. They establish rules for the conduct of international armed conflict, and especially for the treatment of persons who do not, or do no longer, take part in the hostilities, including the wounded, the captured, civilians, etc. All four conventions prohibit the infliction of torture and other forms of ill treatment. Two Protocols, of 1977, additional to the Geneva Conventions, expand the protection and the scope of these conventions. Protocol I (ratified to date by 153 States) further deals with international conflicts. Protocol II (ratified to date by 145 States) deals with non-international conflicts.

More important to the purpose here, however, is what is known as "Common Article 3," found identically in all four conventions. Common Article 3 applies to armed conflicts "not of an international character," no further definition being given. Thus, it is taken to define a "hard core" of obligations that must be respected in ***all*** armed conflicts, and not just in international wars between nations. This is generally taken to mean that no matter what the nature of the war or conflict, certain basic rules cannot be abrogated. The prohibition of torture is one of these, and represents a point of common purpose between IHL and human rights law.

Common Article 3 states:

> ...the following acts are and shall remain prohibited at any time and in any place whatsoever...violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture;...outrages upon personal dignity, in particular humiliating and degrading treatment...

As UN Special Rapporteur on Torture, Nigel Rodley,[6] has stated:

> The prohibition of torture or other ill treatment could hardly be formulated in more absolute terms. In the words of the official commentary on the text by the International Committee of the Red Cross (ICRC), "no possible loophole is left; there can be no excuse, no attenuating circumstances."

A further link between IHL and human rights law is to be found in the preamble to Protocol II, which itself regulates non-international armed conflicts (such as full-fledged civil wars for example), which states that:

> ...international instruments relating to human rights offer a basic protection to the human person.[7]

B. United Nations

To ensure adequate protection for all persons against torture or cruel, inhuman or degrading treatment, the United Nations has sought for many years to develop universally applicable standards. The conventions, declarations and resolutions adopted by the member States of the United Nations clearly state that there may be no exception to the prohibition of torture and establish other obligations to ensure protection against such abuses. The most important of these instruments include: Universal Declaration of Human Rights (UDHR);[8] the International Covenant on Civil and Political Rights(ICCPR);[9] the Standard

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[6] Nigel Rodley: The Treatment of Prisoners Under International Law; Oxford: Clarendon Press, second edition 1999 p.58.
[7] Second preambular paragraph, Protocol II (1977), additional to the Geneva Conventions of 1949.
[8] G.A. res. 217A(III), U.N. Doc. A/810 at 71 (1948), art.5.
[9] G.A. res. 2200A(XXI), 21 U.N. GAOR Supp. (No.16) at 52, U.N. Doc.A/6316 (1966), 999 U.N.T.S. 171, entered into force

Minimum Rules for the Treatment of Prisoners (SMRTP);[10] Declaration on the Protection of All Persons from being subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Declaration on the Protection Against Torture);[11] the Code of Conduct on Law Enforcement (CCLE);[12] Principles of Medical Ethics relevant to the Role of Health Personnel particularly Physicians, in the Protection of Prisoners and Detainees against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (Principles of Medical Ethics);[13] the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (Convention Against Torture);[14] the Body of Principles for the Protection of all Persons Under any Form of Detention or Imprisonment (Body of Principles on Detention);[15] and the Basic Principles for the Treatment of Prisoners (BPTP).[16]

> The UN Convention Against Torture does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.[17]

Other UN human rights bodies and mechanisms have taken action to develop standards for the prevention of torture, as well as standards involving the obligation for States to investigate allegations of torture. These bodies and mechanisms include the Committee Against Torture, the Human Rights Committee, the Commission on Human Rights, the Special Rapporteur on Torture, the Special Rapporteur on Violence Against Women and country-specific Special Rapporteurs appointed by the Commission on Human Rights.

1. Legal Obligations to Prevent Torture

The international instruments cited above establish certain obligations that States must respect to ensure protection against torture. These include:

> 1) Taking effective legislative, administrative, judicial or other measures to prevent acts of torture. No exceptions, including war, may be invoked as a justification of torture (Article 2 of the Convention Against Torture; Article 3 of the Declaration on the Protection Against Torture);
>
> 2) Not expelling, returning ("refouler") or extraditing a person to a State where there are substantial grounds for believing he would be tortured (Article 3 of the Convention Against Torture);
>
> 3) Criminalizing acts of torture, including complicity or participation therein (Article 4 of the Convention Against Torture; Principle 7 of the Body of Principles on Detention; Article 7 of the Declaration on the Protection Against Torture; paragraphs 31, 32 and 33 of the Standard Minimum Rules for the Treatment of Prisoners);
>
> 4) Undertaking to make torture an extraditable offense and assist other States parties in connection with criminal proceedings brought in respect of torture (Articles 8 and 9 of the Convention Against Torture);
>
> 5) Limiting the use of incommunicado detention; ensuring that detainees are held in places officially recognized as places of detention, as well as for the names of persons responsible for their detention to be kept in registers readily available and accessible to those concerned, including relatives and friends; recording the time and place of all interrogations, together with the names of those present; and, granting doctors, lawyers and family members access to detainees (Article 11 of the Convention Against Torture; Principles 11, 12, 13, 15, 16, 17, 18, 19 and 23 of

[10] Adopted Aug. 30, 1955, by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, U.N.Doc. A/CONF/611, annex I, E.S.C. res. 663C, 24 U.N. ESCOR Supp. (No. 1) at 11, U.N. Doc. E/3048 (1957), amended E.S.C. res. 2076, 62 U.N. ESCOR Supp. (No. 1) at 35, U.N. Doc. E/5988 (1977), art. 31.
[11] G.A. res. 3452 (XXX), annex, 30 U.N. GAOR Supp. (No. 34) at 91, U.N. Doc. A/10034 (1975), art. 2 and art. 4.
[12] G.A. res. 34/169, annex, 34 U.N. GAOR Supp. (No. 46) at 186, U.N. Doc. A/34/46 (1979), art.5.
[13] G.A. res. 37/194, annex, 37 U.N. GAOR Supp. (No. 51) at 211, U.N. Doc. A/37/51 (1982), princ. 2, 3, 4, and 5.
[14] G.A. res. 39/46, annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984), entered into force June 26, 1987, art. 2.
[15] G.A. res. 43/173, annex, 43 U.N. GAOR Supp. (No. 49) at 298, U.N. Doc. A/43/49 (1988), princ. 6.
[16] G.A. res. 45/111, annex, 45 U.N. GAOR Supp. (No. 49A) at 200, U.N. Doc. A/45/49 (1990), princ. 1.
[17] For an interpretation of what constitutes "lawful sanctions", see the Report of the Special Rapporteur on Torture to the fifty-third session of the Commission on Human Rights (E/CN.4/1997/7, paras. 3-11), in which the Special Rapporteur expressed the view that the administration of such punishments as stoning to death, flogging and amputation cannot be deemed lawful simply because the punishment has been authorized in a procedurally legitimate manner. The interpretation put forward by the Special Rapporteur, which is consistent with the positions of the Human Rights Committee and other UN mechanisms, was endorsed by the Commission on Human Rights Resolution 1998/38, which "reminds Governments that corporal

the Body of Principles on Detention; paragraphs 7, 22 and 37 of the Standard Minimum Rules for the Treatment of Prisoners);

6) Ensuring that education and information regarding the prohibition of torture is included in the training of law enforcement personnel, civil or military, medical personnel, public officials and other appropriate persons (Article 10 of the Convention Against Torture; Article 5 of the Declaration on the Protection Against Torture; paragraph 54 of the Standard Minimum Rules for the Treatment of Prisoners);

7) Ensuring that any statement which is established to have been made as a result of torture shall not be invoked as evidence in any proceedings except against a person accused of torture as evidence that the statement was made (Article 15 of the Convention Against Torture; Article 12 of the Declaration on the Protection Against Torture);

8) Ensuring that the competent authorities undertake a prompt and impartial investigation wherever there are reasonable grounds to believe that torture has been committed (Article 12 of the Convention Against Torture; Principles 33 and 34 of the Body of Principles on Detention; Article 9 of the Declaration on the Protection Against Torture); and

9) Ensuring that victims of torture have the right to redress and adequate compensation (Articles 13 and 14 of the Convention Against Torture; Article 11 of the Declaration on the Protection Against Torture; paragraphs 35 and 36 of the Standard Minimum Rules for the Treatment of Prisoners).

10) Ensuring that the alleged offender or offenders shall be subject to criminal proceedings if an investigation establishes that an act of torture appears to have been committed. If an allegation of other forms of cruel, inhuman or degrading treatment or punishment is considered to be well-founded, the alleged offender or offenders shall be subject to criminal, disciplinary or other appropriate proceedings (Article 7 of the Convention Against Torture; Article 10 of the Declaration on the Protection Against Torture)

2. UN Bodies and Mechanisms

2a) Committee Against Torture

The Committee Against Torture (CAT) monitors the implementation of the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The CAT consists of 10 experts appointed because of their “high moral standing and recognized competence in the field of human rights.”

Under Article 19 of the Convention Against Torture, the States Parties submit to the CAT, through the Secretary-General of the United Nations, reports on the measures they have taken to give effect to their undertakings under the Convention. The CAT examines how the provisions of the Convention have been incorporated into domestic law and monitors how this functions in practice. Each report is considered by the CAT, which may make general comments and recommendations and include such information in its annual report to the States Parties and to the General Assembly. These procedures take place in public meetings.

Under Article 20 of the UN Convention Against Torture, if the CAT receives reliable information which appears to contain well-founded indications that torture is being systematically practiced in the territory of a State Party, the CAT shall invite the State Party to cooperate in the examination of the information and to this end to submit observations with regard to the information concerned. The CAT may, if it decides that this is warranted, designate one or more of its members to make a confidential inquiry and to report to the CAT urgently. In agreement with that State Party, such an inquiry may include a visit to its territory.

After examining the findings of its member or members, the CAT transmits these findings to the State Party concerned, together with any comments or suggestions that seem appropriate in view of the situation.

All the proceedings of the CAT under Article 20 are confidential and, at all stages of the proceedings, the cooperation of the State Party is sought. After such proceedings have been completed, the CAT may, after

consultations with the State Party concerned, decide to include a summary account of the results of the proceedings in its annual report to the other States Parties and to the General Assembly.[18]

Under Article 22 of the UN Convention Against Torture, a State Party may at any time recognize the competence of the CAT to receive and consider individual complaints from or on behalf of individuals subject to its jurisdiction who claim to be victims of a violation by a State Party of the provisions of the UN Convention Against Torture. The CAT then considers these communications confidentially and shall forward its view to the State Party concerned and to the individual. Only 39 of the 112 States Parties that have ratified the Convention, have recognized the applicability of Article 22.

Among the concerns addressed by the CAT in its annual reports to the General Assembly is the necessity of States Parties to comply with Articles 12 and 13 on the Convention Against Torture to ensure that prompt and impartial investigations of all complaints of torture are undertaken. For example, the CAT has stated that it considers a delay of 15 months in investigating allegations of torture to be unreasonably long and not in compliance with Article 12.[19] The CAT also has noted that Article 13 does not require a formal submission of a complaint of torture, but that "[it] is sufficient for torture only to have been alleged by the victim for [a State Party] to be under an obligation promptly and impartially to examine the allegation."[20]

2b) Human Rights Committee

The Human Rights Committee was established pursuant to Article 28 of the International Covenant on Civil and Political Rights, to monitor the implementation of the Covenant in the States Parties. The Committee is composed of 18 independent experts who are expected to be persons of high moral character and recognized competence in the field of human rights.

States Parties to the Covenant must submit reports every five years on the measures they have adopted which give effect to the rights recognized in the Covenant and on the progress made in the enjoyment of those rights. The Human Rights Committee examines the reports through a dialogue with representatives of the State Party whose report is under consideration. The Committee then adopts concluding observations summarizing its main concerns and making appropriate suggestions and recommendations to the State Party. The Committee also prepares general comments interpreting specific articles of the Convention to guide States Parties in their reporting, as well as their implementation of the Covenant's provisions.
In one such general comment the Committee has undertaken to clarify Article 7 of the International Covenant on Civil and Political Rights, which states that no one shall be subject to torture, or to cruel, inhuman or degrading treatment or punishment. In the Report of the Human Rights Committee, General Comments on Article 7 of the Covenant,[21] the Committee specifically noted that prohibiting torture or making it a crime is not a sufficient implementation of Article 7. The Committee stated, "...States must ensure an effective protection through some machinery of control. Complaints about ill treatment must be investigated effectively by competent authorities."

On 10 April 1992, the Human Rights Committee adopted new General Comments on Article 7, further developing the previous comments. The Committee reinforced its reading of Article 7 by stating that, "[com]plaints must be investigated promptly and impartially by competent authorities so as to make the remedy effective."

Where a State has ratified the First Optional Protocol of the International Covenant on Civil and Political Rights, an individual may submit a communication to the Committee complaining that his rights under the Covenant have been violated. If found admissible, the Committee issues a decision on the merits which are made public in its annual reports.

2c) Commission on Human Rights

The Commission on Human Rights is the primary human rights body of the United Nations. It is composed of 53 Member States elected by the Economic and Social Council for three-year terms. The Commission meets annually for six weeks in Geneva to act on human rights issues. The Commission may initiate

[18] It should be pointed out, however, that the application of Article 20 can be limited because of a reservation by a State Party, in which case Article 20 is not applicable.
[19] See Communication No. 8/1991, paragraph 13.5, reported in General Assembly Report of the Committee Against Torture, 12/06/94 (A/49/44).
[20] See Communication 6/1990, paragraph 10.4, reported in General Assembly Report of the Committee Against Torture, 12/ /95 (A/50/44).

studies and fact-finding missions, draft conventions and declarations for approval by higher UN bodies, and discuss specific human rights violations in public or private sessions.

On 6 June 1967, the Economic and Social Council in resolution 1235,[22] authorized the Commission to examine allegations of gross violations of human rights, and to "make a thorough study of situations which reveal a consistent pattern of violations of human rights." Under this mandate the Commission has, among other procedures, adopted resolutions expressing concern about human rights violations, and has appointed special rapporteurs to address human rights violations falling under a particular theme.

The Commission has adopted resolutions regarding torture and other cruel, inhuman or degrading treatment or punishment. In its resolution 1998/38 the Commission stressed that "all allegations of torture or cruel, inhuman or degrading treatment or punishment should be promptly and impartially examined by the competent national authority"

2d) Special Rapporteur on Torture

In 1985, the Commission decided, in resolution 1985/33, to appoint a Special Rapporteur on Torture. The Special Rapporteur on Torture is charged with seeking and receiving credible and reliable information on questions relevant to torture, and to respond to that information without delay. The Commission has continued to renew the Special Rapporteur's mandate in subsequent resolutions.

The Special Rapporteur's authority to monitor extends to all Member States of the United Nations and to all States with observer status, regardless of the State's ratification of the UN Convention Against Torture. The Special Rapporteur establishes contact with governments and asks them for information on the legislative and administrative measures taken to prevent torture and to remedy its consequences whenever it occurs, as well as asking them to respond to information alleging the actual occurrence of torture. The Special Rapporteur also receives requests for urgent action, which he or she brings to the attention of the governments concerned in order to ensure protection of the individual's right to physical and mental integrity. In addition, s/he holds consultations with government representatives who wish to meet with him or her and, in accordance with the position's mandate, makes ***in situ*** visits to some parts of the world.

The Special Rapporteur on Torture submits reports to the Commission on Human Rights and to the General Assembly. The reports compile actions that the Special Rapporteur has taken under his/her mandate, and persistently draw attention to the importance of prompt investigation of torture allegations. In the Report of the Special Rapporteur on Torture of 12 January 1995,[23] the Special Rapporteur, Nigel Rodley, made a series of recommendations. At paragraph 926 (g) of the report he stated:

> When a detainee or relative or lawyer lodges a torture complaint, an inquiry should always take place...Independent national authorities, such as a national commission or ombudsman with investigatory and/or prosecutorial powers, should be established to receive and to investigate complaints. Complaints about torture should be dealt with immediately and should be investigated by an independent authority with no relation to that which is investigating or prosecuting the case against the alleged victim.

The Special Rapporteur on Torture emphasized this recommendation in his Report of 9 January 1996.[24] Discussing his concerns with torture practices, the Special Rapporteur pointed out at paragraph 136 that "both under general international law and under the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, States are obliged to investigate allegations of torture"

2e) Special Rapporteur on Violence Against Women

The Special Rapporteur on Violence Against Women was established in 1994 by Resolution 1994/45 of the Commission on Human Rights and her mandate was renewed by Resolution 1997/44. The Special Rapporteur has established procedures to seek from Governments, in a humanitarian spirit, clarifications and information on specific cases of alleged violence in order to identify and investigate specific situations and allegations of violence against women in any country. These communications may concern one or more individuals identified by name or information relating to a more general nature of a prevailing situation condoning and/or perpetrating violence against women. The definition of gender-based violence

[22] (XLII), UN Doc. E/4393 (1967).
[23] E/CN.4/1995/34.

against women used by the Special Rapporteur is taken from the United Nations Declaration on the Elimination of Violence Against Women, adopted by the General Assembly in its Resolution 48/104 in December 1993.

Urgent appeals may be sent by the Special Rapporteur in cases of gender-based violence against women which involve or may involve an imminent threat, or fear of threat, to the right to life or to physical integrity of the person. The Special Rapporteur urges the competent national authorities not only to provide comprehensive information on the case but also to carry out an independent and impartial investigation concerning the case transmitted and to take immediate action to ensure that no further violations of human rights of women are incurred.

The Special Rapporteur reports annually to the Commission on Human Rights on communications sent to Governments, as well as on the replies received by him or her. On the basis of information received from Governments and other reliable sources, the Special Rapporteur makes recommendations to the Governments concerned with a view to finding durable solutions to the elimination of violence against women in any country. The Special Rapporteur may send follow-up communications to Governments where no replies have been received or where insufficient information was provided.

Should a particular situation of violence against women in any given country persist and information received by the Special Rapporteur indicate that no measures are or have been taken by a Government to ensure the protection of human rights of women, the Special Rapporteur may consider the possibility of seeking permission from the Government concerned to visit this country in order to carry out an on-site fact-finding mission.

C. Regional Organizations

Regional bodies have also contributed to the development of standards for the prevention of torture. These bodies include the Inter-American Commission on Human Rights, the European Court and Commission of Human Rights, the European Committee for the Prevention of Torture, and the African Commission on Human Rights.

1. Inter-American Commission on Human Rights and Inter-American Court on Human Rights

On 22 November 1969 the Organization of American States (OAS) adopted the American Convention on Human Rights[25] and the American Convention entered into force on 18 July 1978. Article 5 of the Convention states:

> 1. Every person has the right to have his physical, mental, and moral integrity respected.
>
> 2. No one shall be subjected to torture or to cruel, inhuman, or degrading punishment or treatment. All persons deprived of their liberty shall be treated with respect for the inherent dignity of the human person.

Article 33 of the Convention provides for the establishment of the Inter-American Commission on Human Rights and the Inter-American Court of Human Rights. As stated in its regulations, the Commission's principal function is to promote the observance and defense of human rights and to serve as an advisory body to the OAS in this area.[26] In fulfilling this function, the Commission has looked to the Inter-American Convention to Prevent and Punish Torture to guide its interpretation of what is meant by torture under Article 5.[27]

The Inter-American Convention to Prevent and Punish Torture,[28] was adopted by the OAS on 9 December 1985, and entered into force on 28 February 1987. Article 2 of the Convention defines torture as:

> any act intentionally performed whereby physical or mental pain or suffering is inflicted on a person for purposes of criminal investigation, as a means of intimidation, as personal punishment, as a preventive measure, as a penalty, or for any other purpose. Torture shall also be understood to be the use of methods upon a person intended to obliterate the personality of the victim or to

[25] O.A.S. Treaty Series No. 36, 1144 U.N.T.S. 123 entered into force July 18, 1978, reprinted in Basic Documents Pertaining to Human Rights in the Inter-American System, OEA/Ser.L.V/II.82 doc.6 rev.1 at 25 (1992).
[26] Regulations of the Inter-American Commission on Human Rights, OAS/Ser.L.V/II.92, doc. 31 rev. 3, May 3 1996 at Article 1 (1).
[27] See Case 10.832, Report No. 35/96, Inter-American Commission on Human Rights Annual Report 1997, at paragraph 75.

> diminish his physical or mental capacities, even if they do not cause physical pain or mental anguish.

Under Article 1, the States Parties to the Convention undertake to prevent and punish torture in accordance with the terms of the Convention.

States Parties to the Convention are required to conduct an immediate and proper investigation into any allegation that torture has occurred within their jurisdiction.

Article 8 provides that:

> States Parties shall guarantee that any person making an accusation of having been subjected to torture within their jurisdiction shall have the right to an impartial examination of his case.

Likewise, if there is an accusation or well-grounded reason to believe that an act of torture has been committed within their jurisdiction, the States Parties shall guarantee that their respective authorities will proceed properly and immediately to conduct an investigation into the case and to initiate, whenever appropriate, the corresponding criminal process.

In one of its 1998 country reports, the Commission noted that an obstacle to effective prosecution of torturers is the lack of independence in an investigation of claims of torture, as the investigation is required to be undertaken by federal bodies likely to be acquainted with parties accused of committing torture.[29] The Commission cited Article 8 to underscore the importance of an "impartial examination" of each case.[30]

The Inter-American Court of Human Rights has spoken to the necessity of investigating claims of violations of the American Convention on Human Rights. In its decision in the Velasquez Rodriguez Case, Judgment of July 29, 1988, the Court stated that:

> The State is obligated to investigate every situation involving a violation of the rights protected by the Convention. If the State apparatus acts in such a way that the violation goes unpunished and the victim's full enjoyment of such rights is not restored as soon as possible, the State has failed to comply with its duty to ensure the free and full exercise of those rights to the persons within its jurisdiction.

Article 5 of the Convention provides for the right to be free from torture. Although the case dealt specifically with the issue of disappearance, one of the rights referred to by the court as guaranteed by the American Convention on Human Rights, is the right not to be subjected to torture or other forms of ill treatment.

2. European Court and European Commission of Human Rights

On 4 November 1950, the Council of Europe adopted the European Convention for the Protection of Human Rights and Fundamental Freedoms,[31] which entered into force on 3 September 1953. Article 3 of the European Convention states that:

> No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

The European Convention on Human Rights established control machinery consisting of the European Court and the European Commission of Human Rights. Since the reform that entered into force on 1st of November 1998, a new permanent Court replaces the former Court and Commission. The right of individual applications is now mandatory and all victims have direct access to the Court.

The Court has had the occasion to consider the necessity of investigating allegations of torture as a way of ensuring the rights guaranteed by Article 3.

The first judgment on this issue was the decision in the ***Case of Aksoy v. Turkey***,[32] delivered on 18 December 1996. In this case, the Court considered that:

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[29] Report on the Situation of Human Rights in Mexico, 1998, Inter-American Commission on Human Rights at paragraph 323.
[30] Id. at paragraph 324.
[31] 213 UNT.S. 222.
[32] 213 U.N.T.S. 222, as amended by Protocols Nos 3, 5, and 8, which entered into force on 21 September 1970, 20 December

> Where an individual is taken into Police custody in good health but is found to be injured at the time of release, it is incumbent on the State to provide a plausible explanation as to the cause of the injury, failing which a clear issue arises under Article 3 of the Convention.[33]

The Court went on to hold that the injuries inflicted on the applicant resulted from torture, and that Article 3 had been violated.[34]

Furthermore, the Court interpreted Article 13 of the Convention, which provides for the right to an effective remedy before a national authority, as imposing an obligation to thoroughly investigate claims of torture. Considering the "fundamental importance of the prohibition of torture," and the vulnerability of torture victims, the Court held that "Article 13 imposes, without prejudice to any other remedy available under the domestic system, an obligation on States to carry out a thorough and effective investigation of incidents of torture."[35]

According to the Court's interpretation, the notion of an "effective remedy" in Article 13 entails a thorough investigation of every "arguable claim" of torture. The Court noted that although the Convention has no express provision such as Article 12 of the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, "such a requirement is implicit in the notion of an 'effective remedy' under Article 13" (id).[36] The Court then found that the State had violated Article 13 by failing to investigate the applicant's allegation of torture.[37]

In a judgment from 28 October 1998 in the ***Case of Assenov and others vs. Bulgaria*** (90/1997/874/1086), the Court went even further in recognizing an obligation for the State to investigate allegations of torture not only under Article 13 but also under Article 3. In this case, a young Roma arrested by the police showed medical evidence of beatings, but it was impossible to assess, on the basis of available evidence, whether these injuries were caused by his father or by the police. The Court recognized that "the degree of bruising found by the doctor who examined Mr. Assenov indicates that the latter's injuries, whether caused by his father or by the police, were sufficiently serious to amount to ill treatment within the scope of Article 3.[38] Contrary to the Commission, that held that there was no violation of Article 3, the Court did not stop there. It went on and considered that the facts "raised a reasonable suspicion that these injuries may have been caused by the police."[39] Hence the Court held that:

> In these circumstances, where an individual raises an arguable claim that he has been seriously ill treated by the police or other such agents of the State, unlawfully and in breach of Article 3, that provision, read in conjunction with Article 1 of the Convention "to secure everyone within their jurisdiction the rights and freedoms in the Convention," requires by implication that there should be an effective official investigation. This obligation should be capable of leading to the identification and punishment of those responsible. If this is not the case, the general legal prohibition of torture and inhuman and degrading treatment and punishment, despite its fundamental importance, would be ineffective in practice and it would be possible in some cases for agents of the State to abuse the rights of those within their control with virtual impunity.[40]

For the first time, the Court concluded that a violation of Article 3 had occurred, not for ill treatment ***per se*** but for a failure to carry out effective official investigation on the allegation of ill treatment.

In addition, the Court reiterated its position in the Aksoy Case and concluded that there had also been a violation of Article 13. The Court considered that:

> Where an individual has an arguable claim that he has been ill treated in breach of Article 3, the notion of an effective remedy entails, in addition to a thorough and effective investigation as required also by Article 3, effective access for complainant to investigatory procedure and payment of compensation where appropriate.[41]

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[33] Id. at paragraph 61.
[34] Id. at paragraph 64.
[35] Id. at paragraph 98.
[36] Id.
[37] Id. at paragraph 100.
[38] Id. at paragraph 95.
[39] Id. at paragraph 101.
[40] Id. at paragraph 102.

3. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)

In 1987, the Council of Europe adopted the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment that entered into force on 1 February 1989.[42]

By 1 March 1999, all 40 Member States of the Council of Europe had ratified the Convention. This Convention complements the judicial mechanism of the European Convention on Human Rights with a preventive mechanism. The Convention intentionally does not create substantive norms.

The ECPT established the European Committee for the Prevention of Torture (CPT), consisting of one member per Member State. The members elected to the CPT should be of high moral standard, be impartial, independent and also available to carry out field missions.

The CPT carries out visits to Council of Europe countries partially on a regular periodic basis, and partially on an ***ad hoc*** basis. A CPT visiting delegation consists of members of the CPT, accompanying experts in the medical, legal or other fields, interpreters and members of the Secretariat. These delegations visit persons deprived of their liberty[43] by the Authorities of the country visited. The powers of each CPT delegation are quite vast: it may visit any place, where persons are held deprived of their liberty; make unannounced visits to any such place; repeat visits to these places; talk to persons deprived of their liberty in private; visit any or all persons it chooses to in these places; and see all the premises (not only cell areas) without restrictions. The delegation can have access to all papers and files concerning the persons visited. The entire work of the CPT is based on confidentiality and cooperation.

After a visit, the CPT writes up a report. Based on the facts found during the visit, the report comments on the conditions found, makes concrete recommendations and asks any questions that need further clarification.

The State Party answers the report in writing and thereby a dialogue between the CPT and the State Party is established, and continues until the following visit. CPT reports and the States' answers are confidential documents, but the State Party (not the CPT) may decide to publish both the reports and the answers. At the moment, nearly all the States Parties have made public both reports and answers.

In the course of its activities over the last ten years, the CPT has gradually developed a set of criteria for the treatment of persons held in custody that constitutes general standards. These standards deal not only with the material conditions but also with procedural safeguards. For example, three safeguards advocated by the CPT for persons held in police custody are:

> 1) The right for a person deprived of liberty immediately, if he or she so desires, to inform a third party (family member) of the arrest
>
> 2) The right for a person deprived of liberty immediately to have access to a lawyer
>
> 3) The right for a person deprived of liberty to have access to a doctor, including, if he or she so wishes, a doctor of his or her own choice.

Further, the CPT has stressed repeatedly that one of the most effective means of preventing ill treatment by law enforcement officials lies in the diligent examination by the competent authorities of all complaints of such treatment brought before them and, where appropriate, the imposition of a suitable penalty. This will have a strong dissuasive effect.

4. African Commission on Human and Peoples' Rights

In comparison to the European and the Inter-American systems, Africa does not have a convention on torture and its prevention. The question of torture is examined on the same level as are other human rights violations.

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[42] E.T.S 126.

[43] Person deprived of liberty: any person deprived of liberty by a Public Authority, such as, but not exclusively, persons arrested or in any form of detention, prisoners awaiting trial, sentenced prisoners, and persons involuntarily confined to

The question of torture is primarily dealt with in the African (Banjul) Charter of Human and Peoples' Rights which was adopted by the Organization of African Unity (OAU) on 27 June 1981 and entered into force on 21 October 1986.[44] Article 5 of the African Charter states:

> Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited.

In accordance with Article 30 of the African Charter, the African Commission on Human and Peoples' Rights was established in June 1987, and charged to "promote human and peoples' rights and ensure their protection in Africa." In its periodic sessions, the African Commission has passed some country resolutions on matters concerning human rights in Africa, some which dealt with torture among other violations. In some of its country resolutions, the African Commission raised its concerns about the degradation of human rights situations, including the practice of torture.

The African Commission has established new mechanisms such as the Special Rapporteur on Prisons, the Special Rapporteur on Arbitrary and Summary Executions, and the Special Rapporteur on Women, whose mandates are to report during the open sessions of the Commission. These mechanisms have opened opportunities to victims and non-governmental organizations (NGOs) that can send information directly to special rapporteurs. At the same time, a victim or an NGO can make a complaint to the Commission regarding acts of torture as defined by Article 5 of the Charter. While such an individual complaint is pending before the Commission, the victim or an NGO can send the same information to special rapporteurs for their public reports to the commission session.

To provide a forum for adjudicating claims of violations of the rights guaranteed in the African Charter the OAU Assembly adopted a Protocol for the establishment of the African Court of Human and Peoples' Rights in June 1998.

D. International Criminal Court

The Treaty of Rome, adopted 17 July 1998, established a permanent International Criminal Court to try individuals responsible for genocide, crimes against humanity, and war crimes. The Court will have jurisdiction over cases alleging torture either as part of the crime of genocide, as a crime against humanity, if the torture is committed "as part of a widespread or systematic attack," or as a war crime under the Geneva Conventions of 1949. Torture is defined in the Treaty of Rome as the "intentional infliction of severe pain or suffering, whether physical or mental, upon a person in the custody or under the control of the accused.

The Statute International Criminal Court, or Treaty of Rome, will come into force three months after it receives sixty State ratifications. By April 1999, nine months after the conclusion of the Rome Treaty, 81 countries had already signed the treaty. The new Court will be located in The Hague, Netherlands. The Court will only have jurisdictions in cases in which States are unable or unwilling to prosecute individuals responsible for the crimes elaborated in the Treaty of Rome.

III. RELEVANT ETHICAL CODES

All professions work within ethical codes. These provide a statement of the shared values and acknowledged duties of professionals and set the moral standards with which they are expected to comply. Ethical standards are established in two main ways: by international instruments drawn up by bodies like the UN and by the codes of principles drafted by the professions themselves, through their representative associations, nationally and internationally. The fundamental tenets are invariably the same and focus on obligations owed by the professional to individual clients or patients, to society at large and to colleagues to maintain the honor of the profession. These ***obligations*** reflect and complement the ***rights*** to which all people are entitled under international instruments.

A. Ethics of the Legal Profession

As the ultimate arbiters of justice, judges play a special role in the protection of the rights of citizens. International standards provide that there is an ethical duty on the part of judges to ensure that the rights of individuals are protected. Principle 6 of the UN Basic Principles on the Independence of the Judiciary[45] states that:

> The principle of the independence of the judiciary entitles and requires the judiciary to ensure that judicial proceedings are conducted fairly and that the rights of the parties are respected.

Similarly, prosecutors have an ethical duty to investigate and prosecute the crime of torture committed by public officials. Article 15 of the UN Guidelines on the Role of Prosecutors[46] states:

> Prosecutors shall give due attention to the prosecution of crimes committed by public officials, particularly corruption, abuse of power, grave violations of human rights and other crimes recognized by international law and, where authorized by law or consistent with local practice, the investigation of such offenses.

International standards also establish a duty for lawyers, in carrying out their professional functions, to promote and protect human rights and fundamental freedoms. Principle 14 of the UN Basic principles on the role of lawyers[47] provides: "Lawyers, in protecting the rights of their clients and in promoting the cause of justice, shall seek to uphold human rights and fundamental freedoms recognized by national and international law and shall at all times act freely and diligently in accordance with the law and recognized standards and ethics of the legal profession."

B. Health Care Ethics

There are very clear links between concepts of human rights and the well-established principle of health care ethics. The ethical obligations of health professionals are articulated at three levels; they are reflected in UN documents in the same way as they are for the legal profession. They are also embodied in statements issued by international organizations representing health professionals, such as the World Medical Association, World Psychiatric Association and International Council of Nurses.[48] National Medical Associations and nursing organizations also issue codes of ethics which their members are expected to follow. The central tenet of all health care ethics, however articulated, is the fundamental duty to act always in the best interests of the patient, regardless of other constraints, pressures or contractual obligations. In some countries, medical ethical principles, such as that of doctor-patient confidentiality, are incorporated into national law. Even where they are not established in law in this way, all health professionals are morally bound by the standards set by their professional bodies. They are

[45] Adopted by the Seventh United Nations Congress on the Prevention of Crime and the Treatment of Offenders held at Milan from 26 August to 6 September 1985 and endorsed by the General Assembly resolutions 40/32 of 29 November 1985 and 40/146 of 13 December 1985.
[46] Adopted by the Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Havana, Cuba, 27 August to 7 September 1990.
[47] Adopted by the Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Havana, Cuba, 27 August to 7 September 1990.
[48] There are also a number of regional groupings, such as the Commonwealth Medical Association and the International Conference of Islamic Medical Associations, which issue important statements on medical ethics and human rights for their

judged to be guilty of misconduct if they deviate from professional standards without reasonable justification.

1. UN Statements Relevant to Health Professionals

Health professionals, like all others working in prison systems, must observe the Standard Minimum Rules for the Treatment of Prisoners.[49] These require that medical, including psychiatric, services must be available for all prisoners without discrimination and that all sick prisoners or those requesting treatment be seen daily. Such requirements reinforce the ethical obligations of doctors, discussed below, to treat and to act in the best interests of patients for whom they have a duty of care. In addition, the UN has specifically addressed the ethical obligations of doctors and other health professionals in the Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment.[50] These make clear that health professionals have a moral duty to protect the physical and mental health of detainees. They are specifically prohibited from using medical knowledge and skills in any manner which contravenes international statements of individual rights.[51] In particular, it is a gross contravention of health care ethics to participate, actively or passively, in torture or condone it in any way.

"Participation" in torture includes evaluating an individual's capacity to withstand ill treatment; being present at, supervising or inflicting maltreatment; resuscitating individuals for the purposes of further maltreatment or providing medical treatment immediately before, during or after torture on the instructions of those likely to be responsible for it; providing professional knowledge or individuals' personal health information to torturers; intentionally neglecting evidence and falsifying reports, such as autopsy reports and death certificates.[52]

The UN Principles also incorporate one of the fundamental rules of health care ethics by emphasizing that the ***only*** ethical relationship between prisoners and health professionals is one designed to evaluate, protect and improve prisoners' health. Thus assessments of detainees' health in order to facilitate punishment or torture are clearly unethical.

2. Statements from International Professional Bodies

Many statements from international professional bodies focus on principles relevant to the protection of human rights and represent a clear international medical consensus on these issues. Declarations of the World Medical Association (WMA) define internationally agreed aspects of the ethical duties owed by all doctors. The WMA Declaration of Tokyo[53] reiterates the prohibition on any form of medical participation or medical presence in torture or ill treatment. It is reinforced by the UN Principles that specifically refer to the Declaration of Tokyo. Doctors are clearly prohibited from providing information or any medical instrument or substance that would facilitate ill treatment. The same rule is specifically applied to psychiatry in the World Psychiatric Association's Declaration of Hawaii[54] that prohibits the misuse of psychiatric skills to violate the human rights of any individual or group. The International Conference on Islamic Medicine made a similar point in its Declaration of Kuwait[55] which bans doctors from allowing their special knowledge to be used "to harm, destroy or inflict damage on the body, mind or spirit, whatever the military or political reason." Similar provisions are made for nurses by the directive on The Nurse's Role in the Care of Detainees and Prisoners.[56]

[49] Standard Minimum Rules for the Treatment of Prisoners and Procedures for the Effective Implementation of the Standard Minimum Rules, adopted by the UN 1955.
[50] Adopted by the UN General Assembly in 1982.
[51] Particularly the Universal Declaration of Human Rights, the International Covenants on Human Rights and the Declaration on the protection of all Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
[52] Health professionals must, however, bear in mind the duty of confidentiality owed to patients and the obligation to obtain informed consent for disclosure of information, particularly when individuals may be put at risk by such disclosure. See Section III.C.3.
[53] Adopted by the WMA in 1975.
[54] Adopted by the WPA in 1977.
[55] Adopted in 1981 (1401 in the Islamic calendar).

Health professionals also have a duty to support colleagues who speak out against human rights violations. Failure to do so risks not only an infringement of patient rights and a contravention of the declarations listed above, but also brings the health professions into disrepute; tarnishing the honor of the profession is considered to be serious professional misconduct. The WMA's Resolution on Human Rights[57] calls on all national medical associations to review the human rights situation in their own countries and ensure that doctors do not conceal evidence of abuse even where they fear reprisal. It requires such national bodies to provide clear guidance, especially for doctors working in the prison system, to protest about alleged violations of human rights and provide effective machinery for investigating doctors' unethical activities in the human rights sphere. It also requires that they support individual doctors who call attention to human rights abuses. The WMA's subsequent Declaration of Hamburg,[58] reaffirms the responsibility of individuals and organized medical groups worldwide to encourage doctors to resist torture or any pressure to act contrary to ethical principles. It calls upon individual doctors to speak out against maltreatment and urges national and international medical organizations to support doctors who resist such pressure.

3. National Codes of Medical Ethics

The third level at which ethical principles are articulated is through national codes. These reflect the same core values as mentioned above since medical ethics are the expression of values common to all doctors. In virtually all cultures and codes, the same basic presumptions occur about duties to avoid harm, help the sick, protect the vulnerable and not discriminate between patients on any other basis than the urgency of their medical need. Identical values are present in the codes for the nursing profession. A problematic aspect of ethical principles is that they do not, however, provide definitive rules for every dilemma but require some interpretation. When weighing up ethical dilemmas, it is vital that health professionals bear in mind their fundamental moral obligations expressed in the shared professional values but implement them in a manner which reflects the basic duty to avoid harm to their patients.

C. Principles Common to All Codes of Health Care Ethics

The principle of professional independence requires health professionals to concentrate always on the core purpose of medicine that is to alleviate suffering and distress and avoid harm, despite other pressures. Several other ethical principles are so fundamental that they invariably occur in all codes and ethical statements: the most basic are the injunctions to provide compassionate care, do no harm and respect patients' rights. These are central requirements for all health professionals.

1. Duty to Provide Compassionate Care

The duty to provide care is expressed in a variety of ways in national and international codes and declarations. One aspect of it is the medical duty to respond to those in medical need. This is reflected in the WMA's International Code of Medical Ethics[59] that recognizes the moral obligation of doctors to provide emergency care as a humanitarian duty. The duty to respond to need and suffering is echoed in the traditional statements in virtually all cultures.

Traditional statements: Underpinning much of modern medical ethics are the principles established in the earliest statements of professional values which require doctors to provide care even at some risk to themselves. For example, the Caraka Samhita, a Hindu code dating from the first century AD, instructs doctors to "endeavor for the relief of patients with all thy heart and soul; thou shalt not desert or injure thy patient for the sake of thy life or living." Similar instructions were given in early Islamic codes and the modern Declaration of Kuwait requires doctors to focus on the needy, be they "near or far, virtuous or sinner, friend or enemy."

Western medical values have been dominated by the influence of the so-called Hippocratic Oath and similar pledges, such as the Prayer of Maimonides. The Hippocratic Oath represents a solemn promise of solidarity with other doctors and a commitment to benefit and care for patients while avoiding harming them. It also contains a promise to maintain confidentiality. These four concepts are reflected in various forms in all modern professional codes of health care ethics. The WMA's Declaration of Geneva[60] is a modern re-statement of the Hippocratic values. It is a promise in which doctors undertake to make the

[57] Adopted by the WMA in 1990.
[58] Adopted by the WMA in 1997.
[59] Adopted by the WMA in 1949.

health of their patients their primary consideration and vow to devote themselves to the service of humanity with conscience and dignity.

World Medical Association Declarations: Aspects of a duty of care are reflected in many of the WMA's declarations which make clear that doctors must always do what is best for the patient, including for detainees and alleged criminals. The duty is often expressed through the notion of professional independence, requiring doctors to adhere to best medical practice despite any pressures that might be applied. The WMA's International Code of Medical Ethics emphasizes doctors' duty to provide care "in full technical and moral independence, with compassion and respect for human dignity." It also stresses the duty to act only in patient's interest and says that doctors owe their patients complete loyalty. The WMA's Tokyo Declaration and Declaration on Physician Independence and Professional Freedom[61] make unambiguously clear that doctors must insist on being free to act in patients' interests, regardless of other interests. These include the instructions of employers, prison authorities or security forces. The latter declaration requires doctors to ensure that they "have the professional independence to represent and defend the health needs of patients against all who would deny or restrict needed care for those who are sick or injured." Similar principles are enunciated for nurses in the International Council of Nurses Code.

Another way in which duty to provide care is expressed by the WMA is through its recognition of patient rights. Its Declaration of Lisbon on the Rights of Patients[62] recognizes that every person is entitled without discrimination to appropriate health care and again reiterates that doctors must always act in patients' best interests. Patients must be guaranteed autonomy and justice, according to the declaration, and both doctors and providers of medical care must uphold patients' rights. "Whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or restore them."

Individuals are entitled to appropriate health care regardless of factors such as their ethnic origin, political beliefs, nationality, gender, religion or their individual merit; people accused or convicted of crimes have an equal moral entitlement to appropriate medical and nursing care. The WMA's Declaration of Lisbon on the Rights of Patients emphasizes that the only acceptable criterion for discriminating between patients is that of the relative urgency of their medical need.

2. Informed Consent

While the declarations reflecting a duty of care all emphasize the obligation to act in the best interests of the individual being examined or treated, this presupposes that health professionals know what is in the patient's interests. An absolutely fundamental precept of modern medical ethics is that the best judge of their own interests are individuals themselves. This requires that health professionals should normally give precedence to the competent adult patient's wishes rather than to the views of any person in authority about what would be good for that individual. Where the patient is unconscious or otherwise incapable of giving valid consent, health professionals must make a judgment about how that person's best interests can be protected and promoted. Nurses and doctors are expected to act as the advocate of their patients and this is made clear in statements such as the WMA Declaration of Lisbon on the Rights of Patients and International Council of Nurses statement on The Nurse's Role in Safeguarding Human Rights.[63]

The WMA's Declaration of Lisbon on the Rights of Patients specifies the duty for doctors to obtain the unpressured and informed consent from mentally competent patients to any examination or procedure. This means that individuals need to know the implications of agreeing and the consequences of refusing. Before examining patients, health professionals must, therefore, explain frankly the purpose of the examination and treatment. Consent obtained under duress or as a result of false information being given to the patient is invalid and doctors acting on it are likely to be in breach of medical ethics. The graver the implications for the patient of the procedure, the greater is the moral imperative to obtain properly informed consent. That is to say where examination and treatment is clearly of therapeutic benefit to individuals, their implied consent by cooperating in the procedures may be sufficient. In cases, where examination is not primarily for the purposes of providing therapeutic care, great caution is required in (a) ensuring that the patient knows and agrees to this and (b) it is in no way contrary to the individual's best interests. As previously stated, examination to ascertain whether an individual can withstand punishment, torture or physical pressure during interrogation is unethical and contrary to the purpose of medicine. The only ethical assessment of prisoners' health is one designed to evaluate it in order to maintain and improve optimum health, not to facilitate punishment.

[61] Adopted by the WMA in 1986.
[62] Adopted by the WMA in 1981; amended by the 47th General Assembly in September 1995.

Physical examination for evidential purposes in an inquiry requires consent which is informed in the sense of the patient understanding factors such as, how the health data gained from the examination will be used, how it will be stored and who will have access to it. If these and other points relevant to the patient's decision are not made clear in advance, consent to examination and recording of information is invalid.

3. Confidentiality

All ethical codes, from the Hippocratic oath to modern times, include the duty of confidentiality as a fundamental principle. It also features prominently in WMA declarations, such as Declaration of Lisbon on the Rights of Patients. In some jurisdictions, the obligation of professional secrecy is seen as so important, it is incorporated into national law. The duty of confidentiality is not absolute and may be ethically breached in exceptional circumstances where failure to do so will foreseeably give rise to serious harm to people or a serious perversion of justice. Generally, however, the duty of confidentiality covering identifiable personal health information can only be overridden with the informed permission of the patient.[64] Non-identifiable patient information can be freely used for other purposes and should be used for preference in all situations where disclosure of the patient's identity is not essential. (This may be the case, for example, for the collection of data about patterns of torture or maltreatment.) Dilemmas arise where health professionals are pressured or required by law to disclose identifiable information which would be likely to put patients at risk of harm. In such cases, the fundamental ethical obligations to respect the autonomy and best interests of the patient and to do good and avoid harm supersede other considerations. Doctors should make clear to the court or the authority requesting information that they are bound by professional duties of confidentiality. Health professionals responding in this way are entitled to the support of their professional association and colleagues.

In addition, in periods of armed conflict, international humanitarian law gives particular protection to doctor-patient confidentiality, requiring that doctors should not denounce people who are sick or wounded.[65] Health professionals also are protected in that they cannot be compelled to disclose information about their patients in such situations.

D. Health Professionals with Dual Obligations

Health professionals have dual obligations, in that they owe a primary duty to the patient to promote that person's best interests and a general duty to society to ensure that justice is done and violations of human rights prevented. The dilemmas arising from dual obligations are particularly acute, however, for health professionals working with the police, military, and other security services or in the prison system. The interests of their employer and their non-medical colleagues may be in conflict with the best interests of the detainee patients. Whatever the circumstances of their employment, all health professionals owe a fundamental duty of care to the people they are asked to examine or treat. They cannot be obliged by contractual or other considerations to compromise their professional independence. They must make an unbiased assessment of the patient's health interests and act accordingly.

[64] Except for common public health requirements, such as the named reporting of individuals with infectious diseases, drug addiction, mental disorder etc.
[65] Article 16 of Protocol I (1977) and Article 10 of Protocol II (1977), additional to the Geneva Conventions of 1949.

1. Principles Guiding All Doctors with Dual Obligations:[66]

1) In all cases where doctors are acting for another party, they have an obligation to ensure that the patient understands that fact. Doctors must identify themselves to patients and explain the purpose of any examination or treatment.

2) Even when doctors are appointed and paid by a third party, they retain a clear duty of care to any patient whom they examine or treat. They must refuse to comply with any procedures that may harm patients or leave them physically or psychologically vulnerable to harm. They must ensure that their contractual terms allow them professional independence to make clinical judgments.

3) Doctors must ensure that any person in custody has access to medical examination and treatment, as necessary. Where the detainee is a minor, or a vulnerable adult, doctors have additional duties to act as advocate.

4) Doctors retain a general duty of confidentiality so that information should not be disclosed without the patient's knowledge. They must ensure that their medical records are kept confidential.

5) Doctors have a duty to monitor and speak out when services in which they are involved are unethical, abusive, and inadequate or pose a potential threat to patients' health. In such cases, they have an ethical duty to take prompt action as failure to take an immediate stand makes protest at a later stage more difficult. They should report the matter to appropriate authorities or international agencies who can investigate but without exposing patients, their families or themselves to foreseeable serious risk of harm.

6) Doctors and professional associations should support colleagues who take such action on the basis of reasonable evidence.

2. Dilemmas Arising from Dual Obligations

Dilemmas may occur when ethics and law are in contradiction. Circumstances can arise where their ethical duties oblige health professionals not to obey a particular law, such as a legal obligation to reveal confidential medical information about a patient. There is broad consensus in international and national declarations of ethical precepts that other imperatives, including the law, cannot oblige health professionals to act contrary to medical ethics and to their conscience. In such cases, health professionals must decline to comply with the law or regulation rather than compromise basic ethical precepts or expose patients to serious danger.

In some cases, two ethical obligations are in conflict. International codes and ethical principles require the reporting of information concerning torture or maltreatment to a responsible body. (In some jurisdictions, this is also a legal requirement). In some cases, however, patients may refuse to give consent to being examined for such purposes or to having the information gained from examination disclosed to others. They may be fearful of the risks of reprisals for themselves or their families. In such situations, health professionals have dual responsibilities to the patient and to society at large which has an interest in ensuring that justice is done and perpetrators of abuse brought to justice. The fundamental principle of avoiding harm must feature prominently in consideration of such dilemmas. Health professionals should seek solutions which promote justice without breaching the individual's right to confidentiality. Advice should be sought from reliable agencies; in some cases this may be the national medical association or non-governmental agencies. Alternatively, with supportive encouragement, some reluctant patients may agree to disclosure within agreed parameters.

The ethical obligations of the doctor may vary according to the context of the doctor-patient encounter and the possibility of the patient being able to exercise free choice about the disclosure decision. For example, where the doctor and patient are in a clearly therapeutic situation, such as the provision of care in hospital, there is a strong moral imperative for doctors to preserve the usual rules of confidentiality which normally prevail in therapeutic relationships. Reporting evidence of torture obtained in such encounters is entirely appropriate as long as the patient does not forbid it. Doctors should report such evidence if patients request it or give properly informed consent to it. They should support patients in such decisions.

[66] These principles are extracted from guidelines on "Doctors with dual obligations" of a typical national body, the British

Forensic doctors have a different relationship with individuals they examine and usually have an obligation to report factually their observations. The patient has less power and choice in such situations and may not be able to speak openly about what has occurred. Before beginning any examination, forensic doctors must explain their role to the patient and make clear that medical confidentiality is not a usual part of their role, as it would be in a therapeutic context. Regulations may not permit the patient to refuse examination but the patient has an option of choosing whether or not to disclose the cause of any injury. Forensic doctors should not falsify their reports but provide impartial evidence, including making clear in their reports any evidence of maltreatment.[67]

Prison doctors are primarily providers of therapeutic treatment but they also have the task of examining detainees arriving in prison from police custody. In this role or in treatment of people within the prison, they may discover evidence of unacceptable violence, which prisoners themselves are not in a realistic position to denounce. In such situations, doctors must bear in mind the best interests of the patient and their duties of confidentiality to that person but the moral arguments for the doctor denouncing the evidence of maltreatment are strong, since prisoners themselves are often unable to do so, effectively. Where prisoners agree to disclosure, no conflict arises and the moral obligation is clear. If the prisoner refuses to allow disclosure, doctors must weigh the risk and potential danger to the individual patient against the benefits of the prison population and the interests of society in preventing the perpetuation of abuse.

Health professionals also must bear in mind that reporting abuse to the authorities in whose jurisdiction it is alleged to have occurred may well entail risks of harm for the patient or for others, including the whistle-blower. Doctors must not knowingly place individuals in danger of reprisals. They are not exempt from taking action but should use discretion and have to consider reporting the information to a responsible body outside the immediate jurisdiction or, where this would not entail foreseeable risks to health professionals and patients, report it in a non-identifiable manner. Clearly, if the latter solution is taken, health professionals must take into account the likelihood of pressure being brought on them to disclose identifying data or the possibility of having their medical records forcibly seized. While there are no easy solutions, health professionals should be guided by the basic injunction to avoid harm above all other considerations and seek advice, where possible, from national or international medical bodies.

[67] See Iacopino V, Heisler M, Pishevar S, and Kirschner RH. Physician complicity in misrepresentation and omission

IV. LEGAL INVESTIGATIONS OF TORTURE

A. Introduction

States are required under international law to investigate reported incidents of torture promptly and impartially. Where evidence warrants it, a State in whose territory a person alleged to have committed or participated in torture is present, must either extradite the alleged perpetrator to another State that has competent jurisdiction or submit the case to its own competent authorities for the purpose of prosecution under national or local criminal laws. The fundamental principles of any viable investigation into incidents of torture are competence, impartiality, independence, promptness and thoroughness. These elements can be adapted to any legal system and should guide all investigations of alleged torture.

Where investigative procedures are inadequate because of lack of resources, lack of expertise, the appearance of bias, the apparent existence of a pattern of abuse, or other substantial reasons, States shall pursue investigations through an independent commission of inquiry or similar procedure. Members of such a commission shall be chosen for their recognized impartiality, competence and independence as individuals. In particular, they shall be independent of any institution, agency or person that may be the subject of the inquiry.

Section B describes the broad purpose of an investigation into torture.

Section C sets forth basic principles on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment.

Section D sets forth suggested procedures for conducting an investigation into alleged torture. The section first considers the decision regarding the appropriate investigative authority, then offers guidelines regarding collection of oral testimony from the reported victim and other witnesses, and collection of physical evidence.

Section E provides guidelines for establishing a special independent commission of inquiry. These guidelines are based on the experiences of several countries that have established independent commissions to investigate alleged human rights abuses, including extra-judicial killings, torture, and disappearances.

B. Purposes of a Torture Investigation

The broad purpose of the investigation is to establish the facts relating to alleged incidents of torture, with a view to identifying those responsible for the incidents and facilitating their prosecution, or for use in the context of other procedures designed to obtain redress for victims.

The issues addressed here may also be relevant for other types of investigations of torture.

To fulfill this purpose, those carrying out the investigation shall, at a minimum, seek:

1) To obtain statements from the victim(s) of alleged torture;

2) To recover and preserve evidence, including medical evidence, related to the alleged torture to aid in any potential prosecution of those responsible;

3) To identify possible witnesses and obtain statements from them concerning the alleged torture;

4) To determine how, when and where the alleged incidents of torture occurred as well as any pattern or practice that may have brought about the torture

C. Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

The following principles represent a consensus among individuals and organizations having expertise in the investigation of torture.

1) The purposes of effective investigation and documentation of torture and other cruel, inhuman or degrading treatment (hereafter torture or other ill treatment) include the following:

> (i) clarification of the facts and establishment and acknowledgment of individual and State responsibility for victims and their families;
>
> (ii) identification of measures needed to prevent recurrence;
>
> (iii) facilitating prosecution and/or, as appropriate, disciplinary sanctions for those indicated by the investigation as being responsible, and demonstrating the need for full reparation and redress from the State, including fair and adequate financial compensation and provision of the means for medical care and rehabilitation.

2) States shall ensure that complaints and reports of torture or ill treatment shall be promptly and effectively investigated. Even in the absence of an express complaint, an investigation should be undertaken if there are other indications that torture or ill treatment might have occurred. The investigators, who shall be independent of the suspected perpetrators and the agency they serve, shall be competent and impartial. They shall have access to, or be empowered to commission investigations by impartial medical or other experts. The methods used to carry out such investigations shall meet the highest professional standards, and the findings shall be made public.

3a) The investigative authority shall have the power and obligation to obtain all the information necessary to the inquiry.[68] These persons conducting the investigation shall have at their disposal all the necessary budgetary and technical resources for effective investigation. They shall also have the authority to oblige all those acting in an official capacity allegedly involved in torture or ill treatment to appear and testify. The same shall apply to any witness. To this end, the investigative authority shall be entitled to issue summonses to witnesses, including any officials allegedly involved, and to demand the production of evidence.

3b) Alleged victims of torture or ill treatment, witnesses, those conducting the investigation and their families shall be protected from violence, threats of violence or any other form of intimidation that may arise pursuant to the investigation. Those potentially implicated in torture or ill treatment shall be removed from any position of control or power, whether direct or indirect, over complainants, witnesses and their families, as well as those conducting the investigation.

4) Alleged victims of torture or ill treatment and their legal representatives shall be informed of, and have access to, any hearing as well as to all information relevant to the investigation, and shall be entitled to present other evidence.

5a) In cases in which the established investigative procedures are inadequate because of insufficient expertise or suspected bias, or because of the apparent existence of a pattern of abuse, or for other substantial reasons, States shall ensure that investigations are undertaken through an independent commission of inquiry or similar procedure. Members of such a commission shall be chosen for their recognized impartiality, competence and independence as individuals. In particular, they shall be independent of any suspected perpetrators and the institutions or agencies they may serve. The commission shall have the authority to obtain all information necessary to the inquiry and shall conduct the inquiry as provided for under these Principles.[69]

5b) A written report, made within a reasonable time, shall include the scope of the inquiry, procedures and methods used to evaluate evidence as well as conclusions and recommendations based on findings of fact and on applicable law. On completion, this report shall be made public. It shall also describe in detail specific events that were found to have occurred, the evidence upon which such findings were based, and list the names of witnesses who testified with the exception of those whose identities have been withheld

[68] Under certain circumstances professional ethics may require information to be kept confidential. These requirements should be respected.

for their own protection. The State shall, within a reasonable period of time, reply to the report of the investigation, and, as appropriate, indicate steps to be taken in response.

6a) Medical experts involved in the investigation of torture or ill treatment should behave at all times in conformity with the highest ethical standards and in particular shall obtain informed consent before any examination is undertaken. The examination must conform to established standards of medical practice. In particular, examinations shall be conducted in private under the control of the medical expert and outside the presence of security agents and other government officials.

6b) The medical expert should promptly prepare an accurate written report. This report should include at least the following:

(i) Circumstances of the interview: name of the subject and name affiliation of those present at the examination; the exact time and date, location, nature and address of the institution (including, where appropriate, the room) where the examination is being conducted (e.g. detention centre, clinic, house, etc.); and the circumstances of the subject at the time of the examination (e.g. nature of any restraints on arrival or during the examination, presence of security forces during the examination, demeanour of those accompanying the prisoner, threatening statements to the examiner, etc.); and any other relevant factor;

(ii) History: a detailed record of the subject's story as given during the interview, including alleged methods of torture or ill treatment, the times when torture or ill treatment is alleged to have occurred and all complaints of physical and psychological symptoms;

(iii) Physical and psychological examination: a record of all physical and psychological findings on clinical examination including, appropriate diagnostic tests and, where possible, colour photographs or all injuries;

(iv) Opinion: an interpretation as to the probable relationship of the physical and psychological findings to possible torture or ill treatment. A recommendation for any necessary medical and psychological treatment and/or further examination should be given;

(v) Authorship: the report should clearly identify those carrying out the examination and should be signed.

6c) The report should be confidential and communicated to the subject or his or her nominated representative. The views of the subject and his or her representative about the examination process should be solicited and recorded in the report. It should also be provided in writing, where appropriate, to the authority responsible for investigating the allegation of torture or ill treatment. It is the responsibility of the State to ensure that it is delivered securely to these persons. The report should not be made available to any other person, except with the consent of the subject or on the authorization of a court empowered to enforce such transfer.

See Section V for general considerations for writing reports following allegations of torture. Sections VI and VII describe in detail the physical and psychological assessments respectively.

D. Procedures of a Torture Investigation

1. Determination of Appropriate Investigative Body

In cases where involvement in torture by public officials is suspected, including possible orders for the use of torture by ministers, ministerial aides, officers acting with the knowledge of ministers, senior officers in State ministries, senior military leaders, or tolerance of torture by such individuals, an objective and impartial investigation may not be possible unless a special commission of inquiry is established. A commission of inquiry may also be necessary where the expertise or the impartiality of the investigators is called into question.

Factors that support a belief that the State was involved in the torture or that special circumstances exist that should trigger the creation of a special impartial investigation mechanism include:

1) Where the victim was last seen unharmed in police custody or detention;

3) Where persons in the State or associated with the State have attempted to obstruct or delay the investigation of the torture;

4) Where the public interest would be served by an independent inquiry;

5) Where investigation by regular investigative agencies is in question because of lack of expertise or lack of impartiality, or for other reasons including:

   - The importance of the matter, or
   - The apparent existence of a pattern of abuse, or
   - Complaints from the person or the above inadequacies, or
   - Other substantial reasons.

Several considerations should be taken into account when a State decides to establish an independent commission of inquiry. First, persons subject to an inquiry should be guaranteed the minimum procedural safeguards protected by international law at all stages of the investigation. Second, investigators should have the support of adequate technical and administrative personnel, as well as access to objective, impartial legal advice to ensure that the investigation will produce admissible evidence for criminal proceedings. Third, investigators should receive the full scope of the State's resources and powers. Finally, investigators should have the power to seek help from the international community of experts in law and medicine.

2. Interviewing the Alleged Victim and Other Witnesses

Because of the nature of torture cases and the trauma individuals suffer as a result, often including a devastating sense of powerlessness, it is particularly important to show sensitivity to the alleged torture victim and other witnesses. The State must protect alleged victims of torture, witnesses and their families from violence, threats of violence or any other form of intimidation which may arise pursuant to the investigation. Investigators must inform witnesses about the consequences of their involvement in the investigation and about any subsequent developments in the case that may impact them.

2a) Informed consent and other protections for the alleged victim

From the outset, the alleged victim should be informed, wherever possible, of the nature of the proceedings, why his or her evidence is being sought, if and how evidence offered by the alleged victim may be used. Investigators should explain to the person which portions of the investigation will be public information and which portions will be confidential. The person has the right to refuse to cooperate with all or part of the investigation. Every effort should be made to accommodate his or her schedule and wishes.

The alleged torture victim should be regularly informed of the progress of the investigation. The alleged victim should be notified of all key hearings in the investigation and prosecution of the case. The investigators should inform the alleged victim of the arrest of the suspected perpetrator.

Alleged victims of torture should be given contact information for advocacy and treatment groups that might be of assistance to them. Investigators should work with advocacy groups within their jurisdiction to ensure that there is a mutual exchange of information and training concerning torture.

2b) Selection of the investigator

The authorities investigating the case must identify a person primarily responsible for questioning the alleged victim. While the alleged victim may need to discuss his or her case with both legal and medical professionals, the investigating team should make every effort to minimize unnecessary repetitions of the person's story. In selecting a person as the investigator with primary responsibility for the alleged torture victim, special consideration should be given to the person's preference for a person of the same gender, the same cultural background and the ability to communicate in his or her native language.

The primary investigator should have prior training or experience in documenting torture and in working with victims of trauma including torture. In situations where an investigator with prior training

about torture and its physical and psychological consequences before interviewing the individual. Information about torture is available from sources including this Manual, various professional and training publications, training courses, and professional conferences. The investigator should also have access to international expert advice and assistance throughout the investigation.

2c) Context of investigation

Investigators should carefully consider the context in which they are working, and take the necessary precautions, and provide safeguards, accordingly. If interviewing people who are still imprisoned, or in similar situations where reprisals are possible, the interviewer should use care not to put them in danger. In situations where it may endanger someone to be seen talking to an investigator, a “group interview” may be preferable to an individual interview. In other cases, the interviewer must choose a place for the private interview, where the witness feels comfortable to talk freely.

Evaluations occur in a variety of political contexts. This results in important differences in the manner in which evaluations should be conducted. The legal standards to which the investigation is conducted are also affected by the context. For example, an investigation culminating in the trial of an alleged perpetrator will require the highest level of proof, whereas a report supporting an application for political asylum in a third country need only provide a relatively low level of proof of torture. The investigator must adapt the following guidelines according to the particular situation and purpose of the evaluation. Examples of various contexts include but are not limited to the following:

1) In prison or detention in the individual’s home country,

2) In prison or detention in another country,

3) Not in detention in the home country but in a hostile oppressive climate,

4) Not in detention in the home country and during a time of peace and security,

5) In another country that may be friendly or hostile,

6) In a refugee camp setting,

7) In a war crimes tribunal or truth commission.

The political context may be hostile towards the victim and to the examiner, such as when detainees are interviewed while they are held in prison by their governments or while they are detained by foreign governments in order to be deported. In countries where asylum seekers are examined in order to establish evidence of torture, the reluctance to acknowledge claims of trauma and torture may be politically motivated. The possibility of further endangering the safety of the detainee is very real and must be taken into account during every evaluation.

Even in cases where persons alleging torture are not in imminent danger, investigators should use great care in their contact with them. The investigator's choice of language and attitude will greatly affect the alleged victim's ability and willingness to be interviewed. The location of the interview should be as safe and comfortable as possible, including access to toilet facilities and refreshments. Sufficient time should be allotted to interview the alleged torture victim. Investigators should not expect to get the full story during the first interview. Questions of a private nature will be traumatic for the alleged victim. The investigator must be sensitive in tone, phrasing and sequencing of questions, given the traumatic nature of his or her testimony. The witness must be told that he or she has the right to stop the questioning at any time, to take a break if needed, or to choose not to respond to any question.

Psychological or counseling services trained in working with torture victims should be accessible if possible to the alleged torture victim, witnesses and members of the investigating team. Retelling the facts of the torture may cause the person to relive the experience or suffer other trauma-related symptoms (see also Section V.I).

Hearing details of torture may result in secondary trauma symptoms to interviewers, and they must be encouraged to discuss their reactions with each other, respecting their professional ethical requirements of confidentiality. Wherever possible, this should be with the help of an experienced

may identify with those alleging torture and not be sufficiently challenging of the story. Secondly, the interviewer may become so used to hearing histories of torture that he or she diminishes in his or her own mind the experiences of the person being interviewed.

2d) Safety of witnesses

The State is responsible for protecting alleged victims, witnesses and their families from violence, threats of violence or any other form of intimidation that may arise pursuant to the investigation. Those potentially implicated in torture shall be removed from any position of control or power, whether direct or indirect over complainants, witnesses and their families as well as those conducting investigations. Investigators must give constant consideration to the effect of the investigation on the safety of the person alleging torture and other witnesses.

One suggested technique for providing a measure of safety to interviewees, including prisoners in countries in conflict situations, is to write down and keep safe the identities of people visited so that investigators can follow up on the safety of those individuals at a future return visit. Investigators must be allowed to talk to anyone and everyone, freely and in private, and be allowed to repeat the visit to these same persons (thus the need for traceable identities of those interviewed) as the need arises. Not all countries accept these conditions, and investigators may find it difficult to obtain similar guarantees. In cases in which witnesses are likely to be put in danger because of their testimony, the investigator should seek other forms of evidence.

Prisoners are potentially in greater danger than persons who are not in custody. Prisoners might have different reactions to different situations. In one situation, prisoners may put themselves in danger unwittingly by speaking out too rashly, thinking they are protected by the very presence of the "outside" investigator. This may not be the case. In other situations, investigators may come up against a "wall of silence," as prisoners are far too intimidated to trust anyone, even when offered talks in private. In the latter case, it may be necessary to start with "group interviews," so as to be able to clearly explain the scope and purpose of the investigation, and subsequently offer to have interviews in private with those persons who desire to speak. If the fear of reprisals - justified or not - is too great, it may be necessary to interview all prisoners in a given place of custody, so as to not pinpoint any specific person.

Where an investigation leads to prosecution or to another public truth-telling forum, the investigator should recommend measures to prevent harm to the alleged torture victim, by such means as expunging names and other information that identifies the person from the public records, and offering the person the opportunity to testify through image- or voice-altering devices or closed circuit television. These measures must be consistent with the rights of the accused.

2e) Use of interpreters

Working through an interpreter when investigating torture is not easy, even with professionals. It will not always be possible to have on hand interpreters for all different dialects and languages, and sometimes it may be necessary to use interpreters from the person's family or cultural group. This is not ideal, as the person may not always feel comfortable talking about the torture experience through people he or she knows. Ideally, the interpreter should be part of the investigating team, and knowledgeable about torture issues. See also Sections V.J and VII.C. 2.

2f) Information to be obtained from the person alleged to have been tortured

The investigator should attempt to obtain as much of the following information as possible through the testimony of the alleged victim (see also Section V.E):

1) The circumstances leading up to the torture, including arrest or abduction and detention;

2) Approximate dates and times of the torture, including when the last instance of torture occurred. Establishing this information may not be easy, as there may be several places, and perpetrators (or groups of perpetrators) involved. Separate histories may have to be taken about the different places. Expect chronologies to be inaccurate and sometimes even confusing: notions of time are often hard to focus on for someone who has been tortured. Separate histories about different places may be useful when trying to get a global picture of the situation. Survivors will often not know exactly where they have been

testimonies, it may be possible to “map out” specific places, methods and even perpetrators;

3) A detailed description of the person(s) involved in the arrest, detention and torture including whether he or she knew any of them prior to the events relating to the alleged torture; clothing, scars, birthmarks, tattoos, height, weight (person may be able to describe in relation to own size), anything unusual about the perpetrator’s anatomy, language and accent, whether the perpetrator(s) was intoxicated at any time;

4) Contents of what the person was told or asked. This may provide relevant information when trying to identify “secret” or unacknowledged places of detention;

5) Description of the usual routine in the place of detention and the pattern of ill treatment;

6) Description of the facts of the torture, including methods of torture used. This is understandably often difficult, and investigators should not expect to get the full story during a first interview. It is important to get precise information, but questions relating to the intimate humiliations and assaults will be traumatic, often extremely so.

7) Whether the individual was sexually assaulted. Most people will tend to answer a question on “sexual assault” as meaning actual rape or sodomy. Investigators should be sensitive to the fact that verbal assaults, disrobing, groping, lewd or humiliating acts, or blows or electric shocks to the genitals are often not taken by the victim as constituting sexual assault. These acts all violate the individual’s intimacy, and should be considered as being part and parcel of sexual assault. Very often victims of sexual assault will not say anything, or even deny any sexual assault at first. It is often only on the second or even third visit, if the contact made has been empathic and sensitive to the person’s culture and personality, that more of the story will come out;

8) Physical injuries sustained in the course of the torture;

9) A description of weapons or other physical objects used;

10) The identity of witnesses to the events involving torture. The investigator must use care in protecting the safety of witnesses and should consider encrypting the identities of witnesses or keeping the names separate from the substantive interview notes;

2g) Statement from the person who is alleging torture

The investigator should tape record a detailed statement from the person and have it transcribed. The statement should be based on answers given in response to non-leading questions. Non-leading questions do not make assumptions or conclusions and allow the person to offer the most complete and unbiased testimony. Non-leading questions would be, for example, “What happened to you and where?” rather than “Were you tortured in prison?” The latter question assumes that what happened to the witness was torture and limits the location of the actions to prison. Avoid asking questions with lists, as this can force the individual into giving inaccurate answers if what actually happened does not exactly match one of the options. Allow the person to tell his or her own story, but assist by asking questions that increase in specificity.

Encourage the person to use all senses in describing what has happened to him or her. Ask what he or she saw, smelled, heard and felt. This is important, for instance, in situations where the person may have been blindfolded or experienced the assault in the dark.

2h) Alleged perpetrator’s statement

If possible, the investigators should interview the alleged perpetrator(s). The investigators must provide them with legal protections guaranteed under international and national law.

3. Securing and Obtaining Physical Evidence

The investigator should gather as much physical evidence as possible to document an incident or pattern of torture. One of the most important aspects of a thorough and impartial investigation of

custody involved in recovering and preserving physical evidence in order to use such evidence in future legal proceedings, including potential criminal prosecution.

Most torture takes place in places where people are held in some form of custody, where preserving physical evidence or having unrestricted access to may be initially difficult or even impossible. Investigators must be given authority by the State to obtain such access to any place or premises, and be able to secure the setting where torture allegedly took place.

Investigative personnel and other investigators should coordinate their efforts in carrying out a thorough investigation of the place where torture has allegedly occurred. Investigators must have access without restrictions to the alleged scene(s) of torture. Their access must include, but not be limited to, open or closed areas including buildings, vehicles, offices, prison cells or other premises where torture is alleged to have taken place.

1) Any building or area under investigation must be closed off so as not to lose any possible evidence. Only investigators and their staff should be allowed entry into the area once it has been designated as under investigation;

2) Examination of the scene for any material evidence should take place. All evidence must be properly collected, handled, packaged, labeled and placed in safekeeping to prevent contamination, tampering with or loss of evidence. If the torture has allegedly taken place recently enough for such evidence to be relevant, any samples found of body fluids (such as blood or semen), hair, fibers and threads, should be collected, labeled and properly preserved;

3) Any implements that could be used to inflict torture, whether they be destined for that purpose or used circumstantially, should be taken and preserved;

4) If recent enough to be relevant, any fingerprints located, must be lifted and preserved;

5) A labeled sketch of the premises or place where torture has allegedly taken place, must be made to scale, showing all relevant details, such as the location of different floors in a building, different rooms, entrances, windows etc.; furniture, surrounding terrain, etc. Color photographs must also be taken to record the same;

6) A record of the identity of all persons at the alleged torture scene must be made, including complete names, addresses and telephone numbers or other contact information;

7) If torture is recent enough for it to be relevant, the clothing of the person alleging torture: inventory should be taken, and tested at a laboratory, if available, for bodily fluids and other physical evidence;

8) Information must be obtained from anyone present at the premises or areas under investigation, to determine whether they were witness to the incidents of alleged torture;

9) Any relevant papers, records or documents should be saved for evidentiary use and handwriting analysis.

4. Medical Evidence

The investigator should arrange for a medical examination of the alleged victim. Timeliness of such medical examination is particularly important. A medical examination should be undertaken regardless of the length of time since the torture, but if it is alleged to have happened within the past six weeks, such an examination should be arranged urgently before acute signs fade. The examination should include an assessment of the need for treatment of injuries, and illnesses, psychological help, and advice and follow-up. (See Section VI. for a description of the physical examination, and forensic evaluation.) A psychological evaluation and appraisal of the alleged torture victim is always necessary, and may be part of the physical examination, or where there are no physical signs it may be performed by itself. (See Section VII for a description of the psychological examination and evaluation.)

In formulating the clinical impression for the purposes of reporting physical and psychological evidence of torture, there are six important questions to ask:

1) Are the physical and psychological findings consistent with the alleged report of torture?

2) What physical conditions contribute to the clinical picture?

3) Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?

4) Given the fluctuating course of trauma-related mental disorders over time, what is the time-frame in relation to the torture events? Where in the course of recovery is the individual?

5) What other stressful factors are affecting the individual? (e.g. ongoing persecution, forced migration, exile, loss of family and social role, etc.) What impact do these issues have on the victim?

6) Does the clinical picture suggest a false allegation of torture?

5. Photography

Color photographs should be taken of the injuries of persons alleging that they have been tortured, and of the premises where torture has allegedly occurred (interior and exterior) and of any other physical evidence found there. A measuring tape or some other means of showing scale on the photograph is essential. Photographs must taken as soon as possible, even with a basic camera as some physical signs fade rapidly, and locations can be interfered with. Instantly-developed photos may decay over time. More professional photos are preferred and should be taken when the equipment becomes available. If possible photographs should be taken using a 35 millimeter camera with an automatic date feature. The chain of custody of the film, negatives and prints must be fully documented.

E. Commission of Inquiry

1. Defining the Scope of the Inquiry

States and organizations establishing commissions of inquiry need to define the scope of the inquiry by including terms of reference in their authorization. Defining the commission's terms of reference can greatly increase its success by giving legitimacy to the proceedings, assisting commission members in reaching a consensus on the scope of inquiry and providing a measure by which the commission's final report can be judged. Recommendations for defining terms of reference are as follows:

1) They should be neutrally framed so that they do not suggest a predetermined outcome. To be neutral, terms of reference must not limit investigations in areas that might uncover State responsibility for torture;

2) They should state precisely which events and issues are to be investigated and addressed in the commission's final report;

3) They should provide flexibility in the scope of inquiry to ensure that thorough investigation by the commission is not hampered by overly restrictive or overly broad terms of reference. The necessary flexibility may be accomplished, for example, by permitting the commission to amend its terms of reference as necessary. It is important, however, that the commission keep the public informed of any amendments to its mandate.

2. Power of the Commission

The principles set out in a general manner the powers of the commission. More specifically such a commission would need the following:

1) To have the authority to obtain all information necessary to the inquiry including the authority to compel testimony under legal sanction, to order the production of documents including State and medical records, and to protect witnesses, families of the victim and other sources;

2) To have the authority to issue a public report;

3) To have the authority to conduct on-site visits, including at the location where the torture is suspected to have occurred;

4) To have the authority to receive evidence from witnesses and organizations located outside the country.

3. Membership Applications

Commission members should be chosen for their recognized impartiality, competence and independence as individuals:

1) Impartiality: Commission members should not be closely associated with any individual, State entity, political party or other organization potentially implicated in the torture. They should neither be too closely connected to an organization or group of which the victim is a member, as this may damage the commission's credibility. This should not however be an excuse for blanket exclusions from the commission, for instance, of members of large organizations of which the victim is also a member, or of persons associated with organizations dedicated to the treatment and rehabilitation of torture victims.

2) Competence: Commission members must be capable of evaluating and weighing evidence, and exercising sound judgment. If possible, commissions of inquiry should include individuals with expertise in law, medicine and other specialised fields, as appropriate.

3) Independence: Members of the commission should have a reputation in their community for honesty and fairness.

4. Number of Commissioners

The objectivity of the investigation and commission's findings may, among other things, depend on whether it has three or more members rather than one or two. A single commissioner should in general, not conduct investigations into torture. A single, isolated commissioner will generally be limited in the depth of investigation he or she can conduct alone. In addition, a single commissioner will have to make controversial and important decisions without debate, and will be particularly vulnerable to State and other outside pressure.

5. Choosing a Commission Counsel

Commissions of inquiry should have impartial, expert counsel. Where the commission is investigating allegations of State misconduct, it would be advisable to appoint counsel outside the Ministry of Justice. The chief counsel to the commission should be insulated from political influence, as through civil service tenure, or status as a wholly independent member of the bar.

The investigation will often require expert advisors. Technical expertise should be available to the commission, including in such areas as pathology, forensic science, psychiatry, psychology, gynecology, and pediatrics.

7. Choosing Investigators

To conduct a completely impartial and thorough investigation, the commission will almost always need its own investigators to pursue leads and to develop evidence. The credibility of an inquiry will be significantly enhanced to the extent that the commission can rely on its own investigators.

8. Protection of Witnesses

1) The State shall protect complainants, witnesses, those conducting the investigation, and their families from violence, threats of violence or any other form of intimidation (see also Section IV.D.2d);

2) If the commission concludes that there is a reasonable fear of persecution, harassment, or harm to any witness or prospective witness, the commission may find it advisable:
   - To hear the evidence in camera;
   - To keep the identity of the informant or witness confidential;
   - To use only such evidence as will not present a risk of identifying the witness;
   - To take any other appropriate measures.

9. Proceedings

It follows from general principles of criminal procedure that hearings should be conducted in public, unless in camera proceedings are necessary to protect the safety of a witness. In camera proceedings should be recorded and the closed, unpublished record kept in a known location.

Occasionally, complete secrecy may be required to encourage testimony, and the commission will want to hear witnesses privately, informally and without recording testimony.

10. Notice of Inquiry

Wide notice of the establishment of a commission and the subject of the inquiry should be given. The notice should also include an invitation to submit relevant information and/or written statements to the commission, and instructions to persons willing to testify. Notice can be disseminated through newspapers, magazines, radio, television, leaflets and posters.

11. Receipt of Evidence

Power to compel evidence: Commissions of inquiry should have the power to compel testimony and production of documents, including the authority to compel testimony from officials allegedly involved in torture. Practically, this authority may involve the power to impose fines or sentences if State officials or other individuals refuse to comply.

Use of witness statements: Commissions of inquiry should invite persons to testify or submit written statements as a first step in gathering evidence. Written statements may become an important source of evidence if their authors become afraid to testify, cannot travel to proceedings, or are otherwise unavailable.

Use of evidence from other proceedings: Commissions of inquiry should review other proceedings that could provide relevant information.

12. Rights of Parties

Those alleging that they have been tortured and their legal representatives shall be informed of, and have access to, any hearing and to all information relevant to the investigation, and shall be entitled to present evidence. This particular emphasis on the role of the survivor as a party to the proceedings implies the especially important role their interests play in the conduct of the investigation. However, all other interested parties should also have the opportunity at being heard. The investigative body

demand the production of evidence. All these witnesses should be permitted legal counsel if they are likely to be harmed by the inquiry, for example, when their testimony could expose them to criminal charges or civil liability. Witnesses may not be compelled to testify against themselves.

There should be an opportunity for the effective questioning of witnesses by the commission. Parties to the inquiry should be allowed to submit written questions to the commission.

13. Evaluation of Evidence

The commission shall assess all information and evidence it receives to determine the reliability and probity. The commission should evaluate oral testimony based upon the demeanor and overall credibility of the witness. The commission must be sensitive to social, cultural and gender issues that affect demeanor. Corroboration of evidence from several sources will increase the probative value of such evidence. The reliability of hearsay evidence from several sources will increase the probative value of such evidence. The reliability of hearsay evidence must be considered carefully before the commission should accept it as fact. Testimony not tested by cross-examination must also be viewed with caution. In camera testimony preserved in a closed record or not recorded at all is often not subjected to cross-examination and therefore may be given less weight.

14. The Report of the Commission

The commission should issue a public report within a reasonable period of time. It may be added that where the commission is not unanimous in its findings, the minority commissioner(s) should file a dissenting opinion.

Commission of inquiry reports should contain, at a minimum, the following information:

1) The scope of inquiry and terms of reference;

2) The procedures and methods of evaluating evidence;

3) A list of all witnesses, including age and gender, who have testified, except for those whose identities are withheld for protection and who have testified in camera, and exhibits received in evidence;

4) The time and place of each sitting (this might be annexed to the report);

5) The background to the inquiry such as relevant social, political and economic conditions;

6) The specific events that occurred and the evidence upon which such findings are based;

7) The law upon which the commission relied;

8) The commission’s conclusions based upon applicable law and findings of fact;

9) Recommendations based upon the findings of the commission.

15. Response of the State

The State should either reply publicly to the commission’s report, and, where appropriate, indicate what steps it intends to take in response to the report.

V. GENERAL INTERVIEW CONSIDERATIONS

A. Introduction

When a person allegedly tortured is interviewed, there are a number of issues and practical factors that have to be taken into consideration. These general considerations apply to all persons carrying out interviews, whether they are lawyers, medical doctors, psychologists or psychiatrists, human rights monitors or members of any other profession. The following section takes up this "common ground" and attempts to put it into different contexts that may be encountered when investigating torture and interviewing victims of torture.

B. Purpose of Inquiry, Examination and Documentation

The broad purpose of the investigation is to establish the facts relating to alleged incidents of torture. See also Section IV.D.2c and V.I.B. Medical evaluations of torture may be useful evidence in various legal contexts such as:

1) Identifying the perpetrators responsible for torture and bringing them to justice;

2) Support of political asylum applications;

3) Establishing conditions under which false confessions may have been obtained by State officials; and

4) Establishing regional practices of torture. Medical evaluations also may be used to identify the therapeutic needs of survivors, and as testimony in human rights investigations.

The purpose of the written or oral testimony of the physician is to provide expert opinions on the degree to which medical findings correlate with the patient's allegation of abuse, and to effectively communicate the physician's medical findings and interpretations to the judiciary or other appropriate authorities. In addition, medical testimony often serves to educate the judiciary, other government officials, and the local and international community on the physical and psychological sequelae of torture as well. The examiner should be prepared to do the following:

1) To assess for possible injuries and abuse, even in the absence of specific allegations by individuals, or by law enforcement and judicial officials;

2) To document physical and psychological evidence of injuries and abuse;

3) To correlate the degree of consistency between examination findings and specific allegations of abuse by the patient;

4) To correlate the degree of consistency between examination findings of an individual with the knowledge of torture methods and their common after-effects used in a particular region;

5) To render expert interpretations of the findings in medical-legal evaluations and provide expert opinions regarding possible causes of abuse in asylum hearings, criminal trials and civil proceedings; and

6) To utilize information obtained in an appropriate manner to enhance fact-finding and further documentation of torture.

C. Procedural Safeguards with Respect to Detainees

1) Forensic medical evaluations of detainees should be conducted in response to official written requests by public prosecutors or other appropriate officials. Requests for medical evaluations by law enforcement officials are to be considered invalid unless they are acting on written orders of a public prosecutor. In addition, detainees themselves, their lawyer, or relatives have the right to request a medical evaluation to assess for evidence of torture and ill treatment.

2) The detainee should be taken to the forensic medical examination by officials other than soldiers and police since torture and ill treatment may have occurred in the custody of these officials and therefore place unacceptable coercive pressures on the detainee and/or the physician not to effectively document torture or ill treatment. The officials who supervise the transportation of the detainee should be responsible to the public prosecutors, and not other law enforcement officials. The detainee's lawyer should be present during the application for examination and post-examination transport of the detainee.

3) Detainees have the right to obtain a second, or alternative, medical evaluation by a qualified physician during and after the period of detention.

4) Each detainee must be examined in private. Police or other law enforcement officials should never be present in the examination room. This procedural safeguard may only be precluded when, in the opinion of the examining doctor, there is compelling evidence that the detainee poses a serious safety risk to health personnel. Under such circumstances, security personnel of the health facility, not the police or other law enforcement officials, should be available upon the medical examiner's request. In such cases, security personnel should still remain out of earshot (i.e. be only within visual contact) of the patient.

5) Medical evaluations of detainees should be conducted at a location that the physician deems most suitable. In some cases, it may be best to insist on doing them at official medical facilities, and not on the prison or jail premises. In other cases, prisoners may prefer to be examined in the relative safety of their cell, if they feel the medical premises may be "bugged" for example. The best place will be dictated by many factors, but in all cases, investigators should ensure that prisoners are not forced into accepting a place they are not "comfortable" with.

6) The presence of police, soldier, prison officer, or other law enforcement officials in the examination room, for whatever reason, should be noted in the physician's official medical report. Notation of police, soldier, prison officer, or other law enforcement officials presence during the examination may be grounds for disregarding a "negative" medical report. The identity and titles of others who are present in the examination room during the medical evaluations should be indicated in the report.

7) Medical-Legal evaluations of detainees should include the use of a standardized medical report form. See Appendix IV for guidelines that may be used to develop standard medical report forms.

8) The original, completed evaluation should be transmitted directly to the person requesting the report, generally the public prosecutor. Where a detainee requests a medical report, or a lawyer acting on his or her behalf, they will be provided with the report. Copies of each medical report should be retained by the examining physician. A National Medical Association or a Commission of Inquiry may choose to audit medical reports to ensure that adequate procedural safeguards and documentation standards are adhered to, particularly by doctors employed by the State. Reports should be sent to such an organization, providing issues of independence and confidentiality have been addressed. Under no circumstance should a copy of the medical report be transferred to law enforcement officials.

9) It is mandatory that the detainees undergo a medical examination at the time when they are detained and an examination and evaluation on their release.70 Access to the lawyer should be provided at the time of the medical examination. An outside presence during such examinations may be impossible in most prison situations. In such cases, it should be ascertained that the prison doctors working with prisoners respect medical ethics and are capable of conducting their professional duties independent of any third party influence.

10) If the forensic medical examination supports allegations of torture, the detainee should not be returned to the place of detention, but rather should appear before the prosecutor or judge to determine the detainee's legal disposition.[71]

[70] See, for example, the UN Standard Minimum Rules for the Treatment of Prisoners (Section II.B).

D. Official Visits to Detention Centres

Visits to prisoners are not to be considered lightly. They can in some cases be notoriously difficult to carry out in an objective and professional way, particularly in countries where torture is still being practiced. "One-shot" visits, without on-going follow-up to ensure the safety of the interviewees after the visit, may be dangerous. In some cases one visit without a repeat visit may be worse than no visit at all.

Well-meaning investigators may fall into the trap of "visiting" a prison or police station, without knowing exactly what they are doing. They may get an incomplete or false picture of reality. They may inadvertently place prisoners they may not ever be visiting again, in danger. They may be giving an "alibi" to the perpetrators of torture, who may "use" the fact that outsiders visited their prison and "saw nothing."

Visits should best be left for those investigators who can carry them out and follow them up in the most professional way, and who have certain weathered procedural safeguards for their work. The notion that some evidence is better than no evidence is not valid when working with prisoners who might be put in danger by giving testimony. Visits to detention facilities by well-meaning people representing official and non-governmental institutions can be difficult, and worse, can be counter-productive. In the case in point here, the distinction should be made between the bona fide visit necessary for the Inquiry, which is not in question, and a non-essential "visit" that goes beyond that, and when done by non-specialists could cause more harm than good in a country that practices torture.

Independent commissions constituted by jurists and physicians should be given ensured access to periodically visit places of detention and prisons.

Interviews with people who are still in custody, and possibly even in the hands of the possible perpetrators of torture obviously will be very different from interviews in the privacy and security of an outside and safe medical facility. The importance of obtaining the person's trust in such situations cannot be stressed enough. However, it is even more important not to, even unwittingly, betray that trust. All precautions should be taken so that detainees do not place themselves in danger. Detainees who have been tortured should be asked whether the information can be used, and in what way. They may be too afraid to allow use of their names for example, fearing reprisals. Investigators, both clinicians and interpreters, are bound to respect what has been promised to the individuals.

A clear dilemma may arise if, for example, it is evident that a large number of prisoners have been tortured in a given place, but they all refuse to allow investigators to use their stories because of fear. Faced with the options of either betraying the prisoners' trust in the effort to stop torture, or respecting trust and going away without saying anything, it will be necessary to find a useful way out of the dilemma.

When confronted with a number of prisoners with clear signs of whippings, beatings, lacerations caused by canings, etc. on their bodies, but who all refuse that their cases be even mentioned out of fear of reprisals, it is useful to organize a "health inspection" of the whole ward in full view in the courtyard. In that way, the visiting medical investigator walking through the ranks and directly observing the very visible signs of torture on the backs of the prisoners, can make a report on what he has seen, and not have to say that prisoners complained about torture. This first step ensures the prisoners' trust for future follow-up visits.

Clearly other more subtle forms of torture, psychological or sexual for example, cannot be dealt with in the same way. In such cases, it may be necessary for investigators to refrain from comment for one or several visits until the circumstances allow or encourage detainees to be less afraid and authorize the use of their stories.

The physician (and interpreter) should provide his or her name and explain his or her role in conducting the evaluation. Documentation of medical evidence of torture requires specific knowledge by licensed health practitioners - knowledge of torture and its physical and psychological consequences can gained through various publications, training courses, professional conferences and experience. In addition, knowledge about regional practices of torture and ill treatment is important because such information may corroborate an individual's accounts of torture and/or ill treatment. Experience in interviewing and examining individuals for physical and psychological evidence of torture and documenting findings should

Those still in custody may sometimes be "too trusting" in situations where the interviewer simply cannot guarantee that there will be no reprisals (if a repeat visit has not been negotiated and fully accepted by the authorities, or if the person's identity has not been taken down so as to ensure follow-up, for example). Every precaution should be taken to be sure that prisoners do not place themselves at risk unnecessarily, sometimes naively trusting in the outsider to protect them.

Ideally, when visits are made to people still in custody the interpreters should be "outsiders", and not recruited locally. This is mainly to avoid them, or their families, being put under pressure from inquisitive authorities wanting to know what information was given to the investigators. The issue may be more complex when the detainees are from a different ethnic group than their jailers. Should one take along a local interpreter from the same ethnic group as the prisoners, so as to gain their trust, but at the same time have the authorities mistrust and possibly attempt to intimidate the interpreter. Furthermore the interpreter may be reluctant to work in a hostile environment, potentially placing him or her at risk. Or should one take along an interpreter from the same ethnic group as the captors, thereby gaining their trust, but losing that of the prisoners to be seen, while still leaving the interpreter vulnerable to intimidation by the authorities. The answer is obviously, and ideally, neither of the above. Interpreters should be from outside the region, and thereby seen by all to be as independent as the investigators are.

The person interviewed at 8 PM deserves as much attention as the one seen at 8 AM. Investigators should arrange to have enough time, and not overwork themselves - it is not fair to the 8 PM person (who in addition has been waiting all day to tell his/her story) to cut him/her short because of the time. Similarly, the 19th story about ***falanga*** deserves as much attention as the first. Prisoners who do not often see outsiders may never have had a chance to talk about their torture. It is an erroneous assumption to think that prisoners talk constantly among themselves about torture. Prisoners who have nothing new to offer the investigation deserve time as much as the others do.

E. Techniques of Questioning

See also Section IV.D.2g. Several basic rules must be respected:

1) Information is certainly important, but the person being interviewed is more so;

2) Listening is more important than asking questions. If you only ask questions, all you get is answers;

3) To the detainee, it may be more important to talk about family than to talk about torture. This should be duly considered, and time allowed for some discussion of personal matters; and

4) Torture, particularly sexual torture, is a very intimate subject, and may not come up before a follow-up visit - or even later. Individuals should not be "forced" to talk about any form of torture if they feel uncomfortable about it.

F. Taking the History

1. Psychosocial History, Pre-arrest

If he or she is no longer in custody, the examiner should inquire into the person's daily life, relations with friends and family, work/school, occupation, interests, future plans, and use of alcohol and drugs. Similar information should be elicited regarding the person's post-detention psychosocial history. When the individual is still in custody, a more limited psychosocial history regarding occupation and literacy is sufficient.

Inquire about prescription medications being taken by the patient; this is particularly important because such medications may be denied to the person in custody, with significant adverse health consequences.

Inquiries into political activities and beliefs and opinions are relevant insofar as they help to explain why the person was detained and/or tortured, but such inquiries are best made indirectly by asking the person what accusations were made, or why they think they were detained and tortured.

2. Summary of Detention(s) and Abuse

Before obtaining a detailed account of events, elicit summary information, including dates, places, duration of detention, frequency and duration of torture sessions. A summary will help to make effective use of time. In some cases where survivors have been tortured on multiple occasions, they may be able to recall what happened to them, but often can not recall exactly where and when each event occurred. In such circumstances, it may be advisable to elicit the historical account by methods of abuse rather than as a series of events during specific arrests.

Similarly, in taking a history it may often be useful to have "what happened where" documented as much as possible. "Holding places" are operated by different security/police/armed forces, and what events happened in different places may be useful to get a full picture of the torture system. Obtaining a map of where the torture occurred may be useful in piecing together different histories from different people. This will often prove very useful for the overall investigation.

3. Circumstances of Detention(s)

Consider the following questions: What time was it? Where were you? What were you doing? Who was there? Describe the appearance of those who detained you. Were they military or civilian, in uniforms or in plain clothes? What type of weapons were they carrying? What was said? Any witnesses? Was this a formal arrest, administrative detention, or disappearance? Was violence used, threat spoken? Was there any interaction with family members? Note the use of restraints or blindfold, means of transportation, destination, and names of officials, if known.

4. Prison/Detention Place Conditions

Include access to and descriptions of food and drink, toilet facilities, lighting, temperature, ventilation. Also, document any contact with family, lawyers or health professionals, conditions of overcrowding or solitary confinement, dimensions of the detention place, and whether there are other people who can corroborate his/her detention. Consider the following questions: What happened first? Where were you taken? Was there an identification process (personal information recorded, fingerprints, photographs)? Were you asked to sign anything? Describe the conditions of the cell/room (note size, others present, light, ventilation, temperature, presence of insects, rodents, bedding, and access to food, water and toilet). What did you hear, see and smell? Did you have any contact with people outside, or access to medical care? What was the physical layout of the place where you were detained?

5. Methods of Torture and Ill Treatment

In obtaining historical information on torture and ill treatment, one should be cautious about suggesting forms of abuse that a person may have been subjected to. This may help to separate potential embellishment from valid experiences. However, eliciting negative responses to questions about various forms of torture also may help to establish the credibility of the person.

Questions should be designed to elicit a coherent narrative account. Consider the following questions: Where did the abuse take place, when and for how long? Were you blindfolded? Before discussing forms of abuse, note who was present (give names, positions). Describe the room/place. What objects did you observe? If possible, describe each instrument of torture in detail; for electrical torture, the current, device, and number and shape of electrodes. Ask about clothing/disrobing/change of clothing. Record quotations of what was said during interrogation, insults to one's identity, etc. What was said among the perpetrators?

For each form of abuse note: body position/restraint, nature of contact, including duration, frequency, anatomical location, and the area of the body affected. Was there any bleeding, head trauma, or loss of consciousness? Was the loss of consciousness due to head trauma, asphyxiation, or pain. One should also ask about how the person was at the end of the “session.” Could he or she walk? Did s/he have to be helped back or carried back to the cell? Could he or she get up the next day? How long did the feet stay swollen? All this gives a certain completeness to the description, which a "check list" of methods does not.

The history should include the date(s) of positional torture, how many times and for how many days the torture lasted, the period of each episode, the style of the suspension (reverse-linear, being covered by thick cloth-blanket etc., or being tied directly by a rope, putting weight on the legs or pulling down), or other position, etc. In suspension torture, ask what sort of material was used (rope, wire and cloth leave different marks (if any) on the skin after suspension). The examiner must remember that statements of the length of the torture session by the torture survivor are subjective, and may not be correct, since disorientation of time and place during torture is a generally observed finding.

Was the person sexually assaulted in any manner? Elicit what was said during the torture. For example, during electric shock torture to the genitals perpetrators often tell their torture victims that they will no longer have normal sexual function, or something similar. For a detailed discussion of the assessment of an allegation of sexual torture, including rape, see Section VI.E.8

G. Assessment of the History

Torture survivors may have difficulty recounting the specific details of the torture for several important reasons, including:

1) Factors during torture itself such as blindfolding, drugging, lapses of consciousness, etc.;

2) Fear of placing oneself or others at risk;

3) Lack of trust for the examining clinician and/or interpreter;

4) Psychological impact of torture and trauma such as high emotional arousal, and impaired memory secondary to trauma-related mental illnesses such as depression and posttraumatic stress disorder;

5) Neuropsychiatric memory impairment from beatings to the head, suffocation, near drowning, and starvation;

6) Protective coping mechanisms such as denial and avoidance; and

7) Culturally prescribed sanctions that allow traumatic experiences to be revealed only in highly confidential settings.[72]

Inconsistencies in a person's story may arise from any or all of these factors. If possible, the investigator should ask for further clarification. When this is not possible, the investigator should look for other evidence which supports or refutes the story. A network of consistent supporting details can corroborate and clarify the person's story. Although the individual may not be able to provide the details desired by the investigator such as dates, times, frequencies, exact identities of perpetrators, etc., overall themes of the traumatic events and torture will emerge and stand up over time.

H. Review of Torture Methods

After eliciting a detailed narrative account of events, it is advisable to review other possible torture methods. It is essential to learn about regional practices of torture and modify local guidelines accordingly. Questioning about specific forms of torture is helpful when:

1) Psychological symptoms cloud recollections;

2) The trauma was associated with impaired sensory capabilities;

3) In the case of possible organic brain damage; and

4) When there are mitigating educational and cultural factors.

The distinction between physical and psychological methods is artificial. For example, sexual torture generally causes both physical and psychological symptoms, even when there has not been any physical assault. This list of torture methods provided below is given to show some of the categories of abuse possible. It is not meant to be used by investigators as a “check list”, nor as a model for listing torture methods in a report. A method-listing approach may be counter productive, as the entire clinical picture produced by torture is much more than the simple sum of lesions produced by methods on a list. Indeed, experience has shown that when confronted with such a “package-deal” approach to torture, perpetrators often focus on one of the methods and argue about that particular one being, or not, a form of torture. Torture methods to consider include, but are not limited to:

1) Blunt trauma: punch, kick, slap, whips, wires, truncheons, falling down

[72] Mollica and Caspi-Yavin, Overview: the assessment and diagnosis of torture events and symptoms, in Ba_o_lu M (editor),

2) Positional torture: Suspension, Stretching limbs apart, prolonged constraint of movement, forced positioning
3) Burns: cigarettes, heated instrument, scalding liquid, caustic substance
4) Electric shock
5) Asphyxiation: wet and dry methods, drowning, smothering, choking, chemicals
6) Crush injuries: smashing fingers, heavy roller to thighs/back
7) Penetrating injuries: stab and gunshot wounds, wires under nails
8) Chemical exposures: salt, chili, gasoline, etc. (in wounds, body cavities)
9) Sexual: violence to genitals, molestation, instrumentation, rape
10) Crush injury or traumatic removal of digits and limbs
11) Medical: amputation of digits or limbs, surgical removal of organs
12) Pharmacologic torture: toxic doses of sedatives, neuroleptics, paralytics, etc.
13) Conditions of detention, e.g.:
    - Small or overcrowded cell
    - Solitary confinement
    - Unhygienic conditions
    - No access to toilet facilities
    - Irregular and/or contaminated food and water
    - Exposure to extremes of temperature
    - Denial of privacy
    - Forced nakedness
14) Deprivations:
    - Of normal sensory stimulation, such as sound, light, sense of time via hooding, isolation, manipulating brightness of the cell
    - Of physiological needs: restriction of sleep, food, water, toilet facilities, bathing, motor activities, medical care
    - Of social contacts: isolation within prison, loss of contact with outside world - victims often are kept in isolation in order to prevent bonding and mutual identification and to encourage traumatic bonding with the torturer
15) Humiliations: verbal abuse, performance of humiliating acts
16) Threats: of death, harm to family, further torture and/or imprisonment, mock executions
17) Threats to or arranging conditions for attacks by animals such as dogs, cats, rats, and scorpions
18) Psychological techniques to break down the individual: forced “betrayals,” learned helplessness exposure to ambiguous situations and/or contradictory messages, etc.
19) Violation of taboos
20) Behavioral coercion
    - Forced to engage in practices against one’s religion (e.g. forcing Muslims to eat pork)
    - Forced to harm others: e.g. the torture of others, or other abuses
    - Forced to destroy property
    - Forced to betray someone placing them at risk for harm
21) Forced to witness torture or atrocities being inflicted on others

I. Risk of Retraumatisation of the Interviewee

See also Section VII.B.2a. Taking into consideration that lesions of different types and levels may occur according to the methods of torture practiced, the data acquired subsequent to a comprehensive medical history and physical examination should be assessed together with appropriate laboratory and radiologic examinations. Providing information and making explanations for each process to be applied during the medical examination and ensuring detailed awareness about the laboratory methods play a significant role.

The presence of psychological sequelae in torture survivors, particularly the various manifestations of posttraumatic stress disorder, may cause the torture survivor to fear experiencing a re-enactment of his or her torture experience during the interview, physical examination or laboratory studies. Explaining to the torture survivor as to what he or she should expect prior to the medical examination is an important component of the process.

Those who survive torture and remain in their country may experience intense fear and suspicion about being re-arrested, and they are often forced to go "underground" to avoid being arrested again. Those who are exiled, or are refugees, may leave behind their native language, culture, families, friends, work, and everything that is familiar to them.

The torture survivor's personal reactions to the interviewer (and the interpreter, in cases where one is utilized) can have an effect on the interview process and, in turn, the outcome of the investigation. Likewise, the personal reactions of the investigator toward the person can also affect the process of the interview and outcome of the investigation. It is important to examine the barriers to effective communication and understanding which these personal reactions might impose on the investigation. The investigator should maintain an ongoing examination of the process of the interviews and investigation through consultation and discussion with colleagues familiar with the field of psychological assessment and treatment of torture survivors. This type of peer supervision can be an effective means of monitoring the interview and investigation process for biases and barriers to effective communication and obtaining accurate information. See also Section VII.C.2.

Despite all precautions, physical and psychological examinations by their very nature, may re-traumatize the patient by provoking and/or exacerbating symptoms of posttraumatic stress by eliciting painful affect and memories (see Section VII.B.2a). Questions about psychological distress and, especially, about sexual matters are in most traditional societies considered taboo, and the asking of such questions is regarded as irreverent or insulting. If sexual torture was part of the violations incurred the claimant may feel irredeemably stigmatized and tainted in his or her moral, religious, social, and psychological integrity. The expression of one's respectful awareness of these conditions, as well as the clarification of confidentiality and its limits are, therefore, of paramount importance for a well-conducted interview. A subjective assessment has to be made by the evaluator about the extent to which pressing for details is necessary for the effectiveness of the report in court, especially if the claimant demonstrates obvious signs of distress in the interview.

J. Use of Interpreters

For many purposes, it is necessary to use an interpreter to allow the interviewer to understand what is being said. Although the interviewer and the interviewee may share a little of a common language, the information being sought is often too important to risk the errors that come from incomplete understanding of each other. Interpreters must be advised that what they hear and interpret in interviews is strictly confidential. It is the interpreters who get all the information, first hand and uncensored. Individuals must be given assurances that neither the investigator nor the interpreter will misuse his or her information in any way. See also Section VII.C.2.

When the interpreter is not a professional one, there is always the risk of the investigator “losing control” of the interview. Individuals may get “carried away” talking to the person who speaks their language, and the interview may divert from the issues at hand. There is also a risk that an interpreter with a bias might lead the interviewee, or distort the replies. Loss of information, sometimes relevant, sometimes not, is inevitable when working through interpretation. In extreme cases, it may even be necessary for investigators to refrain from taking notes during interviews, and carry out interviews in several short sessions, so as to have time to write down in between the main points of what has been said.

Investigators should remember to talk “to” the person, and to keep eye contact with him or her, even if he or she has a natural tendency to speak to the interpreter. It helps to use the first person through the interpreter, for example “what did you do next”, rather than the third person “ask him what happened next”. All too often, investigators fill out their notes during the time when either the interpreter is translating the question, or the subject is answering it. Some investigators don’t appear to be listening, as the interview is going on in a language they don’t understand. This should not be the case, as it is essential that investigators observe not just the words, but the body language, facial expressions, tone of voice and gestures of the interviewee, if they are to get a full picture.

Investigators should familiarize themselves with torture-related words in the person’s language so as to show that they know about the issue. Reacting, rather than showing a blank face, when hearing a torture-related word such as “submarino” or “darmashakra” will add to the investigator’s credibility.

When visiting prisoners, it is best never to use local interpreters, if there may be a possibility of their being considered untrustworthy by those interviewed. It may also be unfair to the local interpreters, who may be “debriefed” by the local authorities after a visit, or otherwise put under pressure, to involve them with, for example, political prisoners. It is best to use independent interpreters, clearly seen as coming from “elsewhere.” The next best thing to speaking the local language fluently is to work with a trained and clever interpreter, who is sensitive to the issue of torture and to the local culture. As a rule, co-detainees should not be used for interpretation, unless it is obvious that the person has chosen someone he or she trusts. In the case of people who are not in detention, many such rules will also apply, but it may be easier to bring

K. Gender Issues

Ideally an investigation team should contain specialists of both genders, permitting the person who says that they have been tortured to choose the gender of the investigator and, where necessary, the interpreter. This is particularly important when a woman has been detained in a situation where rape is known to happen, even if she has not, so far, complained of it. Even if no sexual assault has taken place, most torture has sexual aspects (see Section VI.E.8). It will often add to the retraumatisation if she feels she has to describe what happened to a person who is physically similar to her torturers, who will inevitably have been mostly or entirely men. In some cultures, it would be impossible for a male investigator to question a female victim, and this must be respected. However, in most cultures, if there is only a male physician available, many women would prefer to talk to him rather than a female of another profession in order to gain the medical information and advice that she wants. In such a case it is essential that the interpreter, if used, is female. Some interviewees may also prefer that the interpreter are from outside their immediate locality, both because of the issues of being reminded of their torture, and because of a perceived threat to their confidentiality (see Section V.J). If no interpreter is necessary, then a female member of the investigating team should be present as a chaperone throughout at least during the physical examination and, if the patient wishes, throughout the entire interview.

When the victim is male and has been sexually abused, the situation is more complex because he too will have been sexually abused mostly or entirely by men. Some men would therefore prefer to describe their experiences to women because their fear of other men is so great, while others would not want to discuss such personal matters in front of a woman.

L. Indications for Referral

Where possible, examinations to document torture for medical-legal reasons should be combined with assessment for other needs, whether referral to specialist physicians and psychologists, physiotherapists, or those who can offer social advice and support. Investigators should be aware of local rehabilitation and support services. The clinician should not hesitate to insist on any consultation and examination that he/she considers necessary in a medical evaluation.

In the course of documenting medical evidence of torture and ill treatment, physicians are not absolved of their ethical obligations. Those who appear to be in need of further medical or psychological care should be referred to appropriate services.

M. Interpretation of Findings and Conclusions

Physical manifestations of torture may vary according to the intensity, frequency, and duration of abuse, the torture survivor's ability to protect him or herself, and the physical condition of the detainee prior to the torture. Other forms of torture may not produce physical findings, but may be associated with other conditions. For example, beatings to the head that resulted in loss of consciousness can cause post-traumatic epilepsy and/or organic brain dysfunction. Also, poor diet and hygiene in detention can cause vitamin deficiency syndromes.

Certain forms of torture are strongly associated with particular sequelae. For example, beatings to the head that result in loss of consciousness are particularly important to the clinical diagnosis of organic brain dysfunction. Trauma to the genitals is often associated with subsequent sexual dysfunction.

It is important to realize that torturers may attempt to conceal their acts. To avoid physical evidence of beating, torture is often performed with wide, blunt objects, and torture victims are sometimes covered by a rug, or shoes in the case of ***falanga***, to distribute the force of individual blows. Stretching, crushing injuries and asphyxiation are also form of torture which have the intent of producing maximal pain and suffering with minimal evidence. For the same reason, wet towels may be used with electric shocks.

The report must list the qualifications and experience of the investigator. Where possible the name of the witness/patient should be given. If this will put the person at significant risk, an identifier can be used that allows the investigating team to relate the person to the record, but that will not allow anyone else to identify the individual. It must indicate who else was in the room at the time of the interview, or any part of it. It should detail the relevant history, avoiding "hearsay," and, where appropriate, the findings. It must be signed and dated, and include any necessary declaration required by the jurisdiction for which it is written. See also Appendix IV.

VI. PHYSICAL EVIDENCE OF TORTURE

A Introduction

Witness and survivor testimony are necessary components in the documentation of torture. To the extent that physical evidence of torture exists, it provides important confirmatory evidence that a person was tortured. However, the absence of such physical evidence should not be construed to suggest that torture did not occur, since such acts of violence against persons frequently leave no marks or permanent scars.

Medical evaluations of patients for legal purposes should be conducted with objectivity and impartiality. The evaluations should be based on the physician's clinical expertise and professional experience. The ethical obligation of beneficence demands uncompromising accuracy and impartiality in order to establish and maintain professional credibility. When possible, clinicians who conduct evaluations of detainees should have specific essential training in forensic documentation of torture and other forms of physical and psychological abuse. They should have knowledge of prison conditions and torture methods used in the particular region where the patient was imprisoned, and the common after-effects of torture. The medical report should be factual and carefully worded. Jargon should be avoided. All medical terminology should be defined so that it is understandable to lay persons.

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

B. Interview structure

These comments apply particularly to interviews conducted with persons no longer in custody. The location of the interview and examination should be as safe and comfortable as possible. Sufficient time should be allotted to conduct a detailed interview and examination. A two to four hour interview may not be sufficient enough time to conduct an evaluation for either physical or psychological evidence of torture. Furthermore, at any given time that an evaluation is conducted, situation-specific variables such as the dynamics of the interview, feelings of powerlessness in the face of having one's intimacy intruded upon, fear of future persecution, shame about the events, and survivor guilt may simulate circumstances of a torture experience. This may enhance the patient's anxiety and increase his or her resistance to disclosure of relevant information. A second, and possibly a third interview, may need to be scheduled to complete the evaluation.

Trust is an essential component of eliciting an accurate account of abuse. Earning the trust of one who has experienced torture and other forms of abuse requires active listening, meticulous communication, courteousness and genuine empathy and honesty. Physicians must have the capacity to create a climate of trust in which disclosure of crucial, though perhaps very painful or shameful, facts can occur. Important here is the awareness that those facts are sometimes intimate secrets that the person may reveal at that moment for the first time. In addition to providing a comfortable setting, adequate time for the interviews, refreshments and access to toilet facilities, the clinicians should explain what the patient can expect in the evaluation; the clinician should be mindful of the tone, phrasing and sequencing (sensitive questions should be asked only after some degree of rapport has developed) of questions; and the clinician should acknowledge the patient's ability to take a break if needed or to choose not to respond to any question he or she may not wish to.

Confidentiality: (See also Section III.C.3) Physicians (and interpreters) have a duty to maintain confidentiality of information and to disclose information only with the patient's consent. Each person should be examined individually, with privacy. He or she should be informed of any limits on the confidentiality of the evaluation that may be imposed by State or judicial authorities. The purpose of the interview needs to be made clear to the person. Physicians must ensure that informed consent is based on adequate disclosure and understanding of the potential benefits and adverse consequences of a medical evaluation, and that consent is given voluntarily without coercion by others, particularly law enforcement or judicial authorities. The person has the right to refuse the evaluation. In such circumstances, the clinician should document the reason(s) for refusal of an evaluation. Furthermore, if the person is a detainee, the report should be signed by his/her lawyer and another health official.

Patients may fear that information that is revealed in the context of an evaluation cannot be safely kept

where physicians or other health workers were participants in the torture. In many circumstances the evaluator will be a member of the majority culture and ethnicity, whereas the patient, in the situation and location of the interview, is likely to belong to a minority group or culture. This dynamic of inequality may reinforce the perceived (and real) imbalance of power, and may increase the potential sense of fear, mistrust, and of forced submission in the patient.

Empathy and human contact may be the most important thing that people still in custody receive from the investigator. The investigation itself may contribute nothing of specific benefit to the person being interviewed, as in most cases their torture will be over. The meager consolation of knowing that the information may serve a future purpose will however be greatly enhanced if the investigator shows appropriate empathy. While this may seem self-evident, all too often, investigators in actual prison visits are so concerned about obtaining information that they fail to empathize with the prisoner being interviewed.

C. Medical History

Obtain a complete medical history, including prior medical, surgical or psychiatric problems. Be sure to document any history of injuries before the period of detention and any possible after-effects. Avoid leading questions. Structure inquiries to elicit an open-ended, chronological account of the events experienced during detention.

Specific historical information may be useful in correlating regional practices of torture with individual allegations of abuse. Examples of useful information include: descriptions of torture devices, body positions and methods of restraint, descriptions of acute and chronic wounds and disabilities, and identifying information about perpetrators and the place(s) of detention. While it is essential to obtain accurate information regarding a torture survivor's experiences, open ended interviewing methods require that a patient disclose these experiences in their own words using free recall. An individual who has survived torture may have trouble expressing in words his or her experiences and symptoms. In some cases it may be helpful to use trauma event and symptom checklists or questionnaires. If the interviewer believes it may be helpful to utilize trauma event and symptom checklists, there are numerous questionnaires available; however, none are specific to torture victims.

Narration of symptoms and disabilities following torture, by the individual alleging torture: all complaints of the torture survivor are of significance although there may or may not be correlation with the physical findings, and they should be reported. Acute and chronic symptoms and disabilities associated with specific forms of abuse and the subsequent healing processes should be documented.

1. Acute Symptoms

The individual should be asked to describe any injuries that may have resulted from the specific methods of alleged abuse. For example, bleeding, bruising, swelling, open wounds, lacerations, fractures, dislocations, joint stress, hemoptysis, pneumothorax, tympanic membrane perforation, genitourinary system injuries, burns, (color, bulla, necrosis according to the degree of burn) electrical injuries (size and number of lesions, their color and surface characteristics), chemical injuries (color, signs of necrosis), pain, numbness, constipation, vomiting, etc. The intensity, frequency and duration of each symptom should be noted. The development of any subsequent skin lesions should be described and whether or not they left scars. Acute symptoms: ask about health on release; was he/she able to walk, confined to bed? If confined, for how long? How long did wounds take to heal? Were they infected? What treatment was received? Was it a doctor or a traditional healer? Note the detainee's ability to make such observations may have been compromised by the torture itself or its after-effects and should be documented.

2. Chronic Symptoms

Elicit information of physical ailments that the individual believes were associated with torture or ill treatment. Note the severity, frequency and duration of each symptom and any associated disability or need for medical and/or psychological care. Even if the after-effects of acute lesions may not be observed months or years later, some physical findings may still remain, such as electrical current or thermal burn scars, skeletal deformities/malunion of fractures, dental injuries, loss of hair, and myofibrosis. Common somatic complaints include headache, back pain, gastrointestinal symptoms, sexual dysfunction, muscle pain, and common psychological symptoms include depressive affect, anxiety, insomnia, nightmares, flashbacks and memory difficulties (see Section IV.B.2).

3. Summary of Interview

Torture victims may display injuries that are substantially different from other forms of trauma. Although acute lesions may be characteristic of the alleged injuries, most lesions heal within about six weeks of torture leaving no scars or non-specific scars. This is often the case when torturers use techniques that prevent or limit detectable signs of injury. Under such circumstances, the physical examinations may be "within normal limits," but this in no way negates allegations of torture. A detailed account of the patient's observations of acute lesions and the subsequent healing process often represents an important source of evidence in corroborating specific allegations of torture or ill treatment.

D. Physical Examination

Subsequent to the acquisition of historical information and after the patient's informed consent has been obtained, a complete physical examination by a qualified physician should be performed. Where possible the patient should be able to choose the gender of the doctor and, where used, interpreter. If the doctor is not the same gender as the patient, a chaperone who is the same gender as the patient should be used unless the patient objects. The patient must understand that he or she is in control, and has the right to limit the examination, or to stop at any time. See also Section V.K.

In this section, there are many references to specialist referral and further investigations. Unless the patient is in detention, it is important that physicians have, wherever possible, access to physical and psychological treatment facilities, so any identified need can be followed up. In many situations, certain diagnostic test techniques will not be available, and their absence must not invalidate the report. See Appendix II for further details of possible diagnostic tests.

In cases with allegation of recent torture, and the clothes worn during the perpetration of torture are still being worn the torture survivor, they should be taken for examination without washing, and a fresh set of clothes provided.

Where possible, the examination room should be equipped with sufficient illumination and medical equipment necessary for the examination, and any deficiencies should be noted in the report.

The examiner should note all pertinent positive and negative findings, using body diagrams to record the location and nature of all injuries (see Appendix III). Some forms of torture such as electrical shock and/or blunt trauma may initially not have detectable findings, which may be manifested and detected on subsequent/follow-up examination findings. Although it will rarely be possible to photographically record lesions of those in custody of their torturers, such photography should otherwise be a routine part of examinations. If a camera is available, it is always better to take poor quality photographs that to have none. They should be followed up with professional photographs as soon as possible. See also Section IV.D.5.

1. Skin

The examination should include the entire body surface to detect signs of:

1) Generalized skin disease including signs of vitamin A, B and C deficiencies

2) Pre-torture lesions

3) Lesions inflicted by torture, such as abrasions, contusions, lacerations, puncture wounds, burns from cigarettes or heated instruments, electrical injuries, alopecia and nail removal

Torture lesions should be described by their localization, symmetry, shape, size, color and surface (e.g. scaly, crusty, ulcerating) as well as their demarcation and level in relation to the surrounding skin. Photography is essential whenever this is possible. Ultimately, the examiner must offer an opinion as to the origin of the lesions as being inflicted, self-inflicted,[73],[74] accidental or the result of a disease process.

2. The Face

[73] Rasmussen OV, Medical Aspects of Torture, ***Danish Medical Bulletin*** 1990, 37 Supplement 1, 1-88.
[74] Bunting R, Clinical Examinations in the Police Context, in McLay WDS (editor), Clinical Forensic Medicine, London,

Facial tissues should be palpated for evidence of fracture, crepitation, swelling or pain. The motor and sensory components including smell and taste of all cranial nerves should be examined. Computerized tomography (CT) rather than routine radiography is the best modality to diagnose and characterize facial fractures, determine alignment, and diagnose associated soft tissue injuries and complications. Intracranial and cervical spinal injuries are often associated with facial trauma.

2a) Eyes

There are many forms of trauma to the eyes, including conjunctival hemorrhage, lens dislocation, subhyeloid hemorrhage, retrobulbar hemorrhage, retinal hemorrhage, and visual field loss. Given the serious consequences of lack of treatment or improper treatment, ophthalmologic consultation should be obtained whenever there is a suspicion of ocular trauma or disease.

CT is the best modality to diagnose orbital fractures and soft tissue injuries to the bulbar and retrobulbar contents. Nuclear magnetic resonance imaging (MRI) may be an adjunct for soft tissue injury. High resolution ultrasound is an alternative method for evaluation of trauma to the eye globe.

2b) Ears

Trauma to the ears, and especially rupture of the tympanic membrane, is a frequent consequence of harsh beatings. The ear canals and tympanic membranes should be examined with an otoscope, and injuries described. A common form of torture, known in Latin America as "telefono" is a hard slap of the palm to one or both ears, rapidly increasing pressure in the ear canal, thus rupturing the drum. Prompt examination is necessary to detect tympanic membrane ruptures less than 2 mm in diameter, which may heal within 10 days. Fluid may be observed in the middle and/or external ear. If otorrhea is confirmed by laboratory analysis, MRI or CT should be preformed to determine the fracture site.

The presence of hearing loss should be investigated using simple screening methods. If necessary, audiometric tests should be conducted by a qualified audiometry technician. The radiographic examination of fractures of the temporal bone or disruption of the ossicular chain is best determined by CT, then hypocycloidal tomography, and lastly linear tomography.

2c) The nose

The nose should be evaluated for alignment, crepitation, and deviation of the nasal septum. For simple nasal fractures, standard nasal radiographs should be sufficient. For complex nasal fractures and when the cartilaginous septum is displaced, CT should be performed. If rhinorrhea is present, CT and/or MRI are recommended.

2d) Jaw, oropharynx, and neck

Mandibular fractures and/or dislocations may result from beatings. Temporomandibular joint syndrome is a frequent consequence of beatings about the lower face and jaw. The patient should be examined for evidence of crepitation of the hyoid bone or laryngeal cartilages resulting from blows to the neck. Findings concerning the oropharynx should be noted in detail, including lesions consistent with burns from electrical shock or other trauma. Gingival hemorrhage and the condition of the gums should also be noted

2e) Oral cavity and teeth

Examination by a dentist should be considered a component of periodic health examination in detention. This examination is often neglected, but is an important component of the physical examination. Dental care may be purposefully withheld to allow caries, gingivitis, or tooth abscesses to worsen. A careful dental history should be taken, and if dental records exist, these should be requested. Tooth avulsions, fractures of the teeth, dislocated fillings and broken prostheses may result from direct trauma or electric shock torture. Dental caries and gingivitis should be noted. Poor quality dentition may be due to conditions in detention, or may have preceded the detention. The oral cavity must be carefully examined. During electric current application, the tongue, gingiva or lips may be bitten. Lesions might be produced by forcing objects or materials into the mouth, as well as by applying electric current. X-rays and MRI are suggested for determining the extent of soft tissue, mandibular and dental trauma.

3. Chest and Abdomen

Examination of the trunk, in addition to noting lesions of the skin, should be directed toward detecting regions of pain, tenderness or discomfort that would reflect underlying injuries of the musculature, ribs or abdominal organs. The examiner must consider the possibility of intramuscular, retroperitoneal and intra-abdominal hematomas, as well as laceration or rupture of an internal organ. Ultrasonography, CT scans and bone scintigraphy should be used, when realistically available, to confirm such injuries. Routine examination of the cardiovascular system, lungs and abdomen should be performed in the usual manner. Pre-existing respiratory disorders are likely to be aggravated in custody, and new respiratory disorders commonly develop.

4. Musculoskeletal System

Complaints of musculoskeletal aches and pains are very common in survivors of torture.[75] They may be the result of repeated beatings, suspension, or other positional torture,[76] or of the general physical environment of the detention. They also may be somatic (see Section VII.B.2g). They are non-specific, but should be documented. They often respond well to sympathetic physiotherapy.[77]

Physical examination of the skeleton should include testing for mobility of joints, the spine and the extremities. Pain with motion, contractures, strength, evidence of compartment syndrome, fractures with or without deformity, and dislocations should all be noted. Suspected dislocations, fractures and osteomyelitis should be evaluated with radiographs. For suspected osteomyelitis, routine radiographs followed by three-phase bone scintigraphy should be performed. Injuries to tendons, ligaments, and muscles are best evaluated with MRI but arthrography can also be performed. In the acute stage, MRI can detect hemorrhage and possible muscle tears. Muscles usually completely heal without scarring; thus, later imaging studies will be negative. On MRI and CT, denervated muscles and chronic compartment syndrome will be imaged as muscle fibrosis. Bone bruises can be detected by MRI or scintigraphy. Bone bruises usually heal without trace findings.

5. Genitourinary system

Genital examination should only be performed with the additional consent of the patient, and if necessary, should be postponed to a later examination. A chaperone must be present if the examining physician gender is different from that of the patient. For more information see Section V.K. See Section VI.E.8 for further information regarding examination of victims of sexual assault. Ultrasonography and dynamic scintigraphy can be used for detecting genitourinary trauma.

6. Central/Peripheral Nervous System

The neurologic examination should evaluate the cranial nerves, sensory organs and peripheral nervous system, checking for both motor and sensory neuropathies related to possible trauma, vitamin deficiencies, or other disease. Cognitive ability and mental status also must be evaluated. See also Section VII.C. In patients who report being suspended, special emphasis on examination for brachial plexopathy (asymmetrical hand strength, wrist drop, arm weakness with variable sensory and tendon reflexes) is necessary. Radiculopathies, other neuropathies, cranial nerve deficits, hyperalgesia, parasthesias, hyperaesthesia, change in position and temperature sensation, motor function, gait and coordination may all result from trauma associated with torture. In patients with a history of dizziness and vomiting, vestibular examination should be conducted, and evidence of nystagmus noted.

Radiologic evaluation should include MRI or CT. MRI is preferred over CT for radiologic evaluation of the brain and/or posterior fossa.

E. Examinations and Evaluations Following Specific Forms of Torture

The following discussion is not meant to be an exhaustive discussion of all forms of torture, but is intended to describe in more detail the medical aspects of many of the more common forms of torture. For each lesion where possible, and for the overall pattern of lesions, the physician should indicate the degree of consistency between it and the attribution given by the patient. The following terms are generally used:

Not consistent: The lesion could not have been caused by the trauma described

[75] Rasmussen OV, Medical Aspects of Torture, ***Danish Medical Bulletin*** 1990, 37 Supplement 1, 1-88.
[76] Forrest D, Examination for the late physical after effects of torture, ***Journal of Clinical Forensic Medicine*** 1999, 6, 4-13.

Consistent with:	The lesion could have been caused by the trauma described, but it is non-specific and there are many other possible causes
Highly consistent:	The lesion could have been caused by the trauma described, and there are few other possible causes
Typical of:	This is an appearance that is usually found with this type of trauma, but there are other possible causes
Diagnostic of:	This appearance could not have been caused in any way other than that described

Ultimately, it is the overall evaluation of all lesions and not the consistency of each lesion with a particular form of torture that is important in assessing the torture story.

See Section V.H for a list of different torture methods.

1. Beatings and Other Forms of Blunt Trauma

1a) Skin damage

Acute lesions are often characteristic since they show a pattern of inflicted injury that differs from non-inflicted injuries, e.g. by their shape, repetitiveness, distribution on the body. Since, however most lesions heal within about six weeks of torture, leaving no scars or non-specific scars, a characteristic history of the acute lesions and their development until healing might be the only basis for a support of the allegation of torture.

Permanent changes in the skin due to blunt trauma are infrequent, non-specific, and usually without diagnostic significance.

A sequel of blunt violence which is diagnostic of prolonged application of tight ligatures is a linear zone extending circularly around the arm or leg, usually at the wrist or ankle. The zone contains few hairs or hair follicles, probably a form of cicatricial alopecia. No differential diagnosis in the form of a spontaneous skin disease exists, and it is difficult to imagine any trauma of this nature occurring in everyday life.

Among acute lesions, abrasions, which are superficial scraping lesions of the skin, may appear as scratches, brush-burn type lesions, or larger scraping lesions. At times, abrasions may show a pattern that reflects the contours of the instrument or surface that inflicted the injury. Repeated or deep abrasions may lead to areas of hypo- or hyperpigmentation depending on skin type, for example inside the wrists if the hands have been tied together tightly.

Contusions or bruises are areas of hemorrhage into soft tissue due to rupture of blood vessels from blunt trauma. The extent and severity of a contusion depend not only upon the amount of force applied, but also the structure and vascularity of the tissue contused. Contusions are more readily incurred in areas with thin skin overlying bone and in fatty areas. Many medical conditions, including vitamin and other nutritional deficiencies, may be associated with easy bruisability or purpura.

Contusions, as do abrasions, indicate that blunt force has been applied to a particular area. Absence of a bruise just as an absence of an abrasion however, does not indicate that there was no blunt force to that area. Contusions may also be patterned, reflecting the contours of the inflicting instrument. For instance, rail-shaped bruising may occur when an instrument such as a truncheon or cane has been used. Therefore, the shape of the object may be inferred by considering the shapes of the bruise.

As contusions resolve they undergo a series of color changes. Most bruises initially appear dark blue, purple, or crimson. As the hemoglobin in the bruise breaks down the color gradually changes to violet, green, dark yellow, and pale yellow and finally disappears. It is very difficult, however, to accurately date the age of contusions. In some skin types this can lead to a hyperpigmentation that can last several years.

Contusions that develop in the deeper subcutaneous tissues may not be observed for several days after injury, when the extravasated blood has reached the surface. Therefore, in cases when there is an allegation but no sign of a contusion, re-examination after several days should be performed. It should be

taken into consideration that the final position and shape of such bruises bear no relation to the original trauma, and that some lesions may have faded by the time of re-examination.[78]

Lacerations, a tearing or crushing of the skin and underlying soft tissues by the pressure of blunt force, develop easily on the protruding parts of the body since the skin is compressed between the blunt object and the bone surface under the subdermal tissues. However, with sufficient force the skin can be torn on any portion of the body. Asymmetrical scars, those in unusual locations, and a diffuse spread of scarring all suggest a deliberate cause.[79]

The scars seen as the result of whipping represent such healed lacerations. The scars are depigmented and often hypertrophic, surrounded by narrow, hyperpigmented stripes. The only differential diagnosis is plant dermatitis, but this is dominated by hyperpigmentation and shorter scars.

By contrast, symmetrical, atrophic, depigmented linear changes of the abdomen, axillae, and legs, which are sometimes claimed to be torture sequelae, represent striae distensae and are not normally related to torture.[80]

Burning is the form of torture that most frequently leaves permanent changes in the skin. Sometimes, they may be of diagnostic value.

Cigarette burns often leave 5-10 mm large, circular or ovoid, macular scars with a hyper- or a hypopigmented centre and a hyperpigmented, relatively indistinct periphery. The burning away of tattoos with cigarettes has also been reported in relation to torture. The characteristic shape of the resulting scar and any tattoo remnants will help in the diagnosis.[81]

Burning via the application of hot objects produces markedly atrophic scars reflecting the shape of the instruments. They are sharply demarcated with narrow hypertrophic or hyperpigmented marginal zones corresponding to an initial zone of inflammation. This may for instance be seen after burning with an electrically heated metal rod or a gas lighter. It is difficult to imagine any differential diagnosis if many scars result. Spontaneously occurring inflammatory processes would lack the characteristic marginal zone and only rarely exhibit such a pronounced loss of tissue. Burning may also result in hypertrophic or keloid scars as is reported following burning with alighted rubber.

When the nail matrix is burnt, subsequent growth produces striped, thin, deformed nails, sometimes broken up in longitudinal segments. If the nail is also pulled off, an overgrowth of tissue may occur from the proximal nail fold, resulting in the formation of pterygium. Changes in the nail caused by lichen planus constitute the only relevant differential diagnosis, but they will usually be accompanied by a widespread skin affection. Fungus infections, on the other hand, are characterized by thickened, yellowish, crumbling nails, different from the above changes.

Sharp trauma wounds are produced when then skin is cut with a sharp object such as a knife, bayonet, or broken glass. Such wounds include stab wounds, incised or cutting wounds and puncture wounds. The acute appearance is usually easy to distinguish from the irregular and torn appearance of lacerations, and scars found on later examinations that may be distinctive. Regular patterns of small incisional scars could be due to traditional healers.[82] If pepper or other noxious substances are applied to the open wounds, the scars may become hypertrophic. An asymmetric pattern and different sizes of scars are probably significant in the diagnosis of torture changes

1b) Fractures

Fractures produce a loss of bone integrity due to the effect of a blunt mechanical forces on various vector planes. A direct fracture occurs at the site of impact or (at the site where the force was applied). An indirect fracture. The location, contours and other characteristics of a fracture reflect the nature and direction of the applied force. It is thus sometimes possible to distinguish inflicted from accidental injury by the appearance of the fracture radiographically. Radiographic aging of relatively recent fractures should be done by an experienced trauma radiologist.

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[78] Gürpinar S, Korur Fincanci S, Insan Haklari Ihlalleri ve Hekim Sorumlulugu (Human Rights Violations and Responsibility of the Physician). In Birinci Basamak Için Adli Tip El Kitabi (Handbook of Forensic Medicine for General Practitioners). Turkish Medical Association, Ankara. 1999.
[79] Rasmussen OV, Medical Aspects of Torture, ***Danish Medical Bulletin*** 1990, 37 Supplement 1, 1-88.
[80] Danielsen L, Skin Changes after Torture, ***Torture*** 1992, Supplement 1, 27-28.
[81] Danielsen L, Skin Changes after Torture, ***Torture*** 1992, Supplement 1, 27-28.

Speculative judgments should be avoided in the evaluations of the nature and age of blunt traumatic lesions since a lesion may vary according to the age, sex, tissue characteristics, the condition and health of the patient, and the severity of the trauma. For example, well conditioned, muscularly fit, younger individuals are more resistant to bruising than frail, older individuals.

1c) Head trauma

Head trauma is among the most common forms of torture. With recurring head trauma, even if not always of serious dimensions, cortical atrophy, and diffuse axonal damage may be expected. In cases of trauma caused by falls, countrecoup lesions (having location in opposition to the trauma) of the brain may be observed; whereas, in cases of direct trauma, contusions of the brain may be observed directly under the region in which the trauma is inflicted. Scalp bruises are frequently not visible externally unless there is swelling. Bruises also may be difficult to see in dark skinned individuals, but will be tender to palpation.

Having been exposed to blows to the head, the torture survivor may complain of continuous headaches. These are often somatic, or may be referred from the neck (see Section VI.D.4). He or she may claim that they suffer pain when touched in that region, and diffuse or local fullness or increased firmness may be observed by means of palpation of the scalp. Scars can be observed in cases where there were lacerations of the scalp. Headache may also be the initial symptom of an expanding subdural hematoma. There may be associated acute onset mental status changes, and a CT scan must be performed urgently. Soft tissue swelling and/or hemorrhage will usually be detected with CT or MRI. It may also be appropriate to arrange psychological or neuropsychological assessment (see Section VII.C.4).

Violent shaking as a form of torture may produce cerebral injury without leaving any external marks, although bruises may be present on the upper chest or shoulders where the victim or his clothing have been grabbed. At its most extreme, shaking has produced injuries identical to those seen in shaken baby syndrome - cerebral edema, subdural hematoma and retinal hemorrhages. More commonly, victims complain of recurrent headaches, disorientation, and mental status changes. Shaking episodes are usually brief - only a few minutes or less - but may be repeated many times over a periods of days to weeks.

1d) Chest and abdominal trauma

Rib fractures are a frequent consequence of beatings to the chest. If displaced, they may be associated with lacerations of the lung and possible pneumothorax. Fractures of the vertebral pedicles may result from direct blunt force.

In case of acute abdominal trauma, the physical examination should seek evidence of abdominal organ and urinary tract injury. However, the examination is often negative. Gross hematuria is the most significant indication of kidney contusion. Peritoneal lavage may detect occult abdominal hemorrhage. Free abdominal fluid detected on CT after peritoneal lavage may be from the lavage or hemorrhage; thus invalidating the finding. On CT, acute abdominal hemorrhage is usually isointense or water density unlike acute CNS hemorrhage, which is hyperintense. Organ injury may present as free air, extraluminal fluid, and areas of low attenuation, which may represent edema, contusion, hemorrhage or a laceration. Peripancreatic edema is one of the signs of acute traumatic and nontraumatic pancreatitis. Ultrasound is particularly useful in detecting subcapsular hematomas of the spleen. Renal failure due to crush syndrome may be seen acutely with severe beatings. Renal hypertension can be a late complication of renal injury.

2. Beatings of the Feet (***Falanga, Falaka, Basinado***)

Falanga is the most common term for repeated application of blunt trauma to the feet (or rarely the hands or hips), usually applied with a truncheon, length of pipe, or similar weapon. The most severe complication of ***falanga*** is closed compartment syndrome, which can cause muscle necrosis, vascular obstruction and gangrene of the distal portion of the foot or of the toes. Permanent deformities of the feet are uncommon but do occur, as do fractures of the carpals, metacarpals and phalanges. Because the injuries are usually confined to soft tissue, CT scan and MRI are the preferred methods for radiologic documentation of injury, but it must be emphasized that physical examination in the acute phase should be diagnostic.

Falanga may produce chronic disability. Walking may be painful and difficult. The tarsal bones may be fixed (spastic) or have increased motion. Squeezing the plantar (sole) of the foot and dorsiflexion of the great toe may produce pain. On palpation, the entire length of the plantar aponeurosis may be tender. The distal attachments of the aponeurosis may be torn, partially at the base of the proximal falanges, partly at

muscle fatigue may follow. Passive extension of the big toe may reveal whether the aponeurosis has been torn. If it is intact, one should feel the start of tension in the aponeurosis on palpation when the toe is dorsiflexed to 20 degrees; the maximum normal extension is about 70 degrees. Higher values suggest injury to the attachments of the aponeurosis.[83,84,85,86]

On the other hand, limited dorsiflexion and pain on hyperextension of the great toe are findings of hallux rigidus, which results from dorsal osteophyte(s) at either or both the first metatarsal head or base of the proximal phalanx.

Numerous complications and syndromes can occur:

1) Closed Compartment Syndrome: This is the most severe complication. Edema in a closed compartment results in vascular obstruction, muscle necrosis, which may result in fibrosis and / or contractures and gangrene of the distal foot and/or toes It is usually diagnosed by measuring pressures in the compartment.

2) Crushed Heel and Anterior footpads: The elastic pads under the calcaneus and proximal phalanxes are crushed during ***falanga***, either directly or as a result of edema associated with the trauma. Also, the connective tissue bands that extend through adipose tissue and connect bone to skin are torn. Adipose tissue becomes deprived of its blood supply and atrophies. The cushioning effect is lost. The feet no longer absorb the stresses arising from walking.

3) Rigid and irregular scars involving the skin and subcutaneous tissues of the foot after the application of ***falanga***: In a normal foot, the dermal and subdermal tissues are connected to the planter aponeurosis through tight connective tissue bands. However, these bands can be partially or completely destroyed due to the edema which ruptures the bands after exposure to ***falanga.***

4) Rupture of the plantar aponeurosis and tendons of the foot: The edema of the post-***falanga*** period, may break rupture these structures. When such supportive function necessary for the arch of foot disappears, the act of walking becomes harder and foot muscles, especially quadratus plantaris longus, are excessively forced.

5) Planter fasciitis: May occur as a further complication of this injury. In ***falanga*** irritation is often present throughout the whole aponeurosis, causing chronic aponeurositis. In studies on the subject, prisoners released after 15 years of detention, who claimed that they had been subjected to ***falanga*** application when first arrested, positive bone scans of hyperactive points in the calcaneus or metatarsal bones were observed.[87]

[83] Sklyv G, Physical sequelae of torture, in Ba_o_lu M (editor), Torture and its consequences, current treatment approaches, Cambridge, Cambridge University Press, 1992, pp38-55.
[84] Forrest D, Examination for the late physical after effects of torture, ***Journal of Clinical Forensic Medicine*** 1999, 6, 4-13.
[85] Prip K, Tived L, Holten N. Physiotherapy for Torture Survivors - a Basic Introduction. Copenhagen, IRCT, 1995.
[86] Bojsen-Moller F, Flagstad KE. Plantar aponeurosis and plantar architecture of the ball of the foot. J Anat 1976, 121:599-611.
[87] Lök V, Tunca M, Kumanlioglu K et al, Bone scintigraphy as clue to previous torture, ***Lancet*** 1991, 337(8745) 846-7;

Radiological methods such as MRI, CT scan and ultrasound can often support histories of trauma occurring as a result of ***falanga*** application. Positive radiological findings also may be secondary to other diseases or trauma. Routine radiographs are recommended as the initial examination. MRI is the preferred radiologic examination to detect soft tissue injury. MRI or scintigraphy may detect bone injury such as a bruise, which may not be detected on routine radiographs or CT.[88]

3. Suspension

Suspension is a common form of torture that can produce extreme pain, but leave little, if any, visible evidence of injury. A person still in custody may be reluctant to admit to being tortured, but the finding of peripheral neurologic deficits diagnostic of brachial plexopathy virtually prove the diagnosis of suspension torture.

Suspension can be applied in various forms:

1) Cross: Applied by spreading the arms and tying them to a horizontal bar or beam.

2) Butchery Suspension: Applied by fixation of hands upwards, either together or one by one

3) Reverse Butchery Suspension: Applied by fixation of feet upward, the head being downward

4) "Palestinian" Suspension: Applied by suspending the individual with the forearms bound together behind the back with the elbows flexed 90 degrees, and the forearms tied to a horizontal bar or beam. Alternatively, the prisoner may be suspended from a ligature tied around the elbows or wrists with the arms behind the back.

5) Parrot Perch: Suspension of a prisoner by the flexed knees by a bar passed below the popliteal region, usually while the wrists are tied to the ankles

Suspension may last from l5-20 minutes to several hours. "Palestinian" suspension may produce permanent brachial plexus injury in a brief period of time; the "parrot perch" may produce tears in the cruciate ligaments of the knees. Victims will often be beaten while suspended, or otherwise abused. In the chronic phase, it is usual for pain and tenderness around the shoulder joints to persist and for lifting of weights and rotation, especially internal, to cause severe pain many years later.

Complications in the acute period following suspension include weakness of the arms and/or hands, pain and parasthesias, numbness, insensitivity to touch, superficial pain, and position, and tendon reflex loss. Intense deep pain may mask the muscle weakness. In the chronic phase, weakness may continue and progress to muscle wasting, numbness and more frequent parasthesia are present. Raising the arms or weight lifting conditions may cause pain, numbness, or weakness, or not be possible. In addition to neurologic injury, there may be tears of the ligaments of the shoulder joints, dislocation of the scapula, and muscle injury in the shoulder region. On visual inspection of the back a “winged scapula” (prominent vertebral border of the scapula) may be observed with injury to the long thoracic nerve or dislocation of the scapula.

Neurologic injury is usually not of the same extent in both arms. Brachial plexus injury manifests itself in motor, sensory, and reflex dysfunction:

1) Motor examination: Muscle weakness, more prominent distally in an asymmetric manner is the most expected finding. Acute pain may make the muscle strength examination difficult to interpret. If the injury is severe enough, muscle atrophy may be seen in the chronic phase.

2) Sensory Examination: Complete loss of sensation or parasthesias along the sensory nerve pathways are common. Positional perception, two-point discrimination, pinprick evaluation, perception of heat and cold should all be tested. If at least 3 weeks later, deficiency and/or reflex loss/decrease are present; then appropriate electrophysiological studies should be performed by a neurologist experienced in the use and interpretation of such methodologies.

[88] See references 82, 83; also Lök V, Tunca M, Kapkin E, et al. Bone scintigraphy as an evidence of previous torture;

3) Reflex Examination: Reflex loss, a decrease in reflexes, or a difference between the two extremities may be present. In Palestinian suspension, even though both brachial plexi are subject to trauma, asymmetric plexopathy may develop due to the manner in which the torture victim has been suspended, such as which arm is placed in a superior position, the method of binding, etc. Although the current literature suggests that brachial plexopathies are usually unilateral, that is at variance with our experience, where bilateral injury is common.

Among the shoulder region tissues, the brachial plexus is the structure most sensitive to traction injury. Palestinian suspension creates brachial plexus damage due to forced posterior extension of the arms. As observed in the classical type of Palestinian suspension, when the body is suspended with the arms in posterior hyper-extension, typically the lower plexus and then the middle and upper plexus fibers (if the force on the plexus is severe enough) are damaged respectively. If the suspension is of a "crucifixion" type, but not including hyper-extension, the middle plexus fibers are likely to be the first ones damaged due to hyper-abduction. Brachial plexus injuries may be categorized as follows:

1) Damage of lower plexus: Deficiencies are localized in the forearm and hand muscles. Sensory deficiencies may be observed on the forearm and at 4th and 5th fingers of the hands medial side in an ulnar nerve distribution.

2) Damage of middle plexus: Forearm, elbow and finger extensor muscles are affected. Pronation of the forearm and radial flexion of the hand may be weak. Sensory deficiency is on the forearm and on the dorsal aspects of the first, second, and third fingers of the hand in a radial nerve distribution. The triceps reflexes may be lost.

3) Damage of upper plexus: Shoulder muscles are affected especially. Abduction of the shoulder, axial rotation and forearm pronation-supination may be deficient. Sensory deficiency is noted in the deltoid region, and may extend to the arm and outer parts of forearm.

4. Other Positional Torture

There are many forms of positional torture, all of which tie or restrain the victim in contorted, hyperextended, or other unnatural positions that cause severe pain, and may produce injuries to ligaments, tendons, nerves and blood vessels. Characteristically, these forms of torture leave few, if any, external marks or radiologic findings despite frequently severe chronic disability that follows.

All such tortures are directed towards tendons, joints and muscles. There are various methods: Parrot-Stand, banana stand or the classic "banana tie" over a chair or just on the ground, motorcycle, forced standing, forcing to stand on a single foot, prolonged standing with arms and hands stretched high on a wall, prolonged forced squatting, keeping people motionless in small animal cages. In accordance with the characteristics of such positions, complaints are characterized as pain in the respective region of the body, limitation of joint movement, pain in back, hand and cervical parts of the body, swelling of lower legs, etc. The same principles of neurologic and musculoskeletal examination apply to these other forms of positional torture as apply to suspension.

MRI is the preferred radiologic modality for evaluation of injuries associated with all forms of positional torture.

5. Electric Shock Torture

Electric current is transmitted through electrodes that may be placed on any part of the body. The most common areas are the hands, feet, fingers, toes, ears, nipples, mouth, lips, and genital area. The power source may be a hand cranked or gasoline/diesel generator, wall source, stun gun, cattle prod, or other electric devices.

Electric current follows the shortest route between the two electrodes. The symptoms that occur when electric current is applied are also in accordance with this characteristic. For example, if electrodes are placed on toes of the right foot and on the genital region, there will be pain, muscle contraction

Since all muscles along the route of the electric current are tetanically contracted, dislocation of the shoulder and lumbar and cervical radiculopathies may be observed when the current is moderately high. However, the type, time of application, current and voltage of the energy used can not be determined with certainty on physical examination of the victim.

Torturers often pour water or use various kinds of gels on the body in order to increase the efficiency of the torture, extend the entrance point of the electric current on the body, and prevent detectable electric burns. Application of gels or water increases the efficiency of the electric current, extends the entrance point, and helps prevent electric burns. Trace electric burns are usually a red brown circular lesion from 1 to 3mm in diameter, usually without inflammation, which may result in a hyperpigmented scar. Involved skin surfaces must be carefully examined because the lesions are often not easily discernible.

The decision to biopsy recent lesions to prove their origin is controversial. Electrical burns may produce specific histologic changes, but these are not always present, and the absence of such changes in no way mitigates against the lesion being an electrical burn. The decision must be made on a case by case basis as to whether or not the pain and discomfort associated with a skin biopsy can be justified by the potential results of the procedure. (See Appendix II.2)

6. Dental Torture

Dental torture may be in form of breaking or extraction of the teeth, as well as applying electric current to the teeth. It may end in loss or breaking of the teeth, swelling of the gums, bleeding, pain, gingivitis, stomatitis, mandibular fractures, or loss of fillings from teeth. Temporomandibular joint syndrome will produce pain in the temporomandibular joint, limitation of jaw movement, and in some cases subluxation of this joint due to muscle spasms occurring as a result of electric current and blows to the face.

7. Asphyxiation

Near asphyxiation by suffocation is an increasingly common method of torture. It usually leaves no marks and recuperation is rapid. This method of torture was so widely used in Latin America, that its Spanish name "submarino" became part of the human rights vocabulary. Normal respiration might be prevented through methods such as covering the head with plastic bag, closure of the mouth and the nose, pressure or ligature around the neck, or forced aspiration of dusts, cement, hot peppers, etc. This is also known as "dry submarino." Various complications might develop such as petechiae of the skin, nosebleeds, bleeding from the ears, congestion of the face, infections in the mouth and acute and chronic respiratory problems.

Forcible immersion of the head into water, often contaminated with urine, feces, vomit, or other impurities, may result in near drowning or drowning. Aspiration of the water into the lungs may lead to pneumonia. This form of torture is also called "wet submarino."

In hanging or in other ligature asphyxiations, patterned abrasions or contusions can often be found on the neck. The hyoid bone and laryngeal cartilage may be fractured in partial strangulation, or from blows to the neck.

8. Sexual Torture Including Rape

Sexual torture begins with forced nudity, which in many countries is a constant factor in torture situations. One is never so vulnerable as when one is naked and helpless. Nudity enhances the psychological terror of every aspect of torture, as there is always the background of potential abuse and rape/sodomy. Furthermore, verbal sexual threats and abuse and mocking are also part of sexual torture, as they enhance the humiliation and degrading aspects of it, all part and parcel of the procedure. Groping women is traumatic in all cases, and considered torture also.

There are some differences between sexual torture of men and sexual torture of women, but some of the issues apply to both. Rape is always associated with the risk of developing sexually transmitted diseases, particularly Human Immunodeficiency Virus (HIV).[88] At present the only effective prophylaxis against HIV needs to be taken within hours of the incident, and is not generally available

[88] Lunde D and Ortmann J. Sexual torture and the treatment of its consequences, in Ba_o_lu M (editor), Torture and its consequences,

in most countries where torture occurs routinely. In most cases there will be the lewd “sexual” component and in many other cases torture targeted on the genitals. Electricity and blows are generally targeted on the genitals in men with or without additional anal torture. The resulting physical trauma is enhanced by verbal abuse. In men there are often threats of loss of masculinity and the consequent respect in society. Prisoners may also be placed naked in cells with family members, friends, or total strangers, breaking cultural taboos. This can be made worse by the absence of privacy when using toilet facilities (if any). Additionally, prisoners may be forced to abuse each other sexually, which can be particularly difficult to cope with emotionally.

Also, the concern of potential rape among women, given profound cultural stigmas associated with rape, also can add to the trauma. Not to be neglected is the obvious trauma of potential pregnancy, which males obviously will not have, the fear of losing virginity, the fear of not being able to have children (even if she can hide the rape from a potential husband and from the rest of society), etc.

Particularly in cases of sexual abuse, if the victim does not wish the event to be known due to socio-cultural pressures or personal reasons, the physician who carries out the medical examination, investigative agencies and the courts have an obligation to co-operate in maintaining the privacy of the victim.

Establishing rapport with torture survivors who have been sexually assaulted recently requires special psychological education and requires appropriate psychological support. Any kind of treatment that would increase the psychological trauma of the torture survivor should be avoided. Before starting the examination, permission from the individual must be obtained for any kind of examination, and this should be checked before the more intimate parts of the examination. The individual should be informed about the importance of the examination and its possible findings in a clear and comprehensible manner.

8a) Review of symptoms

A thorough history of the alleged assault should be taken as detailed earlier in the Manual (see Section V.E and V.F). However, there are some specific questions that are relevant only to an allegation of sexual abuse. These will be directed to elicit current symptoms resulting from a recent assault, e.g. bleeding, vaginal or anal discharge, and location of pain, bruises, and sores. For sexual assaults that occurred in the past, questions should be directed to ongoing symptoms that resulted form the assault:

1) Urinary frequency or incontinence, and/or dysuria

2) Irregularity of menstrual periods

3) Subsequent history of pregnancy, abortion, vaginal hemorrhage

4) Problems with sexual activity/intercourse

5) Anal pain, bleeding, and/or constipation or incontinence

Ideally, there should be adequate physical and technical facilities under which survivors of sexual violations may be examined appropriately, and a team that includes professions such as experienced psychiatrists, psychologists, gynecologists, and nurses who are trained in the treatment of survivors of sexual violation. An additional purpose of the consultation after sexual assault is to offer support, advice and, if appropriate, reassurance. This will cover issues such as sexually transmitted diseases and HIV, pregnancy if the victim is a woman, and permanent physical damage as torturers often tell victims that they will never function normally sexually again, which can become a self-fulfilling prophecy.

8b) Examination following a recent assault

It is rare that a victim of rape as a part of torture is released whilst it is still possible to identify acute signs of the assault. In these cases, there are many issues to be aware of that may impede the medical evaluation. Recently assaulted victims may be conflicted and confused about seeking medical or legal help due to their fears, socio-cultural concerns, or the destructive nature of the abuse. In such a case, a doctor should explain to the victim all possible medical and judicial options, and

should act in accordance with the victim's requests. The duties of the physician include: to obtain voluntary informed consent for the examination; to record all medical findings of abuse; and to obtain the required samples for forensic examination. Where possible the examination should be performed by an expert in documenting sexual assault. Otherwise the examining doctor should speak to such an expert, or consult a standard text of clinical forensic medicine.[89]

Where the doctor is of a different gender than the victim, he or she should be offered the opportunity of having a chaperone of her/his own gender in the room. If an interpreter is to be used, then s/he may fulfill the role of chaperone as well. Given the sensitive nature of investigation into such assaults, a relative of the victim is not normally an ideal person to use in this role. See also Section V.K.

The patient should be comfortable and relaxed prior to the examination. A thorough physical examination should be performed, including meticulous documentation of all physical findings including their size, location and color, and, where possible, photography of these findings and collection of evidence of specimens from the examination.

Physical examination should not be directed to the genital area at first. Upon examination, documentation of any deformities should be noted. Particular attention must be directed to perform a thorough examination of the skin looking for cutaneous lesions that could result from the assault. These include bruises, lacerations, and ecchymoses and petechiae from sucking or bites. This may help the patient to be more relaxed for a complete examination. On occasions when genital lesions are minimal, lesions located on other parts of the body may be the most significant evidence of an assault.

Even on examination of the female genitalia immediately after rape there is identifiable damage in less than 50% of cases. Anal examination of males and females after anal rape shows lesions in less than 30% of cases. Clearly where relatively large objects have been used to penetrate the vagina and/or anus, the probability of identifiable damage is much greater.

Where there is a forensic laboratory available, the facility should be contacted before the examination to discuss what types of specimen they are capable of testing, and therefore what samples should be taken and how. Many laboratories provide kits to allow doctors to take all the necessary samples from individuals alleging sexual assault. If there is no laboratory available, it still may be worth obtaining wet swabs and letting them dry in the air. These samples can then be used for DNA testing at a later date. Sperm can be identified up to five days from a high vaginal swab and after up to three days from a rectal swab. Strict precautions must be taken to prevent allegations of cross-contamination where samples have been taken from several different victims, and particularly if they are taken from alleged perpetrators. There must be complete protection and documentation of the chain of custody of all forensic samples.

8c) Examination after the immediate phase

Where the alleged assault occurred more than a week ago and there are no signs of bruises, lacerations, etc., there is less immediacy in conducting a pelvic examination. Time can be taken to try to find the most qualified person to document findings, and the best environment in which to interview the individual. However, there might still be benefits in arranging proper photography of residual lesions if this is possible.

The history should be taken as described above, then examination and documentation of the general physical findings. In women who have delivered babies before the rape, and particularly in those who have delivered them afterwards, pathognomonic findings are not likely, although an experienced female doctor can tell a considerable amount from the demeanor of a woman when she is describing her history and being examined.[90] It may take some time before the individual is willing to discuss those aspects of the torture that he or she finds most embarrassing. Similarly, patients may wish to postpone the more intimate parts of the examination to a subsequent consultation if time and circumstances permit.

[89] see, for example, Howitt J and Rogers D, Adult Sexual Offenses and Related Matters, in McLay WDS (editor), Clinical Forensic Medicine, London, Greenwich Medical Media, 1996, pp193-218.

[90] Hinshelwood G, Gender-based persecution, Toronto, United Nations Expert Group Meeting on Gender-based Persecution,

8d) Follow-up

Many infectious diseases can be transmitted by sexual assault. Some of these infectious diseases include:

1) Sexually Transmitted Diseases:
   - Gonorrhea
   - Chlamydia
   - Syphilis
   - HIV
   - Hepatitis B, and C
   - Herpes Simplex
   - Condyloma Acuminatum-Venereal Warts

2) Vulvovaginities Associated with Sexual Abuse:
   - Trichomonas
   - Moniliasis vaginitis
   - Gardenarella vaginitis
   - Enterobius vermicularis-pinworms

3) Urinary Tract Infections

Appropriate cultures and treatment should be considered in all cases of sexual abuse. In the case of Gonorrhea and Chlamydia, concomitant infection of the anus and oropharynx should be considered for at least culture purposes. Initial cultures and or serologic tests should be obtained in cases of sexual assault and appropriate therapy initiated.

Sexual dysfunction is common among survivors of torture, particularly among those who have suffered sexual torture or rape, but not exclusively. Symptoms may be of physical or psychological origin, or a combination of both, and include:

1) Aversion to members of the opposite sex

2) Fear of sexual activity

3) Decreased interest in sexual activity

4) Inability to trust a sexual partner

5) Fear that any sexual partner will “know” that the victim has been sexually abused

6) Fear of having been damaged sexually - torturers may have threatened this

7) Fear of homosexuality in men who have been anally abused (some heterosexual men have had an erection and, on occasion, ejaculated during non-consensual anal intercourse. They should be reassured that this is a physiological response).

8) Disturbance in sexual arousal

9) Erectile dysfunction

10) Dyspareunia (painful sexual intercourse in females)

11) Infertility due to acquired sexually transmitted disease, direct trauma to reproductive organs, or to poorly performed abortions of pregnancies secondary to rape

8e) Genital examination of females

In many cultures it is completely unacceptable to penetrate the vagina of a woman who is a virgin with anything, including a speculum, finger or swab. If the woman demonstrates clear evidence of rape on external inspection, it may not be necessary to conduct an internal pelvic examination. Genital examination findings may include:

1) Small lacerations or tears of the vulva: these may be seen acutely and are caused by excessive stretching. They normally heal completely, but if repeatedly traumatized they may result in scarring.

2) Abrasions of the female genitalia: abrasions can be caused by contact with rough objects such as fingernails or rings.

3) Vaginal lacerations: these are rare, but, if present, may be associated with atrophy of the tissues or previous surgery. They cannot be differentiated from incisions from inserted sharp objects.

It is rare to find any physical evidence when examining the female genitalia more than one week after an assault. Later on when the woman may well have had subsequent sexual activity, whether consensual or not, or delivered a baby, it may be almost impossible to attribute any findings to a specific incident of alleged abuse. Therefore, the most significant component of a medical evaluation may be the examiner's assessment of historical information (i.e. correlation between allegations of abuse and acute injuries observed by the individual) and demeanor of the individual – bearing in mind the cultural context of the woman's experience.

8f) Genital examination of males

Men who have been subjected to torture of the genital region, including the crushing, wringing, pulling of the scrotum or direct trauma to the region, usually complain of pain and sensitivity in the acute period. Hyperemia, marked swelling and ecchymosis can be observed. The urine may contain large numbers of erythrocytes and leucocytes. If a mass is detected, it should be determined whether it is a hydrocele, hematocele or inguinal hernia. In the case of an inguinal hernia, the examiner cannot palpate the spermatic cord above the mass. With a hydrocele and a hematocele, normal spermatic cord structures are usually palpable above the mass. A hydrocele results from excessive accumulation of fluid within the tunica vaginalis due to inflammation of testis and its appendages, or to diminished drainage secondary to lymphatic or venous obstruction in the cord or retroperitoneal space. A hematocele is an accumulation of blood within tunica vaginalis secondary to trauma. Unlike the hydrocele, it does not transilluminate.

Testicular torsion also may result from trauma to the scrotum. With this injury, the testis becomes twisted at its base, obstructing blood flow to the testis. This causes severe pain and swelling, and constitutes a surgical emergency. Failure to reduce the torsion immediately will lead to infarction of the testis. Under conditions of detention, where medical care may be denied, the late sequelae of this lesion may be observed.

Individuals, who were subject to scrotal torture may suffer from chronic urinary tract infections, erectile dysfunction, or atrophy of the testes. Symptoms of posttraumatic stress disorder are not uncommon. In the chronic phase, it may be impossible to distinguish between scrotal pathology caused by torture and that caused by other disease processes. Failure to discover any physical abnormalities on full urological examination suggests that urinary symptoms, impotence or other sexual problems may be explained on psychological grounds. Scars on the skin of the scrotum and penis may be very difficult to visualize. For this reason, the absence of scarring in these locations, in particular, does not demonstrate the absence of torture. Also, the presence of scarring usually indicates that substantial trauma was sustained.

8g) Examination of the anal region

After anal rape or insertion of objects into the anus of either gender, pain and bleeding can occur for days or weeks afterwards. This often leads to constipation that can be exacerbated by the poor diet in many places of detention. Gastrointestinal and urinary symptoms also may occur. In the acute phase, any examination beyond visual inspection may require local or general anesthesia, and should be performed by a specialist. In the chronic phase some symptoms may persist and they should be investigated. There may be anal scars of unusual size or position and these should be documented. Anal fissures may persist for many years, but it is not normally possible to differentiate those caused by torture from those caused by other mechanisms.

On visualization of the anus, the following findings should be looked for and documented:

1) Fissures tend to be non-specific findings as they can occur in a number of “normal” situations (constipation, poor hygiene). However, when seen in an acute situation (i.e. within 72 hours) fissures are a more specific finding and can be considered evidence of penetration.

2) Rectal tears with or without bleeding may be noted.

3) Disruption of the rugal pattern may manifest as smooth fan-shaped scarring. When such scars are seen out of midline (i.e. not at 12 or 6 o’clock), they can be an indication of penetrating trauma.

4) Skin tags which can be the result of healing trauma.

5) Purulent discharge from the anus. Cultures should be taken for gonorrhea and chlamydia in all cases of alleged rectal penetration, regardless of whether a discharge is noted.

F. Specialised Diagnostic Tests

Diagnostic tests are not an essential part of the clinical assessment of a person who alleges that he or she has been tortured. In many cases a medical history and physical examination is sufficient. However, there are circumstances in which such tests are valuable supporting evidence. For example, where there is a legal case against members of the authorities or a claim for compensation. In these cases, a "positive" test might make the difference between a case succeeding and failing. Additionally, if diagnostic tests are performed for therapeutic reasons, the results should be added to a clinical report.

It must be recognized that, as with physical findings, the absences of a positive diagnostic test result must not be used to suggest that torture has not occurred.

There are many situations in which diagnostic tests are not available for technical reasons, but their absence should never invalidate an otherwise properly written report. It is also inappropriate to use limited diagnostic facilities to document injuries for legal reasons alone when there are greater clinical needs for those facilities.

For further details, see Appendix II

VII. PSYCHOLOGICAL EVIDENCE OF TORTURE

A. General Considerations

1. Central Role of the Psychological Evaluation

It is a widely held view that torture is an extraordinary life experience capable of causing a wide range of physical and psychological suffering. Most clinicians and researchers agree that the extreme nature of the torture event is powerful enough on its own to produce mental and emotional consequences, regardless of the individuals pre-torture psychological status. The psychological consequences of torture, however, occur in the context of personal attribution of meaning, personality development, and social, political and cultural factors. For this reason, one cannot assume that all forms of torture have the same outcome. For example, the psychological consequences of a mock execution are not the same as those due to a sexual assault, and solitary confinement and isolation are not likely to produce the same effects as physical acts of torture. Likewise, one cannot assume that the effects of detention and torture on an adult will be the same as those on a child. Nevertheless, there are clusters of symptoms and psychological reactions that have been observed and documented in torture survivors with some regularity.

Perpetrators often attempt to justify their acts of torture and ill treatment by the need to gather information. Such conceptualizations obscure the purpose of torture and its intended consequences. One of the central aims of torture is to reduce the individual to a position of extreme helplessness and distress that can lead to a deterioration of cognitive, emotional and behavioral functions.[91] Thus, torture can be a means of attacking the individual's fundamental modes of psychological and social functioning. Under such circumstances, the torturer strives not only for physical incapacitation of the victim, but for the disintegration of the individual's personality; the torturer attempts to destroy the victim's sense of being grounded in a family and society as a human being with dreams, hopes and aspirations for the future. By dehumanizing and breaking the will of their victims, torturers set horrific examples for those who come in contact with the victim. In this way, torture can break or damage the will and coherence of entire communities. In addition, torture can profoundly damage intimate relationships between spouses, parents, children and other family members, and relationships between the victims and their communities.

It is important to recognize that not everyone who has been tortured develops a diagnosable mental illness. However, many victims experience profound emotional reactions and psychological symptoms. The main psychiatric disorders associated with torture are posttraumatic stress disorder (PTSD) and major depression. While these disorders are present in the general population, their prevalence is much higher among traumatized populations. The unique cultural, social and political meanings that torture has for each individual, influences his or her ability to describe and speak about it. These are important factors that contribute to the impact that the torture inflicts psychologically and socially, and that must be considered when performing an evaluation on an individual from another culture. Cross-cultural research reveals that phenomenological or descriptive methods are the most rational approaches to use when attempting to evaluate psychological or psychiatric disorders. What is considered disordered behavioror a disease in one culture may not be viewed as pathological in another.[92,93,94] Since World War II, progress has been made in understanding the psychological consequences of violence. Certain psychological symptoms and clusters of symptoms have been observed and documented among survivors of torture and other types of violence.

In recent years, the diagnosis of posttraumatic stress disorder (PTSD) has been applied to an increasingly broad array of individuals suffering from the impact of widely varying types of violence, however, the utility of this diagnosis in non-western cultural groups has not been established. Nevertheless, evidence suggests that there are high rates of PTSD and depression symptoms among traumatized refugee populations from multiple different ethnic and cultural backgrounds.[95,96,97] The

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[91] Fischer, G. &. Gurris, N.F. (1996). Grenzverletzungen: Folter und sexuelle Traumatisierung. In W. Senf & M. Broda (Hrsg.), Praxis der Psychotherapie-Ein integratives Lehrbuch f=FCr Psychoanalyse und Verhaltenstherapie. Stuttgart, Thieme.

[92] Kleinman A (1986)Anthropology and psychiatry: the role of culture in cross-cultural research on illness and care. Paper delivered at WPA Regional symposium on "Psychiatry and its Related Disciplines."

[93] Engelhardt HT.(1975) The concepts of health and disease. In: HT Englehardt and SF Spicker (Eds.) Evaluation and Explanation in the Biomedical Sciences, 125-141. Holland: D. Reidel Publishing Co.

[94] Westermeyer J. (1985)Psychiatric diagnosis across cultural boundaries. American Journal of Psychiatry, 142(7),798-805).

[95] Mollica RF, Donelan K, Tor S, et al. The effect of trauma and confinement on the functional health and mental health status of

World Health Organization's cross-cultural study of depression[98] provides a helpful guiding principle. That is, while some symptoms may be present across differing cultures, they may not be the symptoms that concern the individual the most.

2. The Context of the Psychological Evaluation

Evaluations occur in a variety of political contexts. This results in important differences in the manner in which evaluations should be conducted. The physician or psychologist must adapt the following guidelines according to the particular situation and purpose of the evaluation. See Section IV.D.2c.

Whether or not certain questions can be asked safely will vary considerably and depend on the degree to which confidentiality and security can be assured. For example, an examination by a visiting physician in a prison that may be limited to fifteen minutes cannot follow the same course as a forensic examination in a private office that may last for several hours. Additional problems arise when trying to assess whether psychological symptoms or behaviors are pathological or adaptive. When a person is examined while in detention or living under considerable threat or oppression, some symptoms might be adaptive. For example, diminished interest in activities, feelings of detachment and estrangement would be understandable findings in a person in solitary confinement. Likewise, hypervigilance and avoidance behaviors may be necessary for those living in repressive societies.[99] The potential limitations of certain interview conditions, however, does not preclude aspiring to the guidelines set forth in this Manual. It is particularly important in difficult circumstances that the government and authorities involved be held to these standards as much as possible.

B. Psychological Consequences of Torture

1. Cautionary Remarks

Before entering into a technical description of symptoms and psychiatric classifications, it should be noted that such classifications are generally considered Western medical concepts and that the application, either implicitly or explicitly, to non-Western populations presents certain difficulties. It can be argued that Western cultures suffer from an undue medicalization of psychological processes. The idea that mental suffering represents a "disorder" that resides in an individual and features a particular set of typical symptoms may not be acceptable to many members of non-Western societies. Nonetheless, there is considerable evidence for biological changes that occur in PTSD and, from that perspective, PTSD is a diagnosable syndrome amenable to treatment both biologically and psychologically.[100]

As much as possible, the evaluating physician or psychologist should attempt to relate to mental suffering in the context of the individual's beliefs and cultural norms. This includes respect for the political contexts as well as cultural and religious beliefs. Given the severity of torture and its consequences, when performing a psychological evaluation, one should adopt an attitude of informed learning rather than the rush to diagnose and classify. Ideally, such an attitude will communicate to the individual that his or her complaints and suffering are being recognized as real and expectable under the circumstances. In this sense, a sensitive empathic attitude may offer the victim some relief from experiences of alienation.

2. Common Psychological Responses

2a) Re-experiencing the trauma

1) Flashbacks or intrusive memories, i.e. the subjective sense that the traumatic event is happening all over again, even while the person is awake and conscious

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[96] Kinzie JD, Boehnlein JK, Leung P et al. The prevalence of Post-traumatic stress disorder and its clinical significance among Southeast Asian refugees. Am J Psychiatry.1990;147(7)913-917.
[97] Allden K et al Burmese Political Dissidents in Thailand: Trauma; and survival among young adults in exile. Am J Public Health. 1996;86;1561-1569.
[98] Sartorius, N 1987 Cross-cultural research on depression. Psychopathology, 19(2), 6-11.
[99] Simpson, M.A. (1995) What Went Wrong?: Diagnostic and Ethical Problems in Dealing with the Effects of Torture and Repression in South Africa. In Kleber, R.J., Figley, C.R., Gersons, B.P.R. (Eds.) ***Beyond Trauma-Cultural and Societal Dynamics*** (pp.188-210). New York: Plenum Press.
[100] Friedman, M. and Jaranson, J. The Applicability of the Post-Traumatic Concept to Refugees in Marsella, T. et al. (Eds.) Amidst Peril and Pain: The Mental Health and Well-being of the World's Refugees. Washington, D.C.: American

2) Recurrent nightmares that include elements of the traumatic event(s) in either their original or symbolic form

3) Distress at exposure to cues that symbolize or resemble the trauma. This may include lack of trust and fear of persons of authority, including physicians and psychologists. In countries or situations where authorities participate in human rights violations, lack of trust and fear of authority figures should not be assumed to be pathological.

2b) Avoidance and emotional numbing

1) Avoidance of any thoughts, conversations, activities, places or people that arouse recollection of the trauma

2) Profound emotional constriction

3) Profound personal detachment and social withdrawal

4) Inability to recall an important aspect of the trauma

2c) Hyperarousal

1) Difficulty falling or staying asleep

2) Irritability or outbursts of anger

3) Difficulty concentrating

4) Hypervigilance

5) Exaggerated startle response

6) Generalized anxiety

7) Shortness of breath, sweating, dry mouth, dizziness

8) Gastrointestinal distress

2d) Symptoms of depression

1) Depressed mood

2) Anhedonia: markedly diminished interest or pleasure in activities

3) Appetite disturbance and resulting weight loss

4) Insomnia or hypersomnia

5) Psychomotor agitation or retardation

6) Fatigue and loss of energy

7) Feelings of worthlessness and excessive guilt

8) Difficulty in attention, concentration and memory

9) Thoughts of death and dying, suicidal ideation, suicide attempts

2e) Damaged self-concept and foreshortened future

1) A subjective feeling of having been irreparably damaged[101] and of having undergone an irreversible personality change

2) A sense of foreshortened future: not expecting to have a career, marriage, children or a normal life span

2f) Dissociation, depersonalisation and atypical behavior

1) Dissociation: a disruption in the integration of consciousness, self-perception, memory and actions. A person may be cut off or unaware of certain actions or may feel split in two and feel as if observing him or herself from a distance.

2) Depersonalisation: feeling detached from oneself or one's body

3) Impulse control problems, resulting in behaviors that the survivor considers highly atypical with respect to his or her pre-trauma personality. A previously cautious individual may engage in high-risk behavior.

2g) Somatic complaints

Somatic symptoms such as pain and headache and other physical complaints, with or without objective findings, are common problems among torture victims. Pain may be the only presenting complaint. It may shift in location and vary in intensity. Somatic symptoms can be directly due to physical consequences of torture; they can be of psychological origin, or both. For example, pain of all kinds may both be a direct physical consequence of torture, be of psychological origin or both. Typical somatic complaints include:

1) Headaches: a history of beatings to the head and other head injuries are very common among torture survivors. These injuries often lead to post-traumatic headaches that are chronic in nature. Headaches may also be caused by or exacerbated by tension and stress.

2) Back pain

3) Musculoskeletal pain

2h) Sexual dysfunction

Sexual dysfunction is common among survivors of torture, particularly among those who have suffered sexual torture or rape, but not exclusively. See Section VI.E.8.

2i) Psychosis

Cultural and linguistic differences may be confused with psychotic symptoms. Before labeling someone as psychotic, one must evaluate the symptoms within the individual's unique cultural context. Psychotic reactions may be brief or prolonged. The psychotic symptoms may occur while the person is detained and tortured as well as afterwards. The following is a list of possible findings:

1) Delusions

2) Hallucinations: auditory, visual, tactile, olfactory

3) Bizarre ideation and behavior

4) Illusions or perceptual distortions: These may take the form of pseudo-hallucinations and may border on true psychotic states. False perceptions and hallucinations that occur on falling asleep or on waking are common among the general population and do not denote psychosis. It is not uncommon for torture victims to report occasionally hearing screams,

[101] Holtan, N.R. How Medical Assessment of Victims of Torture Relates to Psychiatric Care. In J.M. Jaranson & M.K.Popkin

his or her name being called, or seeing shadows, but not have florid signs or symptoms of psychosis.

5) Paranoia and delusions of persecution

6) Recurrence of psychotic disorders or mood disorders with psychotic features may develop among those who have a past history of mental illness. Individuals with a past history of bipolar disorder, recurrent major depression with psychotic features, schizophrenia and schizoaffective disorder may experience an episode of that disorder.

2j) Substance abuse

Alcohol and drug abuse often develops secondarily in torture survivors as a way of obliterating traumatic memories, regulating affect and managing anxiety.

2k) Neuropsychological impairment

Torture can involve physical trauma that leads to various levels of brain impairment. Blows to the head, suffocation, and prolonged malnutrition may have long-term neurological and neuropsychological consequences that may not be readily assessed during the course of a medical examination. As in all cases of brain impairment that can not be documented through head imaging or other medical procedures, neuropsychological assessment and testing may be the only reliable way of documenting its effects. Frequently, the target symptoms for such assessments have significant overlap with the symptomatology arising from PTSD and major depressive disorder. Fluctuations or deficits in level of consciousness, orientation, attention, concentration, memory and executive functioning may result from functional disturbances as well as organic causes. Therefore, specialised skill in neuropsychological assessment, as well as awareness of problems in cross-cultural validation of neuropsychological instruments is necessary when such distinctions are to be made. See Section VII.C.4.

3. Diagnostic Classifications

While the chief complaints and most prominent findings among torture survivors are widely diverse and relate to the individual's unique life experiences and his or her unique cultural, social and political context, it is wise for evaluators to become familiar with the most commonly diagnosed disorders among trauma and torture survivors. Also, it is not uncommon for more than one mental disorder to be present, as there is considerable co-morbidity among trauma-related mental disorders. Various manifestations of anxiety and depression are the most common symptoms resulting from torture. Not infrequently the symptomatology described above will be classified within the categories of anxiety and mood disorders. The two prominent classification systems are the International Classification of Disease (ICD-10)[102] Classification of Mental and Behavioral Disorders and the American Psychiatric Association's Diagnostic and Statistical Manual, Fourth Edition (DSM-IV).[103] For complete descriptions of diagnostic categories, the reader should refer to ICD-10 and DSM-IV. This review will focus on the most common trauma related diagnoses, PTSD, major depression, and enduring personality changes.

3a) Depressive disorders

Depressive states are almost ubiquitous among survivors of torture. In the context of evaluating the consequences of torture, it is problematic to assume that PTSD and major depressive disorder are two separate disease entities with clearly distinguishable etiologies. Depressive disorders include Major Depressive Disorder, Single Episode or Major Depressive Disorder, Recurrent (more than one episode). Depressive disorders can be present with or without psychotic, catatonic, melancholic or atypical features. According to DSM-IV, in order to make a diagnosis of Major Depressive Episode five or more of the following symptoms must be present during the same two week period and represent a change from previous functioning (at least one of the symptoms must be depressed mood or loss of interest or pleasure): 1) depressed mood, 2) markedly diminished interest or pleasure in all or almost all activities, 3) weight loss or decreased or increased appetite, 4) insomnia or hypersomnia, 5) psychomotor agitation or retardation, 6) fatigue or loss of energy, 7) feelings of worthlessness or

[102] World Health Organization. The ICD-10 Classification of mental and behavioral disorders and diagnostic guidelines. Geneva. 1994.

excessive or inappropriate guilt, 8) diminished ability to think or concentrate, and 9) recurrent thoughts of death or suicide. To make this diagnosis the symptoms must cause significant distress or impaired social or occupational functioning, not be due to a physiological disorder, and can not be accounted for by another DSM-IV diagnosis.

3b) Posttraumatic stress disorder

The diagnosis most commonly associated with the psychological consequences of torture is posttraumatic stress disorder (PTSD). The association between torture and this diagnosis has become very strong in the minds of health providers, immigration courts and the informed lay public. This has created the mistaken and simplistic impression that PTSD is the main psychological consequence of torture.

The DSM-IV definition of PTSD relies heavily on the presence of memory disturbances in relation to the trauma such as intrusive memories, nightmares, and/or the inability to recall important aspects of the trauma. The individual may not be able to recall with precision, specific details of the torture events but will be able to recall the major themes of the torture experiences. For example, the victim may be able to recall being raped on several occasions but not be able to give the exact dates, locations, and details of the setting or perpetrators. Under such circumstances, the inability to recall precise details supports, rather than discounts, the credibility of a survivor's story. Major themes in the story also will be consistent upon re-interviewing. The ICD-10 diagnosis of PTSD is very similar to that of DSM-IV.

According to DSM-IV, PTSD can be acute, chronic or delayed. The symptoms must be present for more than one month and the disturbance must cause significant distress or impairment in functioning. In order to make the diagnosis of PTSD, the individual must have been exposed to a traumatic event that involved life-threatening experiences for him/herself or others and produced intense fear, helplessness or horror.

The event must be "re-experienced" persistently in one or more of the following ways: 1) intrusive distressing recollections of the event, 2) recurrent distressing dreams of the event, 3) acting or feeling as if the event were happening again including hallucinations, flashbacks, and illusions, 4) intense psychological distress at exposure to reminders of the event, and 5) physiological reactivity when exposed to cues that resemble or symbolize aspects of the event.

The individual must persistently demonstrate avoidance of stimuli associated with the traumatic event and/or show general numbing of responsiveness as indicated by at least three of the following: 1) efforts to avoid of thoughts, feelings or conversations associated with the trauma, 2) efforts to avoid activities, places or people that remind him/her of the trauma, 3) inability to recall an important aspect of the event, 4) diminished interest in significant activities, 5) detachment or estrangement from others, 6) restricted affect, and 7) foreshortened sense of future.

Also necessary to make the DSM-IV diagnosis of PTSD is the persistence of symptoms of increased arousal that were not present before the trauma as indicated by at least two of the following: 1) difficulty falling or staying asleep, 2) irritability or angry outbursts, 3) difficulty concentrating, 4) hypervigilance, and 5) exaggerated startle response.

Symptoms of PTSD can be chronic or fluctuate over extended periods of time. During some intervals, symptoms of hyperarousal and irritability dominate the clinical picture, at these times the survivor will usually also report increased intrusive memories, nightmares and flashbacks. At other times the survivor may appear relatively asymptomatic or emotionally constricted and withdrawn. One must keep in mind that not meeting diagnostic criteria of PTSD does not mean that torture was not inflicted. According to ICD-10, in a certain proportion of cases, PTSD may follow a chronic course over many years, with eventual transition to an enduring personality change.

3c) Enduring personality change

After catastrophic or prolonged extreme stress, disorders of adult personality may develop in persons with no previous personality disorder. The types of extreme stress that can change the personality include concentration camp experiences, disasters, prolonged captivity with an imminent possibility of being killed, exposure to life-threatening situations such as being a victim of terrorism, and torture. According to ICD-10, the diagnosis of an enduring change in personality should only be made when

there is evidence of a definite, significant and persistent change in the individual's pattern of perceiving, relating, or thinking about the environment and him/herself, associated with inflexible and maladaptive behaviors not present before the traumatic experience. The diagnosis excludes changes that are a manifestation of another mental disorder or a residual symptom of any antecedent mental disorder, as well as personality and behavioral changes due to brain disease, dysfunction or damage.

To make the ICD-10 diagnosis of Enduring Personality Change after Catastrophic Experience, the changes in personality must be present for at least two years following exposure to catastrophic stress. ICD-10 specifies that the stress must be so extreme that "it is not necessary to consider personal vulnerability in order to explain its profound effect of the personality." This personality change is characterized by a hostile or distrustful attitude towards the world, social withdrawal, feelings of emptiness or hopelessness, a chronic feeling of "being on edge" as if constantly threatened, and estrangement.

3d) Substance abuse

Clinicians have observed that alcohol and drug abuse often develops secondarily in torture survivors as a way of suppressing traumatic memories, regulating unpleasant affects, and managing anxiety. Although co-morbidity of PTSD with other disorders is common, systematic research has seldom studied the abuse of substances by torture survivors. The literature on populations that suffer from PTSD may include torture survivors such as refugees, prisoners of war, and veterans of armed conflicts and may provide some insight. Studies of these groups reveal: 1) substance abuse prevalence varies by ethnic or cultural group,[104,105] 2) former prisoners of war with PTSD were at increased risk for substance abuse,[106,107] and 3) combat veterans have high rates of co-morbidity of PTSD and substance abuse.[108,109,110,111] In summary, there is considerable evidence from other populations at risk for PTSD that substance abuse is a potential co-morbid diagnosis for torture survivors.

3e) Other diagnoses

As evident from the catalogue of symptoms described in the section "Common psychological responses and symptoms," (see Section VII.B.2) there are other diagnoses to be considered in addition to PTSD, major depressive disorder and enduring personality change. The other possible diagnoses include but are not limited to:

1) Generalized anxiety disorder: featuring excessive anxiety and worry about a variety of different events or activities, motor tension and increased autonomic activity.

2) Panic disorder: recurrent and unexpected attacks of intense fear or discomfort including four symptoms such as sweating, choking, trembling, rapid heart rate, dizziness, nausea, chills or hot flashes.

3) Acute stress disorder: this disorder features essentially the same symptoms as PTSD but is diagnosed within one month of exposure to the traumatic event.

4) Somatoform disorders: featuring physical symptoms that cannot be accounted for by a medical condition.

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[104] Farias, P.J. (1991). Emotional distress and its socio-political correlates in Salvadoran refugees: Analysis of a clinical sample. Culture, Medicine and Psychiatry, 15: 167-192.
[105] Dadfar, A. (1994) The Afghans: Bearing the scars of a forgotten war. In: Amidst peril and pain, A. Marsella, T. Bornemann, S. Ekblad, and J. Orley. Washington, D.C.: American Psychological Association.
[106] Beebe, G.W. (1975) Follow-up studies of World War II and Korean War prisoners, II: Morbidity, disability, and malajustments. American Journal of Epidemiology, 101, 400-422.
[107] Engdahl, B.E., Dikel, T., Eberly, R.E., & Blank, A. (in review). The comorbidity and course of psychiatric disorders in a community sample of former Prisoners of War.
[108] Keane, T. M; Wolfe, J. Comorbidty in post-traumatic stress disorder: an analysis of community and clinical studies. Journal of Applied Social Psychology v. 20, no. 21 (Pt 1), pp. 1776-1788 (1990).
[109] Kulka, R. A., Schlenger, W. E., Fairbank, J. A, Hough, R. L, Jordan, K. Marmar, C.R., Weiss, D. Trauma and the Vietnam War generation: report of findings from the National Vietnam Veterans Readjustment Study. New York: Brunner/Mazel, (1990).
[110] Jordan, K.; Schlenger, W. E; Hough, R.L; Kulka, R.A; Weiss, D..S; Fairbank, J.A; Marmar, C.R. Lifetime and current prevalence of specific psychiatric disorders among Vietnam veterans and controls. Archives of General Psychiatry v. 48, no. 3, pp. 207-215 (1991).
[111] Shalev, A.Y; Bleich, A.; Ursano, R.J. Post-traumatic stress disorder: somatic comorbidity and effort tolerance. J

5) Bipolar disorder: featuring manic or hypomanic episodes with elevated, expansive or irritable mood, grandiosity, decreased need for sleep, flight of ideas, psychomotor agitation and associated psychotic phenomena.

6) Disorders due to a general medical condition: often in the form of brain impairment with resultant fluctuations or deficits in level of consciousness, orientation, attention, concentration, memory and executive functioning.

7) Phobias: such as social phobia and agoraphobia.

C. The Psychological/Psychiatric Evaluation

1. Ethical and Clinical Considerations

Psychological evaluations can provide critical evidence of abuse among torture victims for several reasons:

1) Torture often causes devastating psychological symptoms

2) Torture methods are often designed to leave no physical lesions

3) Physical methods of torture may result in physical findings that either resolve or lack specificity

Psychological evaluations provide useful evidence in various settings, such as a medical-legal examinations, support of political asylum applications, establishing conditions under which false confessions may have been obtained, understanding regional practices of torture, identifying the therapeutic needs of victims, and as testimony in human rights investigations.

The overall goal of a psychological evaluation is to assess the degree of consistency between an individual's account of torture and the psychological findings observed during the course of the evaluation. To this end, the evaluation should provide a detailed description of the individual's history (See Section IV.D.2f and Section V.F), mental status examination, assessment of social functioning, and the formulation of clinical impressions. A psychiatric diagnosis should be made if appropriate. Because psychological symptoms are so prevalent among survivors of torture, it is highly advisable that all evaluations of torture include a psychological assessment.

The assessment of psychological status and the formulation of a clinical diagnosis should always be made with an awareness of the cultural context. Awareness of culture specific syndromes and native language-bound idioms of distress through which symptoms are communicated is of paramount importance for both conducting the interview and formulating the clinical impression and conclusion. When the interviewer has little or no knowledge about the victim's culture, the assistance of an interpreter is essential. Ideally, an interpreter from the victim's country knows the language, customs, religious traditions, and other beliefs that will need to be considered during the investigation.

The interview may induce fear and mistrust on the part of the individual and possibly remind him or her of previous interrogations. To reduce the effects of retraumatisation, the clinician should communicate a sense of understanding of the individual's experiences and cultural background. It is not appropriate to observe the strict "clinical neutrality" that is used in some forms of psychotherapy during which the clinician is inactive and says little. The clinician should communicate that he or she is an ally of the individual and adopt a supportive, non-judgmental approach.

2. Interview Process

The clinician should introduce the interview process in a manner that explains in detail the procedures to be followed (questions asked about psychosocial history including history of torture and current psychological functioning) and that prepares the individual for the difficult emotional reactions that the questions may elicit. The individual needs to be given the opportunity to request breaks, interrupt the interview at any time, and be able to leave if the stress level becomes intolerable, with the option of a consecutive appointment. Clinicians need to be sensitive and empathic in their questioning while remaining objective in their clinical assessment. At the same time the interviewer should be aware of potential personal reactions to the survivor and the descriptions of

The interview process may remind the survivor of being interrogated during torture. Therefore, strong negative feelings toward the clinician may be evoked such as fear, rage, revulsion, helplessness, confusion, panic, hatred, etc. The clinician should allow for the expression and explanation of such feelings, and express understanding for the individual's difficult predicament. In addition, the possibility that the person may still be under persecution and oppressed by authorities has to be kept in mind. When necessary, questions about activities forbidden by the authorities should be avoided.

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

Clinicians who conduct physical and psychological evaluations should be aware of the potential emotional reactions that evaluations of severe trauma may elicit in the interviewee and interviewer. These emotional reactions are known as transference and countertransference. For example, mistrust, fear, shame, rage and guilt are among the typical reactions that torture survivors experience, particularly when being asked to recount and remember details of their trauma history. Tranference relates to feelings a survivor has towards the clinician that relate to the past experiences but are misunderstood as directed towards the clinician personally. In addition, the clinician's emotional responses to the torture survivor, known as countertransference, may affect the psychological evaluation. Transference and countertransference are mutually interdependent and interactive.

The potential impact of transference reactions on the evaluation process becomes evident when it is considered that an interview or examination that involves recounting and remembering the details of a traumatic history will result in exposure to distressing and unwanted memories, thoughts and feelings. Thus, even though a torture victim may consent to an evaluation with the hope of benefiting from it, the resulting exposure will be experienced in light of the trauma experience itself. This may include the following phenomena:

1) The evaluator's questions may be experienced as a forced exposure akin to an interrogation. The evaluator may be suspected of having voyeuristic and sadistic motivations, e.g. "Why does he/she make me reveal every last terrible detail of what happened to me?" "Why would a normal person choose to listen to stories like mine in order to make a living? He/she must have some strange kind of motivation." etc.

2) There may be prejudices towards the evaluator because he/she hasn't been arrested and tortured. This may lead the subject to perceive the evaluator as a member of the enemy side.

3) The evaluator is perceived as a person in a position of authority (which is often the case) and may for that reason not be trusted with certain aspects of the trauma history. Alternatively, as often with cases of subjects still in custody, the subject may be too trusting in situations where the interviewer cannot guarantee that there will be no reprisals. Every precaution should be taken to ensure that prisoners do not put themselves at risk unnecessarily, naively trusting in the outsider to protect them.

4) Torture victims may fear that information that is revealed in the context of an evaluation cannot be safely kept from being accessed by persecuting governments. Fear and mistrust may be particularly strong in cases where physicians or other health workers were participants in the torture.

5) In many circumstances the evaluator will be a member of the majority culture and ethnicity, whereas the subject, in the situation and location of the interview, will belong to a minority group or culture. This dynamic of inequality may reinforce the perceived (and real) imbalance of power, and may increase the potential sense of fear, mistrust, and forced submission in the subject. In some cases, particularly of subjects still in custody, this dynamic may relate more to the interpreter than the evaluator. Therefore, ideally, the interpreter also should be an "outsider" and not be recruited locally so that he/she can be

member be used as an interpreter on whom the authorities can later apply pressure to find out what was discussed in the evaluation.

6) If the gender of the evaluator and of the torturer is the same, the interview situation may be perceived as resembling more strongly the torture situation than if the genders were different. For example, a woman who was raped and tortured in prison by a male guard is likely to experience more distress, mistrust, and fear when facing a male evaluator than she might experience with a female interviewer. This is the same for the men who have been assaulted sexually. They may be ashamed to tell the details of these offenses to a female evaluator. Experience has shown, particularly in cases of those still in custody, that in all but the most “traditionally fundamentalist” societies (where it is out of the question for a male to even interview - let alone examine- a woman), it may be much more important to be a physician, to whom the victim may ask precise questions, rather than not being a male, in the cases of rape. Victims of rape have been known not to say anything to non-medical female investigators, but to ask to talk to a physician, even if male, so as to be able to ask specific questions to the medical professional. Typical questions are about possible sequelae, such as being pregnant, being able to conceive later on, about the future of sexual relations between spouses, etc.

7) In the context of evaluations conducted for legal purposes, the necessary attention to details and the precise questioning about history is easily perceived as a sign of mistrust or doubt on the part of the examiner.

Under the aforementioned psychological pressures, survivors may either feel re-traumatized and overwhelmed with memories and affect or mobilize very strong defenses that result in profound withdrawal and affective flattening during examinations or interviews. For the purposes of documentation, it is particularly the withdrawal and flattening that presents difficulties because torture victims may be least able to effectively communicate their history and current suffering when it would be most beneficial for them to do so.

Countertransference reactions are often unconscious. When one is not aware of one’s countertransference, it becomes a problem. Having feelings when listening to individuals speak of their torture is to be expected. Although these feelings can interfere with the clinician’s effectiveness, when understood, they can also guide the clinician. Physicians and psychologists involved in the evaluation and treatment of torture victims agree that attention to and understanding of typical countertransference reactions are crucial because countertransference can have significantly limiting effects on the ability to evaluate and document the physical and psychological consequences of torture. Effective documentation of torture and other forms of ill treatment requires an understanding of personal motivations for working in this area. There is consensus that professionals who continuously conduct this kind of examination should get the supervision and professional support from peers who are experienced in this field. Common countertransference reactions include:

1) Avoidance, withdrawal and defensive indifference in reaction to being exposed to disturbing material. This may lead to forgetting some details and underestimating the severity of physical or psychological consequences.

2) Disillusionment, helplessness, hopelessness and over-identification that may lead to symptoms of depression or "vicarious traumatisation" such as nightmares, anxiety, and fearfulness.

3) Omnipotence and grandiosity in the form of feeling like a savior, the great expert on trauma or the last hope for the survivor’s recovery and well-being.

4) Feelings of insecurity in one’s professional skills in the face of the gravity of the reported history or suffering. This may manifest as a lack of confidence in one’s ability to do justice to the survivor and unrealistic preoccupation with idealized medical norms.

5) Feelings of guilt over not sharing the torture survivor's experience and pain or over the awareness of what has not been done on a political level may result in overly sentimental or idealized approaches to the survivor.

6) Anger and rage toward torturers and persecutors is expectable but may undermine the ability to maintain necessary objectivity when it is driven by unrecognized personal experiences and thus becomes chronic or excessive.

7) Anger or repugnance against the individual may arise as a result of feeling exposed to unaccustomed levels of anxiety. They also may arise as a result of feeling used by the individual when the clinician experiences doubt about the truth of the alleged torture history and the individual stands to benefit from an evaluation that documents the consequences of the alleged history.

8) Significant differences in cultural value systems between the clinician and individual alleging torture may include a belief in myths about ethnic groups, condescending attitudes and underestimation of individuals' sophistication or capacity for insight. Conversely, clinicians who are members of the same ethnic group as victims might form a non-verbalized alliance that can also effect the objectivity of the evaluation.

Most clinicians agree that many countertransference reactions are not merely examples of distortion but may be important sources of information about the psychological state of the torture victim. Clinicians' effectiveness can be compromised when countertransference is acted upon rather than reflected upon. Clinicians engaged in the evaluation and treatment of torture victims are advised to examine countertransference and obtain supervision and consultation from a colleague when necessary.

Circumstances may require that interviews have to be conducted by a clinician from a different cultural and/or linguistic group different from that of the survivor. In such cases, there are two possible approaches. Each has advantages and disadvantages. The interviewer can use literal, word for word translations provided by an interpreter. See Section V.I. Alternatively, the interviewer can utilize a bicultural approach to interviewing. This approach consists of utilizing an interviewing team composed of the investigating clinician and an interpreter who provides linguistic interpretation and facilitates an understanding of cultural meanings attached to events, experiences, symptoms and idioms. Because the clinician will often not recognize relevant cultural, religious, and social factors, a skilled interpreter will be able to point out and explain these issues to the clinician. If the interviewer is relying strictly on literal word for word translations, this type of in depth of information will not be available. On the other hand, if interpreters are expected to point out relevant cultural, religious and social factors to the clinician, it is crucial that they don't attempt to influence in any way the tortured person's responses to the clinician's questions. When literal translation is not used, the clinician needs to be sure that the interviewee's responses, as communicated by the interpreter, represent exclusively what the person said, without additions or deletions by the interpreter. Regardless of the approach, the interpreter's identity and ethnic, cultural, and political affiliation, are important considerations in the choice of an interpreter. The torture victim will have to trust the interpreter to understand what he or she is saying and to communicate it accurately to the investigating clinician. Under no circumstances should the interpreter be a law enforcement official or government employee. For the sake of privacy, a family member should not be used as an interpreter. The investigating team should choose an independent interpreter.

3. Components of the Psychological/Psychiatric Evaluation

3a) Introduction

1) Referral source

2) Summary of collateral sources (such as medical, legal, psychiatric records)

3) Methods of assessment utilized (interviews, symptom inventories and checklists, neuropsychological testing, etc.)

3b) History of torture and ill treatment

1) History of torture (see Sections IV.D.2f and V.F)

2) Persecution

4) Other relevant traumatic experiences

This part of the evaluation is often exhausting for the person being evaluated. Therefore, it may be necessary to proceed in several sessions. One may consider starting with a general summary of the events before eliciting the details of torture experiences. The interviewer needs to know the legal issue at hand because that will determine the nature and amount of information necessary to achieve that legal standard.

3c) Current psychological complaints

The assessment of current psychological functioning constitutes the core of the evaluation. As severely brutalized prisoners of war and rape victims show a lifetime prevalence of PTSD of between 80% and 90%,[112,113] specific questions about the three DSM-IV categories of PTSD (re-experiencing of the traumatic event, avoidance or numbing of responsiveness including amnesia, and increased arousal) need to be asked. Affective, cognitive, and behavioral symptoms should be described in detail, and frequencies as well as examples (of nightmares, hallucinations, startle response, etc.) should be stated. An absence of symptoms can be due to the episodic or often delayed nature of PTSD, or to denial of symptoms because of shame.

3d) Post-torture history

This component of the psychological evaluation obtains information about current life circumstances. It is important to inquire about current sources of stress such as separation or loss of loved ones, flight from one's home country, and life in exile. The interviewer should also inquire about the individual's ability to be productive, earn a living, care for his or her family, and availability of social supports.

3e) Pre-torture history

1) Developmental history: if relevant describe childhood, adolescence, early adulthood

2) Family history: family background, family illnesses, family composition

3) Educational history

4) Occupational history

5) History of past trauma: childhood abuse, war trauma, domestic violence, etc.

6) Cultural and religious background

The summary of pre-trauma history is important to assess mental health status and level of psychosocial functioning of the torture victim prior to the traumatic events. In this way, the interviewer can compare the current mental health status with that of the individual before he or she was tortured.

In evaluating background information the interviewer should keep in mind that the duration and severity of responses to trauma are affected by multiple factors. These factors include, but are not limited to, the following:

1) The circumstances of the torture;

2) The perception and interpretation of torture by the victim;

3) The social context before, during and after torture;

4) Community and peer resources, values and attitudes about traumatic experiences;

[112] Rothbaum, B.O., Foa, E.B., Riggs, D.S., et al. (1992), A prospective examination of post-traumatic stress disorder rape victims. Journal of Traumatic Stress, 5, 455-475

[113] Sutker, P.B., Winstead, D.K., Galina, Z.H.(1991), Cognitive deficits and psycho-pathology among former prisoners of war

5) Political and cultural factors;

6) Severity and duration of the traumatic events;

7) Genetic and biological vulnerabilities;

8) Developmental phase and age of the victim;

9) Prior history of trauma; and

10) Preexisting personality.

In many interview situations, due to time limitations and other problems, it may be difficult to obtain much of the above information. It is important, nonetheless, to obtain enough data about the individual's previous mental health and psychosocial functioning to obtain an impression of the degree to which torture has contributed to psychological problems.

3f) Medical history (see Section VI.C)

The medical history summarizes pre-trauma health conditions, current health conditions, body pain, somatic complaints, use of medication and their side effects, relevant sexual history, past surgical procedures, and other medical data.

3g) Past psychiatric history

One should inquire whether the individual has a past history of mental or psychological disturbances, the nature of the problems, and whether they received treatment or required psychiatric hospitalization. The inquiry also should include prior therapeutic use of psychotropic medications.

3h) Substance use and abuse history

The clinician should inquire about substance use before and after the torture, changes in the pattern of use and abuse, and whether substances are being used to cope with insomnia or psychological/psychiatric problems. These substances not only should include alcohol, cannabis, and opium, but regional substances of abuse such as betel nut and many others.

3i) Mental status examination

The mental status examination begins the moment the clinician meets the subject. The interviewer should make note of the person's appearance (such as signs of malnutrition, lack of cleanliness, etc.), changes in motor activity during the interview, use of language, presence of eye contact, the ability to relate to the interviewer, and means the individual uses to establishes communication. The following list summarizes the components of the examination. All aspects of the mental status examination should be included in the report of the psychological evaluation:

1) General appearance

2) Motor activity

3) Speech

4) Mood and affect

5) Thought content

6) Thought process

7) Suicidal and homicidal ideation

8) Cognitive examination: orientation, long term memory, intermediate recall, and immediate recall.

Trauma and torture can directly and indirectly affect a person's ability to function. Torture also can indirectly cause loss of functioning and disability if the psychological consequences of the experience impair the individual's ability to care for himself or herself, earn a living, support a family, pursue education, etc. The clinician should assess the individual's current level of functioning by inquiring about daily activities, social role function (as housewife, student, worker, etc.), social and recreational activities, and perceptions of health status. One should ask the individual to assess his or her own health condition, to state the presence or absence of feelings of chronic fatigue, and to report potential changes in overall functioning.

3k) Psychological testing and the use of checklists and questionnaires

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

Little published data exist on the use of psychological testing (projective and objective personality tests) in the assessment of torture survivors. Also, psychological tests of personality lack cross-cultural validity. These factors combine to severely limit the utility of psychological testing in the evaluation of torture victims. Neuropsychological testing, however, may be helpful in assessing cases of brain injury resulting from torture. See Section VII.C.4.

3l) Clinical impression

In formulating the clinical impression for the purposes of reporting psychological evidence of torture, there are six important questions to ask:

1) Are the psychological findings consistent with the alleged report of torture?

2) Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?

3) Given the fluctuating course of trauma-related mental disorders over time, what is the timeframe in relation to the torture events? Where in the course of recovery is the individual?

4) What are the coexisting stressors impinging on the individual? (e.g. ongoing persecution, forced migration, exile, loss of family and social role, etc.) What impact do these issues have on the individual?

5) What physical conditions contribute to the clinical picture? Pay special attention to head injury sustained during torture and/or detention.

6) Does the clinical picture suggest a false allegation of torture?

Clinicians should comment on the consistency of psychological findings and the extent to which these findings correlate with the alleged abuse. The emotional state and expression of the person during the interview, his or her symptoms, history of detention and torture, and personal history prior to torture should be described. Factors such as the onset of specific symptoms in relation to the trauma, the specificity of any particular psychological findings, as well as patterns of psychological functioning should be noted. Additional factors such as forced migration, resettlement, difficulties of acculturation, language problems, loss of home, family, social status, as well as unemployment should be considered. The relationship and consistency between events and symptoms should be evaluated and described. Physical conditions such as head trauma or brain injury may require further evaluation. If available, these individuals can be referred for neurological and/or neuropsychological assessment.

If the survivor has symptom levels consistent with a DSM IV or ICD 10 psychiatric diagnosis, the diagnosis should be stated. More than one diagnosis may be present. Again, it must be stressed that even though a diagnosis of a trauma related mental disorder supports the claim of torture, not meeting criteria for a psychiatric diagnosis does not mean the person was not tortured. A survivor of torture may not have the level of symptoms required to fully meet diagnostic criteria for a DSM IV or ICD 10

that he/she claims to have experienced, should be considered as a whole. The degree of consistency between the torture story and the symptoms that the individual reports should be evaluated and included in the report.

It is important to recognize that some people falsely allege torture for a range of reasons, and that others may exaggerate a relatively minor experience for personal or political reasons. The investigator must always be aware of these possibilities and try to identify potential reasons for exaggeration or fabrication. The clinician should keep in mind, however, that such fabrication requires a detailed knowledge about trauma related symptoms that individuals rarely possess. Inconsistencies in testimony can occur for a number of valid reasons such as memory impairment due to brain injury, confusion, dissociation, and cultural differences in perception of time, or fragmentation and repression of traumatic memories. Effective documentation of psychological evidence of torture requires clinicians to have the capacity to evaluate consistencies and inconsistencies in the report. If the interviewer suspects fabrication, additional interviews should be scheduled to help clarify inconsistencies in the report. Family or friends may be able to corroborate details of the history. If the clinician conducts additional examinations and still suspects fabrication, the clinician should refer the individual to another clinician and ask for the colleague's opinion. The suspicion of fabrication should be documented with the opinion of two clinicians.

3m) Recommendations

The recommendations resulting from the psychological evaluation depend on the original question posed at the time the evaluation was requested. The issues under consideration may vary widely. They may concern legal and judicial matters, asylum and/or resettlement, and need for treatment. Recommendations can include further assessment such as neuropsychological testing, medical or psychiatric treatment, and/or need for security or asylum.

4. Neuropsychological Assessment

Clinical neuropsychology is an applied science concerned with the behavioral expression of brain dysfunction. Neuropsychological assessment in particular is concerned with the measurement and classification of the behavioral disturbances associated with organic brain impairment. The discipline has long been recognized as useful in discriminating between neurological and psychological conditions and in guiding treatment and rehabilitation of patients suffering from the consequences of various levels of brain damage. Neuropsychological evaluations of torture survivors are performed infrequently and, to date, there are no neuropsychological studies of torture survivors available in the literature. The following remarks therefore are limited to a discussion of general principles that may guide health providers in understanding the utility of and indications for neuropsychological assessment among subjects suspected of being tortured. Before discussing the issues of utility and indications, it is essential to recognize the limitations of neuropsychological assessment in this population.

4a) Limitations of neuropsychological assessment

There are a number of common factors complicating the assessment of torture survivors in general that are outlined elsewhere in this Manual. These factors apply to neuropsychological assessment in the same way as to a medical or psychological examination. Neuropsychological assessments may be limited by a number of additional factors including: 1) lack of research on torture survivors; 2) reliance on population-based norms; 3) cultural and linguistic differences; and 4) retraumatisation of those who have experienced torture.

1) Lack of research on torture survivors: As mentioned above, very few references exist at present in the literature concerning the neuropsychological assessment of torture victims. The pertinent body of literature concerns various types of head trauma and the neuropsychological assessment of PTSD in general. Therefore, the following discussion and subsequent interpretations of neuropsychological assessments are necessarily based on applying general principals established in other subject populations to torture victims.

2) Reliance on population-based norms: neuropsychological assessment as it has been developed and practiced in Western countries relies heavily on an actuarial approach. This approach typically involves comparing the results of a battery of standardized tests

neuropsychological assessments may be supplemented by a Lurian approach of qualitative analysis,[114,115] particularly when the clinical situation demands it, a reliance on the actuarial approach predominates. Moreover, a reliance on test scores is typically greatest when the severity of the brain impairment is mild to moderate in severity, rather than severe, or when neuropsychological deficits are thought to be secondary to a psychiatric disorder.

3) Cultural and linguistic differences: cultural and linguistic differences may significantly limit the utility and indications for neuropsychological assessments among suspected torture victims. Neuropsychological assessments are of questionable validity when:

   · Standard translations of tests are not available and the clinical examiner is not fluent in the subject's language: Unless standardized translations of tests are available and examiners are fluent in the subject's language, verbal tasks cannot be administered at all or cannot be interpreted in a meaningful way. This means that only nonverbal tests may be used, and precludes comparisons between verbal and nonverbal faculties. In addition, an analysis of the lateralization (or localization) of deficits would be more difficult. Such analysis is often useful because of the brain's asymmetrical organization, with the left hemisphere typically being dominant for speech.

   · Population-based norms are not available for the subject's cultural and linguistic group: An estimate of IQ is one of the central benchmarks that allow examiners to place neuropsychological test scores into proper perspective. Within the U.S. population, for example, such estimates are often derived from verbal subtests of the Wechsler scales, particularly the Information subscale because in the presence of organic brain impairment, acquired factual knowledge is less likely to suffer deterioration than many other tasks and be representative of past learning ability than other measures. It may also be based on educational and work history and demographic data. Obviously, neither one of these two considerations apply to subjects for whom population-based norms have not been established. Therefore, only very coarse estimates concerning pre-trauma intellectual functioning can be made. As a result, neuropsychological impairment that is anything less than severe or moderate may be difficult to interpret.

4) Retraumatisation: neuropsychological assessments may retraumatize those who have experienced torture. Great care must be taken in order to minimize any potential retraumatisation of the subject in any form of diagnostic procedure. See Section V.I. To cite only one obvious example specific to neuropsychological testing, it would be potentially very damaging to proceed with a standard administration of the Halstead-Reitan Battery, in particular the Tactual Performance Test (TPT), and routinely blindfold the subject. For most torture victims who have experienced blindfolding during detention and torture, and even for those who were not blindfolded, it would be very traumatic to introduce the experience of helplessness inherent in this procedure. In fact, any form of neuropsychological testing in itself may be problematic, regardless of the particular instrument used. Being asked to give maximum effort on an unfamiliar task, being observed and timed with a stop watch, and in general being asked to perform rather than having a dialogue, may prove to be too stressful or reminiscent of a torture experience.

4b) Indications for neuropsychological assessment

In evaluating behavioral deficits in suspected torture victims there are two primary indications for neuropsychological assessment: 1) brain injury and 2) posttraumatic stress disorder and related diagnoses. While both sets of conditions have areas of overlap and will often coincide, it is only the former that is a typical and traditional application of clinical neuropsychology, whereas the latter is relatively new, not well researched and rather problematic (see below).

1) Brain Injury

[114] Luria, A.R. & Majovski, L.V. (1977). Basic approaches used in American and Soviet clinical neuropsychology. ***American Psychologist***, ***32*** (11), 959-968.

- Causes: brain injury and resulting brain damage may result from various types of head trauma and metabolic disturbances that can be inflicted during periods of persecution, detention and torture. This may include gunshot wounds, effects of poisoning and malnutrition as a result of starvation or forced ingestion of harmful substances, effects of hypoxia or anoxia resulting from asphyxiation and near drowning, and most commonly from blows to the head suffered during beatings. Blows to the head are frequently encountered during periods of detention and torture. For example, in one sample of torture survivors, blows to the head were the second most frequently cited form of bodily abuse (45%) behind blows to the body (58%).[116] Thus the potential for resulting brain damage must be considered high among torture victims.

- Assessment: closed head injuries resulting in mild to moderate levels of long-term impairment are perhaps the most commonly assessed cause of neuropsychological abnormality. Signs of injury may include scars on the head, but brain lesions typically can not be detected by diagnostic imaging of the brain. Mild to moderate levels of brain damage might be overlooked or underestimated by treating mental health professionals because symptoms of depression and Posttraumatic stress are likely to figure prominently in the clinical picture, resulting in less attention being paid to the potential effect of head trauma. Commonly, the subjective complaints of survivors include difficulties with attention, concentration and short term memory, which can be either the result of brain impairment or PTSD. Since the aforementioned complaints are so common in survivors suffering from PTSD, the question whether they are actually due to head injury may not even be asked.

- Differential diagnosis: the diagnostician must rely, in an initial phase of examination, on reported history of head trauma and the course of symptomatology. As is usually the case with brain injured subjects, information from third parties, particularly relatives might prove most helpful. It must be remembered that brain injured subjects often have great difficulty articulating or even appreciating their limitations because they are, so to speak, “inside” the problem. In gathering first impressions regarding the difference between organic brain impairment and PTSD, an assessment concerning the chronicity of symptoms is a helpful staring point. If symptoms of poor attention, concentration and memory are observed to fluctuate over time and to co-vary with levels of anxiety and depression, this is more likely due to the phasic nature of PTSD. On the other hand, if impairment seems to appear chronic, lack fluctuation and when complaints and observations in that regard are offered by family members, the possibility of brain impairment should be entertained, even in the initial absence of a clear history of head trauma.

- Neurological evaluation and referral: once there is a suspicion of organic brain impairment, the first step for the mental health professional is to consider a referral to a physician for further neurological examination. Depending on initial findings, the physician may then consult a neurologist and/or order diagnostic tests. An extensive medical work-up, specific neurological consultation and neuropsychological evaluation are among the possibilities to be considered. The use of neuropsychological evaluation procedures are usually indicated if: 1) there is a lack of gross neurological disturbance, 2) reported symptoms are predominantly cognitive in nature, or 3) a differential diagnosis between brain impairment and PTSD has to be made.

- Test selection: the selection of neuropsychological tests and procedures is subject to the limitations specified above and therefore can not follow a standard battery format, but rather be case-specific and sensitive to individual characteristics. The flexibility required in the selection of tests and procedures demands considerable experience, knowledge and caution on the part of the examiner. As was pointed out above, the range of instruments to be used will often be limited to non-verbal tasks and the psychometric characteristics of any standardized tests will most likely suffer when population-based norms do not apply to an individual subject. The absence of verbal measures represents a very serious limitation. Many areas of cognitive functioning

[116] Traue, H.C., Schwarz-Langer, G. & Gurris, N.F. (1997). Extremtraumatisierung durch Folter. Die psychotherapeutische

are mediated through language and systematic comparisons between various verbal and nonverbal measures are typically used in order to arrive at conclusions regarding the nature of deficits.

What complicates matters further, is the fact there is evidence that significant intergroup differences have been found in the performances on nonverbal tasks between relatively closely related cultures. For example, Jacobs et al.[117] compared the performance of randomly selected, community based samples of 118 English and 118 Spanish speaking elders on a brief neuropsychological test battery. The samples were randomly selected and demographically matched. Yet, while scores on verbal measures were similar, the Spanish speaking subjects scored significantly lower on almost all of the nonverbal measures. These results suggest that caution is warranted when using nonverbal as well as verbal measures to assess non-English speaking individuals when tests are normed on English speaking subjects.

The choice of instruments and procedures in neuropsychological assessment among suspected torture victims must be left to the individual clinician who will have to select according to the demands and possibilities of the situation. Neuropsychological tests cannot be used properly without extensive training and knowledge in brain-behavior relations. Comprehensive lists of neuropsychological procedures and tests and their proper application can be found in standard references.[118]

2) Posttraumatic stress disorder (PTSD)

- PTSD and Neuropsychological Impairment: the considerations offered above should make it clear that great caution is needed when attempting neuropsychological assessment of brain impairment in suspected torture victims. This must be even more strongly the case in attempting to document PTSD in suspected survivors through neuropsychological assessment. Even in the case of assessing PTSD subjects for whom population-based norms are available, there are considerable difficulties to consider. PTSD is a psychiatric disorder and traditionally has not been the focus of neuropsychological assessment. Furthermore, PTSD does not conform to the classical paradigm of an analysis of identifiable brain lesions that can be confirmed by medical techniques. With an increased emphasis on and understanding of the biological mechanisms involved in psychiatric disorders generally, neuropsychological paradigms have been invoked more frequently than in the past. However, as Knight points out, "…comparatively little has been written to date on PTSD from a neuropsychological perspective."[119]

  There is great variability among the samples used for the study of neuropsychological measures in posttraumatic stress. This may account for the variability of the cognitive problems reported from these studies. As Knight points out, "clinical observations suggest that PTSD symptoms show the most overlap with the neurocognitive domains of attention, memory and executive functioning." This is consistent with complaints heard frequently from survivors of torture. Subjects complain of difficulties in concentrating, of feeling unable to retain information and in engaging in planned, goal-directed activity.

- Distinguishing PTSD from other disorders: neuropsychological assessment methods appear able to identify the presence of neurocognitive deficits in PTSD, even though the specificity of these deficits is more difficult to establish. Some studies have documented the presence of deficits in PTSD subjects when compared to normal controls but failed to discriminate these subjects from matched psychiatric controls.[120,121] In other words, it is likely that neurocognitive deficits on test performances will be evident in cases of PTSD but insufficient for diagnosing PTSD.

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[117] Jacobs, D.M., Sano, M, Albert, S., Schofield, P. et al (1997). Cross-cultural neuropsychological assessment: A comparison of randomly selected, demographically matched cohorts of English- and Spanish-speaking older adults. ***Journal of Clinical and Experimental Neuropsychology, 19*** (3), 331-339.

[118] Spreen, O. & Strauss, E.: ***A Compendium of Neuropsychological Tests.*** NY, NY: Oxford University Press.

[119] Knight, J.A. (1997). Neuropsychological Assessment in Post-traumatic Stress Disorder, in Wilson, J.P. & Keane, T.M. (Eds.) ***Assessing Psychological Trauma and PTSD.*** NY, NY: Guilford.

[120] Dalton, J.E., Pederson, S.L., & Ryan, J.J. (1989). Effects of Post-traumatic stress disorder on neuropsychological test performance. ***International Journal of Clinical Neuropsychology, 11*** (3), 121-124.

As in many other types of assessment, interpretation of test results must be integrated into a larger context of interview information and possibly personality testing. In that sense, specific neuropsychological assessment methods can make a contribution to the documentation of PTSD in the same manner that they may do so for other psychiatric disorders associated with known neurocognitive deficits.

4c) Conclusion

Despite significant limitations, neuropsychological assessment may be useful in evaluating individuals suspected of having brain injury and in distinguishing brain injury from PTSD. Neuropsychological assessment also, may be used to evaluate specific symptoms, such as problems with memory that occur in PTSD and related disorders.

5. Children and Torture

5a) Introduction

Torture can impact a child directly or indirectly. The impact can be due to the child's having been tortured or detained, the torture of his/her parents or close family member, or witnessing torture and violence. When individuals in a child's environment are tortured, the torture will inevitably have an impact on the child, albeit indirect, because torture affects the entire family and community of torture victims. A complete discussion of the psychological impact of torture on children and complete guidelines for conducting an evaluation of a child who has been tortured is beyond the scope of this Manual. Nevertheless, several important points can be summarized.

First, when evaluating a child who is suspected of having undergone or witnessed torture, the clinician must make sure that the child receives support from caring individuals and that he/she feels secure during the evaluation. This may require a parent or trusted care provider be present during the evaluation. Second, the clinician must keep in mind that children often do not express their thoughts and emotions regarding trauma verbally, but rather behaviorally.[122] The degree to which children are able to verbalize thought and affect depends on the child's age and developmental level as well as on other factors such as family dynamics, personality characteristics, and cultural norms.

If a child has been physically or sexually assaulted it is important, if at all possible, for the child to be seen by an expert in child abuse. Genital examination of children, likely to be experienced as traumatic, should be performed by clinicians experienced in interpreting the findings. Sometimes it is appropriate to videotape the examination so that other experts can give opinions on the physical findings without the child having to be examined again. It may not be appropriate to perform a full genital or anal examination without a general anaesthetic. Furthermore, the examiner should be aware that the examination itself may be reminiscent of the assault and it is possible that the child may make a spontaneous outcry or psychologically decompensate during the examination.

5b) Developmental Considerations

A child's reactions to torture depend on age, developmental stage and cognitive skills. The younger the child, the more his/her experience and understanding of the traumatic event is influenced by the immediate reactions and attitudes of caregivers following the event.[123] For children under the age of three who have experienced or witnessed torture, the protective and reassuring role of their caregivers is crucial.[124] Very young children's reactions to traumatic experiences typically involve hyperarousal, such as restlessness, sleep disturbance, irritability, heightened startle reactions and avoidance. Children over three often tend to withdraw and refuse to speak directly about traumatic experiences. The ability for verbal expression increases during development. A marked increase occurs around the concrete operational stage (8-9 years old) when children develop the ability to provide a reliable chronology of events. During this stage, concrete operations and temporal and spatial capacities develop.[125] These new skills are still fragile and it is usually not until the beginning of the formal operational stage (12 years old) that children are consistently able to construct a coherent narrative. Adolescence is a turbulent developmental period. The effects of torture can vary

[122] Schlar, C. (1999). Evaluation and documentation of psychological evidence of torture (unpublished paper).
[123] von Overbeck Ottino, S. (1998). Familles victimes de violences collectives et en exil: Quelle urgence, quel modèle de soins? Le point de vue d'une pédopsychiatre. ***La Revue Française de Psychiatrie et de Psychologie Médicale***, 14, 35-39.
[124] Grappe, M. (1995). La guerre en ex-Yougoslavie: un regard sur les enfants réfugiés. In M.R. Moro et S. Lebovici (Eds.), ***Psychiatrie humanitaire en ex-Yougoslavie et en Armenie, Face au traumatisme***. PUF, Paris.

widely. Torture experiences may cause profound personality changes in adolescents resulting in antisocial behavior.[126] Alternatively, the effects of torture on adolescents may be similar to those seen in younger children.

5c) Clinical Considerations

Symptoms of posttraumatic stress disorder may appear in children. The symptoms can be similar to those observed in adults,[127,128,129,130] but the clinician must rely more heavily on observations of the child's behavior than on verbal expression. For example, the child may demonstrate symptoms of re-experiencing as manifested by monotonous, repetitive play representing aspects of the traumatic event, visual memories of the events in and out of play, repeated questions or declarations about the traumatic event, and nightmares. The child may develop bedwetting, loss of control of bowel movements, social withdrawal, restricted affect, attitude changes toward self and others, and feelings that there is no future. He/she may experience hyperarousal and have night terrors, problems going to bed, sleep disturbance, heightened startle response, irritability, and significant disturbances in attention and concentration. Fears and aggressive behavior that were non-existent before the traumatic event may appear such as aggressiveness toward peers, adults or animals, fear of the dark, fear of going to the toilet alone, and phobias. The child may demonstrate sexual behavior that is inappropriate for age, and somatic reactions. Anxiety symptoms may appear such as exaggerated fear of strangers, separation anxiety, panic, agitation, temper tantrums and uncontrolled crying. The child also may develop eating problems.

5d) Role of the Family

The family plays an important dynamic role in persisting symptomatology among children. In order to preserve cohesion in the family, dysfunctional behaviors and delegation of roles may occur. Family members, often children, can be assigned the role of patient and develop severe disorders. A child may be overly protected or important facts about the trauma may be hidden. Alternatively, the child can be parentified and expected to care for the parents.

When the child is not the direct victim of torture but only affected indirectly, adults often tend to underestimate the impact on child's psyche and development. When loved ones around a child have been persecuted, raped and tortured or the child has witnessed severe trauma or torture, he/she may develop dysfunctional beliefs such as that he/she is responsible for the bad events or that he/she has to bear the parent's burdens. These types of beliefs can lead to long term problems with guilt, loyalty conflicts, personal development and maturing into an independent adult.

[126] Grappe, M. (1995). La guerre en ex-Yougoslavie: un regard sur les enfants réfugiés. In M.R. Moro et S. Lebovici (Eds), ***Psychiatrie humanitaire en ex-Yougoslavie et en Armenie. Face au traumatisme***. PUF, Paris.
[127] Terr, L. C. (1991). "Childhood traumas. An outline and overview." ***American Journal of Psychiatry*** 148, 10-20.
[128] Zero to Three. National Center for Infants, Toddlers and Families. (1994).
[129] Sironi, F. (1995). "On torture un enfant, ou les avatars de l'ethnocentrisme psychologique. ***Enfances***, 4, 205-215.

APPENDIX I

PRINCIPLES ON THE EFFECTIVE INVESTIGATION AND DOCUMENTATION OF TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

1) The purposes of effective investigation and documentation of torture and other cruel, inhuman or degrading treatment (hereafter torture or other ill treatment) include the following:

(i) clarification of the facts and establishment and acknowledgment of individual and State responsibility for victims and their families;

(ii) identification of measures needed to prevent recurrence;

(iii) facilitating prosecution and/or, as appropriate, disciplinary sanctions for those indicated by the investigation as being responsible, and demonstrating the need for full reparation and redress from the State, including fair and adequate financial compensation and provision of the means for medical care and rehabilitation.

2) States shall ensure that complaints and reports of torture or ill treatment shall be promptly and effectively investigated. Even in the absence of an express complaint, an investigation should be undertaken if there are other indications that torture or ill treatment might have occurred. The investigators, who shall be independent of the suspected perpetrators and the agency they serve, shall be competent and impartial. They shall have access to, or be empowered to commission investigations by impartial medical or other experts. The methods used to carry out such investigations shall meet the highest professional standards, and the findings shall be made public.

3a) The investigative authority shall have the power and obligation to obtain all the information necessary to the inquiry.[131] These persons conducting the investigation shall have at their disposal all the necessary budgetary and technical resources for effective investigation. They shall also have the authority to oblige all those acting in an official capacity allegedly involved in torture or ill treatment to appear and testify. The same shall apply to any witness. To this end, the investigative authority shall be entitled to issue summonses to witnesses, including any officials allegedly involved, and to demand the production of evidence.

3b) Alleged victims of torture or ill treatment, witnesses, those conducting the investigation and their families shall be protected from violence, threats of violence or any other form of intimidation that may arise pursuant to the investigation. Those potentially implicated in torture or ill treatment shall be removed from any position of control or power, whether direct or indirect, over complainants, witnesses and their families, as well as those conducting the investigation.

4) Alleged victims of torture or ill treatment and their legal representatives shall be informed of, and have access to, any hearing as well as to all information relevant to the investigation, and shall be entitled to present other evidence.

5a) In cases in which the established investigative procedures are inadequate because of insufficient expertise or suspected bias, or because of the apparent existence of a pattern of abuse, or for other substantial reasons, States shall ensure that investigations are undertaken through an independent commission of inquiry or similar procedure. Members of such a commission shall be chosen for their recognized impartiality, competence and independence as individuals. In particular, they shall be independent of any suspected perpetrators and the institutions or agencies they may serve. The commission shall have the authority to obtain all information necessary to the inquiry and shall conduct the inquiry as provided for under these Principles.[132]

5b) A written report, made within a reasonable time, shall include the scope of the inquiry, procedures and methods used to evaluate evidence as well as conclusions and recommendations based on findings of fact and on applicable law. On completion, this report shall be made public. It shall also describe in detail specific events that were found to have occurred, the evidence upon which such findings were based, and list the names of witnesses who testified with the exception of those whose identities have been withheld

[131]Under certain circumstances professional ethics may require information to be kept confidential. These requirements should be respected.

for their own protection. The State shall, within a reasonable period of time, reply to the report of the investigation, and, as appropriate, indicate steps to be taken in response.

6a) Medical experts involved in the investigation of torture or ill treatment should behave at all times in conformity with the highest ethical standards and in particular shall obtain informed consent before any examination is undertaken. The examination must conform to established standards of medical practice. In particular, examinations shall be conducted in private under the control of the medical expert and outside the presence of security agents and other government officials.

6b) The medical expert should promptly prepare an accurate written report. This report should include at least the following:

(vi) Circumstances of the interview: name of the subject and name affiliation of those present at the examination; the exact time and date, location, nature and address of the institution (including, where appropriate, the room) where the examination is being conducted (e.g. detention centre, clinic, house, etc.); and the circumstances of the subject at the time of the examination (e.g. nature of any restraints on arrival or during the examination, presence of security forces during the examination, demeanour of those accompanying the prisoner, threatening statements to the examiner, etc.); and any other relevant factor;

(vii) History: a detailed record of the subject's story as given during the interview, including alleged methods of torture or ill treatment, the times when torture or ill treatment is alleged to have occurred and all complaints of physical and psychological symptoms;

(viii) Physical and psychological examination: a record of all physical and psychological findings on clinical examination including, appropriate diagnostic tests and, where possible, colour photographs or all injuries;

(ix) Opinion: an interpretation as to the probable relationship of the physical and psychological findings to possible torture or ill treatment. A recommendation for any necessary medical and psychological treatment and/or further examination should be given;

(x) Authorship: the report should clearly identify those carrying out the examination and should be signed.

6c) The report should be confidential and communicated to the subject or his or her nominated representative. The views of the subject and his or her representative about the examination process should be solicited and recorded in the report. It should also be provided in writing, where appropriate, to the authority responsible for investigating the allegation of torture or ill treatment. It is the responsibility of the State to ensure that it is delivered securely to these persons. The report should not be made available to any other person, except with the consent of the subject or on the authorization of a court empowered to enforce such transfer.

APPENDIX II
DIAGNOSTIC TESTS

See also Section VI.F. Diagnostic tests are being developed and tested all the time. Those following were considered to be of value at the time of writing this Manual. However, where there is a requirement for additional supporting evidence, investigators should attempt to find up to date sources of information, for example by approaching one of the specialised centres for the documentation of torture.

1. Radiologic Imaging

In the acute phase of injury, various imaging modalities may be quite useful in providing additional documentation of both skeletal and soft tissue injuries. Once the physical injuries of torture have healed, however, the residual sequelae generally are no longer detectable by these same imaging methods. This is often true even when the survivor continues to suffer significant pain or disability from his or her injuries.

Reference has already been made to various radiologic studies in the discussion of the examination of the patient or in the context of various forms of torture. What follows is a summary of the application of these methods, recognizing that the more sophisticated (and expensive) technology is not universally available, or at least not to the person in custody.

Radiologic and imaging diagnostic examinations include routine radiographs (x-rays), radioisotopic scintigraphy, computerized tomography (CT), nuclear magnetic resonance imaging (MRI), and ultrasonography (USG). Each has advantages and disadvantages. X-rays, scintigraphy, and CT scanning use ionizing radiation, which may be a concern in pregnant women and children. MRI uses a magnetic field; potential biologic effects on fetuses and children are theoretical, but thought to be minimal. Ultrasound uses sound waves; no biologic risk is known.

X-rays are readily available. Excluding the skull, all injured areas should have routine radiographs as the initial examination. While routine radiographs will demonstrate facial fractures, CT is a superior examination as it demonstrates more fractures, fragment displacement, and associated soft tissue injury and complications. When periosteal damage or minimal fractures are suspected, bone scintigraphy should be used in addition to x-rays.

A percentage of x-rays will be negative even when there is an acute fracture or early osteomyelitis. It is possible for a fracture to heal leaving no radiographic evidence of previous injury; this is especially true in children.

Routine radiographs are not the ideal examination for evaluation of soft tissues.

Scintigraphy is an examination of high sensitivity but low specificity. Scintigraphy is an economic and effective examination to screen the entire skeleton for disease processes such as osteomyelitis or trauma. Testicular torsion can also be evaluated but ultrasound is better suited to this task. Scintigraphy is not the examination to identify soft tissue trauma.

Scintigraphy can detect an acute fracture within twenty-four hours, but generally it takes two to three days and may occasionally take a week or more, particularly in the elderly. Generally the scan returns to normal after two years. However, it may remain positive in both fractures and cured osteomyelitis for years. The use of bone scintigraphy to detect fractures at the epiphysis or metadiaphysis (ends of long bones) in children is very difficult because of the normal uptake of the radiopharmaceutical at the epiphysis. Scintigraphy is often able to detect rib fractures that are not apparent on routine x-ray films.

a) Application of Bone Scintigraphy to the Diagnosis of ***Falanga***:

Bone scans may be performed either with delayed images at about three hours or as a three-phase examination. The three phases are: 1) radionucleide angiogram (arterial phase) 2) blood pool images (venous phase, which is soft tissue), and 3) delayed phase (bone phase). Patients examined soon after ***falanga*** should have two bone scans performed at one-week intervals. A negative first delayed scan and positive second scan, indicates exposure to ***falanga*** within days before the first scan. In acute cases, two negative bone scans at an interval of 1 week do not necessarily mean that ***falanga*** did not occur, but that the severity of the ***falanga*** applied was under the sensitivity level of the

angiogram phase and in blood pool images and no increase uptake in the bone phase would indicate hyperemia compatible with soft tissue injury. Trauma in the foot bones and soft tissue can also be detected with MRI.[133]

b) Ultrasound

Ultrasound is inexpensive and is without biological hazard. The quality of the examination depends on the skill of the operator. In parts of the world where CT is not available, USG is used to evaluate acute abdominal trauma. Tendonopathy can also be evaluated by USG, and it is a method of choice for testicular abnormalities.

Shoulder USG is carried out in acute and chronic periods following suspension torture. In the acute period, edema, fluid collection on and around the shoulder joint, lacerations and hematomas of the rotator cuffs can be observed by USG. Reapplication of USG and observing that such findings in acute period disappear in time, strengthen the diagnosis. In such cases, EMG, scintigraphy and other radiological examinations should be carried out together and their correlation should be examined. Even lacking positive results from other examinations, USG findings alone are adequate to prove suspension torture.

c) CT scans

CT is excellent for imaging both soft tissue and bone. MRI is better for soft tissue than bone. However, MRI may detect an occult fracture before it can be imaged by either routine radiographs or scintigraphy. Use of open scanners and/or sedation may alleviate anxiety and claustrophobia that are especially prevalent among torture survivors.

CT is also excellent for diagnosing and evaluating fractures, especially temporal bone and facial bones. Other advantages determining include alignment and displacement of fragments especially spinal, pelvic, shoulder and acetabular fractures. CT cannot identify bone bruising.

CT with and without intravenous infusion of a contrast agent should be the initial examination for acute, subacute, and chronic central nervous system (CNS) lesions. If the CT examination is negative, equivocal, or does not explain the survivor's CNS complaints or symptoms, proceed to MRI.

CT with bone windows and a pre- and post-contrast examination should be the initial examination for temporal bone fractures. Bone windows may demonstrate fractures and ossicular disruption. The pre-contrast examination may demonstrate fluid and cholesteatoma. Contrast is recommended because of the common vascular anomalies that occur in this area. For rhinorrhea, injection of contrast into the spinal canal should follow a temporal bone. MRI may also demonstrate the tear responsible for the leakage of fluid.

When rhinorrhea is suspected, a CT of the face with soft tissue and bone windows should be performed. Then, a CT should be obtained after contrast is injected into the spinal canal.

d) MRI:

MRI is more sensitive than CT in detecting central nervous system (CNS) abnormalities. The time course of CNS hemorrhage is divided into immediate, hyperacute, acute, subacute, and chronic phases. The time course of CNS hemorrhage has ranges that correlate with imaging characteristics of the hemorrhage. Thus, the imaging findings may allow estimation of the timing of head injury and correlation to alleged incidents. CNS hemorrhage may completely resolve or produce sufficient hemosiderin deposits that the CT scan will be positive even years later. Hemorrhage in soft tissue, especially in muscle, usually completely resolves leaving no trace, but rarely can ossify. This is called heterotrophic bone formation or myositis ossificans and is detectable on CT scan.

2. Biopsy of Electric Shock Injury

Electric shock injuries may, but do not necessarily, exhibit microscopic changes that are highly diagnostic and specific for electric current trauma. The absence of these specific changes in a biopsy specimen does not mitigate against a diagnosis of electric shock torture, and judicial authorities must not be permitted to make such an assumption. Unfortunately, if a court requests that a petitioner

alleging electric shock torture submit to a biopsy for confirmation of the allegations, refusal to consent to the procedure, or a "negative" result is bound to have a prejudicial impact upon the court. Furthermore, clinical experience with biopsy diagnosis of torture-related electrical injury is limited, and the diagnosis can usually be made with confidence from the history and physical examination alone.

This procedure is therefore one that should currently be done in a clinical research setting, and not promoted as a diagnostic standard. In giving informed consent for biopsy, the person must be informed of the uncertainty of the results, and permitted to weigh the potential benefit against the impact upon an already traumatized psyche.

a) Rationale for biopsy:

There has been extensive laboratory research measuring the effects of electric shocks on the skin of anesthetized pigs.[134,135,136,137,138,139] This work has shown that there are histologic findings specific for electrical injury that can be established by microscopic examination of punch biopsies of the lesions. However, further discussion of this research, which may have significant clinical application, is beyond the scope of this publication. The reader is referred to the above cited references for further information

Few cases of electric shock torture of humans have been studied histologically.[140,141,142,143] Only in one case, where lesions were excised probably 7 days after the injury, were alterations in the skin believed to be diagnostic of electrical injuries observed (deposition of calcium salts on dermal fibers in viable tissue located around necrotic tissue). Lesions excised a few days after alleged electrical torture in other cases have shown segmental changes and deposits of calcium salts on cellular structures highly consistent with influence of an electrical current, but not diagnostic since deposits of calcium salts on dermal fibers were not observed. A biopsy taken one month after alleged electrical torture showed a conical scar, 1-2 mm broad, with increased number of fibroblasts and tightly packed, thin collagen fibers, arranged parallel to the surface, consistent with but not diagnostic of electrical injury.

b) Method:

After receiving informed consent from the patient, and before biopsy, the lesion must be photographed according to accepted forensic methods. Under local anesthesia, a 3-4 mm punch biopsy is obtained, and placed in buffered formalin or similar fixative. Skin biopsy should be performed as soon as possible after injury. Since electrical trauma is usually confined to the epidermis and superficial dermis, the lesions may quickly disappear. Biopsies can be taken from more than one lesion, but the potential distress to the patient must be considered.[144]

Biopsy material should be examined by a pathologist experienced in dermatopathology.

c) Diagnostic findings for electrical injury:

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[134] Thomsen, H.K., Danielsen, L., Nielsen, O., Aalund, O., Nielsen, K.G., Karlsmark, T., Genefke, I.K. Early epidermal changes in heat- and electrically injured pig skin I. A light microscopic study, Forensic Sci Int. 1981;17:133-43.

[135] Thomsen, H.K., Danielsen, L., Nielsen, O., Aalund, O., Nielsen K.G., Karlsmark, T., Genefke, I.K., Christoffersen, P. The effect of direct current, sodium hydroxide, and hydrochloric acid on pig epidermis. A light microscopic and electron microscopic study. Acta path microbiol. immunol. scand Sect A 1983; 91:307-16.

[136] Thomsen, H.K. Electrically induced epidermal changes. A morphological study of porcine skin after transfer of low-moderate amounts of electrical energy (Dissertation), University of Copenhagen: F.A.D.L. 1984, 1-78.

[137] Karlsmark, T., Danielsen, L. Thomsen, H.K., Aalund O., Nielsen, K.G., Johnson, E., Genefke, I.K., Tracing the use of torture: Electrically induced calcification of collagen in pig skin: Nature 1983; 301:75-78.

[138] Karlsmark, T., Danielsen, L., Aalund, O., Thomsen, H.K., Nielsen, O., Nielsen, K.G., Lyon, H., Ammitsbøll, T., Møller, R., Genefke, I.K.: Electrically-induced collagen calcification in pig skin. A histopathologic and histochemical study. Forensic Science International 1988; 39: 163-74.

[139] Karlsmark, T.: Electrically induced dermal changes. A morphological study of porcine skin after transfer of low to moderate amounts of electrical energy (Dissertation)University of Copenhagen, Dan. Med Bull 1990;37:507-20.

[140] Danielsen, L., Karlsmark, T, Thomsen, H.K., Thomsen, J.L. Balding, L.E. Diagnosis of electrical skin injuries. A review and a description of a case. Am. J. Forensic Med Pathol 1991;12:222-6.

[141] Öztop, F., Lök, V., Baykal, T., Tunca, M. Signs of electrical torture on the skin, in: Human Rights Foundation of Turkey, Treatment and Rehabilitation Centers Report 1994, HRFT Publication 11:97-104.

[142] Danielsen, L., Karlsmark, T., Thomsen, H.K. Diagnosis of skin lesions following electrical torture. Rom J. Leg. Med. 1997; 5:15-20.

[143] Jacobsen, H.: Electrically induced deposition of metal on the human skin. Forensic Sci Int 1997; 90:85-92.

[144] Gürpinar S, Korur Fincancı _, Insan Hakları Ihlalları ve Hekim Sorumlulu_u (Human Rights Violations and Responsibility of the Physician). In Birinci Basamak cin Adlı Tıp El Kitabı (Handbook of Forensic Medicine for General Practitioners). Turkish Medical

1. Vesicular nuclei in epidermis, sweat glands and vessel walls (only one differential diagnosis: injuries via basic solutions)
2. Deposits of calcium salts distinctly located on collagen and elastic fibers (the differential diagnosis, calcinosis cutis, is a rare disorder only found in 75 of 220.000 consecutive human skin biopsies, and the calcium deposits are usually massive without distinct location on collagen and elastic fibers.[145]

d) Typical (but not diagnostic) findings for electrical injury:

1. Lesions appearing in conical segments, often 1-2 mm large
2. Deposits of iron or copper on epidermis (from the electrode)
3. Homogenous cytoplasm in epidermis, sweat glands and vessel walls
4. Deposits of calcium salts on cellular structures in segmental lesions
5. No abnormal histologic observations

APPENDIX III
ANATOMICAL DRAWINGS FOR DOCUMENTATION OF TORTURE AND ILL TREATMENT

APPENDIX IV
GUIDELINES FOR MEDICAL EVALUATIONS
OF TORTURE AND ILL TREATMENT

The following guidelines are based on the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol). These guidelines are not intended as a fixed protocol. Rather, they should be applied with due consideration to the purpose of an individual evaluation and a reasonable assessment of available resources.

NOTE: assessments of physical and psychological evidence of torture and ill treatment may be conducted by one or more clinicians depending on their qualifications.

I. Case Information

Date of Evaluation:…… Exam. Requested By (Name/Position):……
Case ID/Report #: …… Duration of Evaluation: ……Hours, ……Minutes
Subject's Given Name:…… Birth Date:……; Birth Place……
Subject's Family Name:……Gender: female / male
Reason for Exam:…… Subject's ID#:……

Clinician's Name:…….. Interpreter Yes/No: Name:……
Informed Consent: Yes/No If "No," Provide Reason:……

Subject Accompanied By (Name/Position):……
Person(s) Present During Examination (Name/Position):……
Subject Restrained During Exam: Yes/No; If "Yes," How/Why?.....
Medical Report Transferred to (Name/Position/ID#):……
Transfer Date: .....; Transfer Time: .....
Medical Evaluation/Investigation Conducted without Restriction ***(For Subjects in Custody)***:
Yes/No
Provide Details of Any
Restrictions:……..

II. Clinician's Qualifications *(For Judicial Testimonies)*

1. Medical Education and Clinical Training
2. Psychological/Psychiatric Training
3. Experience in Documenting Evidence of Torture and Ill Treatment
4. Regional Human Rights Expertise Relevant to the Investigation
5. Relevant Publications, Presentations and Training Courses
6. Provide ***Curriculum Vitae***

III. Statement Regarding Veracity of Testimony (*For Judicial Testimonies*): For example: "I personally know the facts recited below, except as to those stated on information and belief, which I believe to be true. I would be prepared to testify to the above statements based on my personal knowledge and belief."

IV. Background Information:

1. General Information: (age, occupation, education, family composition, etc.)
2. Past Medical History
3. Review of Prior Medical Evaluations of Torture and Ill Treatment:
4. Psychosocial History Pre-Arrest

V. Allegations of Torture and Ill Treatment:

1. Summary of Detention(s) and Abuse
2. Circumstances of Arrest and Detention
3. Initial and Subsequent Places of Detention: (chronology, transportation, and detention conditions)
4. Narrative Account of Ill Treatment of Torture: (in each place of detention)
5. Review of Torture Methods

VI. Physical Symptoms and Disabilities: Describe the development of acute and chronic symptoms and disabilities and the subsequent healing processes.

1. Acute Symptoms and Disabilities
2. Chronic Symptoms and Disabilities

VII. Physical Examination

1. General Appearance
2. Skin
3. Face/Head
4. Eyes/Ears/Nose/Throat
5. Oral Cavity/Teeth
6. Chest/Abdomen (including vital signs)
7. Genitourinary System
8. Musculoskeletal System
9. Nervous System (Central and Peripheral)

VIII. Psychological History/Examination:

1. Methods of Assessment
2. Current Psychological Complaints
3. Post-Torture History
4. Pre-Torture History
5. Past Psychological/Psychiatric History
6. Substance Use and Abuse History
7. Mental Status Examination
8. Assessment of Social Functioning
9. [Psychological Testing: See Section VII.C.3k for indications and limitations]
10. [Neuropsychological Testing: See Section VII.C.4 for indication and limitations]

IX. Photographs

X. Diagnostic Test Results (see Appendix II for indications and limitations)

XI. Consultations

XII. Interpretation of Findings

1. Physical Evidence:

A. Correlate the degree of consistency between the history of acute and chronic physical symptoms and disabilities with allegations of abuse.
B. Correlate the degree of consistency between physical examination findings and allegations of abuse. (Note: the absence of physical findings does not exclude the possibility that that torture or ill treatment was inflicted.)
C. Correlate the degree of consistency between examination findings of the individual with knowledge of torture methods and their common after-effects used in a particular region.

2. Psychological Evidence:

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

XIII. Conclusions and Recommendations:

1. Statement of opinion on the consistency between all sources of evidence cited above (physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports, etc.) and allegations of torture and ill treatment

2. Reiterate the symptoms and/or disabilities that the individual continues to suffer as a result of the alleged abuse.
3. Provide any recommendations for further evaluation and/or care for the individual.

XIV. Statement of Truthfulness *(For Judicial Testimonies)*: For example, "I declare under penalty of perjury, pursuant to the laws of (XX country), that the foregoing is true and correct and that this affidavit was executed on X/X/X at (City), (State or Province)."

XV. Statement of Restrictions on the Medical Evaluation/Investigation *(For Subjects in Custody)*: For example, “The undersigned clinician(s) personally certify that they were allowed to work freely and independently, and permitted to speak with and examine (the subject) in private, without any restriction or reservation, and without any form of coercion being used by the detaining authorities;” or alternatively: “The undersigned clinician(s) had to carry out his/her/their evaluation/investigation with the following restrictions:...”

XVI. Clinician’s Signature, Date, Place

XVI. Relevant Appendices: e.g. Clinician’s ***Curriculum Vitae***, Anatomical Drawings for Identification of Torture and Ill Treatment, Photographs, Consultations, and Diagnostic Test Results, among others.